Alabama Medicaid Management Information System

Provider Manual
October 2007

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Quarterly Revision October 2007

This table contains a listing of pages containing changes made to the *Alabama Medicaid Provider Manual.* This version replaces the entire manual.

To update your paper copy of the manual, replace the entire manual.

Changes have been tracked throughout the provider manual and noted in the margins. Additions are easily identified by underlines and deletions by a ~~strikethrough~~.

To request additional copies of the *Alabama Medicaid Provider Manual*, contact the EDS Provider Assistance Center by calling 1(800) 688-7989.

You can also go to http://www.medicaid.alabama.gov to download a complete, updated, electronic version of the *Alabama Medicaid Provider Manual* from Medicaid's web site.

Find out more about the online version of the *Alabama Medicaid Provider Manual* in Chapter 1, Section 1.2, Using the Online Version of the Manual.

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Bookmark Usage Instructions

Bookmarks are used for easy navigation throughout the Alabama Medicaid Provider Manual. These bookmarks are located on a palette on the left side of your screen. To jump to a topic using its bookmark, click the bookmark icon or text in the palette that represents that topic.

Bookmarks can be subordinate to other bookmarks in their hierarchy; a higher level bookmark in this relationship is the parent, and a lower level bookmark is the child.

You can collapse a parent bookmark to hide all its children. When a parent bookmark is collapsed, it has a plus sign (+) next to it. If the bookmark you want to click is hidden in a collapsed parent, click the plus sign (+) next to the parent to show it.

1

1 Introduction

Thank you for your participation in the Alabama Title XIX Medicaid Program. The *Alabama Medicaid Provider Manual* has been developed to assist you in receiving reimbursement for providing medically necessary services to eligible Medicaid recipients living in the state of Alabama.

Please note this manual is not a legal description of all aspects of the Medicaid law. It is a practical guide for providers who participate in the Medicaid Program. Should there be a conflict between material in this manual and pertinent laws or *Alabama Medicaid Administrative Code* provisions governing this program, the latter are controlling.

The Alabama Medicaid Agency is the single state agency responsible for the administration of the Alabama Title XIX Medicaid program. The Alabama Medicaid Agency has contracted with EDS to be the fiscal agent for the Medicaid program. Medicaid and EDS developed this manual for Medicaid providers. EDS is responsible for maintaining and distributing the manuals to the Alabama Medicaid provider community.

The EDS Provider Relations Department is composed of field representatives who are committed to assisting Alabama Medicaid providers in the submission of claims and the resolution of claims processing concerns. If you have any comments or suggestions for improving this manual, please contact EDS Provider Relations at the following address:

EDS Provider Relations
P.O. Box 241685
Montgomery, AL 36124-1685
1 (800) 688-7989
e-mail: provrelations@alxix.slg.eds.com

This chapter describes how the manual is organized, how to access and use the online version of the manual, and the method for distributing and documenting changes to the manual.

1.1 How to Use this Manual

This section describes the organization of the *Alabama Medicaid Provider Manual* and provides tips for using the manual to resolve billing and eligibility-related questions.

1.1.1 Manual Organization

The *Alabama Medicaid Provider Manual* is divided into three parts:

Part I – Provider Information

The information in Part I is intended for all health care providers who are enrolled in the Alabama Medicaid Program and who provide services to Medicaid recipients. Specifically, Part I addresses the following:

- *Introduction*, which describes the purpose and organization of the manual
- *Becoming a Medicaid Provider*, which briefly describes the enrollment process required for participation in the Alabama Medicaid program
- *Verifying Recipient Eligibility*, which describes how to determine whether a recipient is eligible to receive Medicaid benefits, and how to interpret the eligibility verification response received through the Provider Electronic Solutions software or Automated Voice Response System (AVRS)
- *Obtaining Prior Authorization,* which describes how to submit a request for services requiring prior authorization
- *Filing Claims*, which informs providers how to correctly complete a claim form for submission to Medicaid
- *Receiving Reimbursement*, which describes the Explanation of Payment (EOP) statement, a report that lists claim and payment activity for a provider
- *Understanding Your Rights and Responsibilities as a Provider*, which describes fair hearings, utilization review, maintaining provider records, and other information regarding provider rights and responsibilities

Part II – Alabama Medicaid Services

Part II provides enrollment, billing, and reimbursement information specific to each program type identified by the Alabama Medicaid Agency. Each chapter within Part II describes a different program.

Providers who are unaccustomed to general billing or reimbursement requirements should refer to Part I before using the information in Part II.

Part III – Appendices

Part III contains referential information important to all providers, including the following:

- Guidelines for billing EPSDT, family planning, and managed care claims
- Samples of forms used by Alabama Medicaid providers
- Lists of codes and other data useful for providers

1.1.2 Tips for Using the Manual

This section provides information that can enhance your ability to quickly locate information in the manual. To make the manual easier to read, it includes standardized section numbering and use of bold, italics, and notes. Introductions to chapters and sections allow you to quickly determine whether a particular section contains the information you seek. The manual also contains an index and a table of contents to help you locate both broad topics and specific information quickly.

Section Numbering and Page Numbering

The first page of each chapter features a large chapter number, shaded in black, at the top right margin of the page. All major headings within chapters include section numbers. The section numbers may contain up to three heading levels, all of which are documented in the table of contents.

The header for each odd-numbered page identifies the chapter number. All pages also contain the chapter title. The footer of each page contains a unique page number, including the corresponding chapter number. Each chapter begins again at page one: for instance, Chapter 1 numbers 1-1, 1-2, 1-3; Chapter 2 numbers 2-1, 2-2; and so on.

Date Field

The bottom of each page contains a date field indicating when the page went to print. The date field includes the month and year of distribution (for instance, January 2004). Changes to the provider manual are distributed as change pages. The date at the bottom of each page reflects the date the policy changed or procedural information went into effect.

Use of Bold and Italics

To help you locate important information more quickly, chapter and section headings are designated by bold and italics. As much as possible, the section headings describe the content of the sections they introduce.

Index and Table of Contents

The provider manual features a table of contents that uses three heading levels. In the online version of the manual, these headings are referred to as “bookmarks.” You can position your cursor on a bookmark and click your left mouse button to jump to the corresponding page of the manual. For more information about the online version of the manual, please refer to Section 1.2, Using the Online Version of the Manual.

The paper version of the manual also contains an index. The online version of the manual features search capability, so an index is not included.

Notes

Throughout this document, note boxes and margin notes emphasize important details, messages, or references to other sections in the manual. Because the manual will be updated periodically, note boxes and margin notes do not contain specific page references; rather, they contain section references as appropriate. This way, as pages are added to the manual, you may still refer to the same section references to access important data quickly and efficiently.

NOTE:
Note boxes display like this.

General Writing Style

To make the manual easier to read and understand, the manual uses a standard writing approach that includes the following:

- Introductory paragraphs for each chapter and major section heading, which briefly but clearly describe the contents of the chapter or section, enabling you to scan the first few lines of a chapter or section to determine whether it contains the information you seek
- Shorter sentences and paragraphs that employ bullet lists where necessary, enabling you to quickly locate important information
- Tables and graphs, which can convey complex information more clearly than text

1.2 Using the Online Version of the Manual

For your convenience, a copy of the billing manual is available in online format. The online and paper versions of the manual have identical content. However, the online version includes enhanced features that allow you to access information more quickly. Some of these features include:

- Point-and-click access to all sections of the manual, allowing you to quickly locate information by section title
- Update tracking features, such as an update log and online notes indicating the exact location and nature of all modifications to the provider manuals
- Powerful online search capabilities, allowing you to locate information by keywords

Refer to the Section 1.3, Manual Update Log, for a description of the update log. Refer to Section 1.2.2, Benefits of Using the Online Manual, for more information about the other features described.

The manual may be downloaded from the Alabama Medicaid Web site at no charge.

1.2.1 Downloading the Online Manual

The online version of the manual is produced using Adobe® Acrobat™. Acrobat files are in a *portable document format* (*pdf*). A *pdf* file is platform-independent, meaning it may be viewed on a personal computer (PC) running on practically any platform. You may already be familiar with this type of file: the federal government uses *pdf* files as the standard for delivering documents over the Internet. For instance, anyone who has ever downloaded a tax form from the Internet has used a *pdf* file.

NOTE:

To use the online version of the manual, you must have **all** of the following:

- A PC with minimum hardware and software requirements, as listed below
- The Acrobat Reader™, available to you at no charge through the Alabama Medicaid Web Site or other sources on the World Wide Web (WWW)
- An Online version of the *Alabama Medicaid Provider Manual*

This section describes the PC hardware and software requirements, how to download the Acrobat Reader®, and how to download the online manual.

Hardware and Software Requirements

To use the online version of the *Alabama Medicaid Provider Manual*, your computer must meet, at a minimum, the following hardware and software requirements:

- **Windows System Requirements:** i486 or Pentium® processor-based personal computer with Microsoft Windows 95, Windows 98, or Windows NT 4.0 with Service Pack 3 or later. Requires 8 MB of RAM (16 recommended) on Windows 95 or 98; 16 MB of RAM (24 recommended) on Windows NT
- **Macintosh System Requirements:** Apple Power Macintosh computer with Apple System Software version 7.1.2 or later. Requires 4.5 MB of available RAM (6.5 recommended) and 8 MB of available hard-disk space
- **OS/2® System Requirements:** i386, i486, Pentium, or Pentium Pro processor-based personal computer with IBM® OS/2 Warp or Warp Connect 3.0 or later (IBM OS/2 Warp 4.0 recommended). Fixpak 26 required for printing using OS/2 Warp 3.0 or Warp Connect 3.0. Requires 4 MB of application RAM available to Acrobat Reader, 8 MB of RAM available for system, and 5 MB of hard-disk space plus 5 MB of temporary space available during installation. Netscape Navigator 2.02E or later for viewing *pdf* files inside a Web browser

Acrobat files are also viewable on other platforms. For a complete listing of system requirements, please refer to the Adobe home page. Click on the Download Acrobat Reader icon and scroll down the page to access the System Requirements link.

Acrobat Reader

To view a *pdf* file, you must have the Acrobat Reader installed on your PC, or you must be able to access the Reader through a Local Area Network (LAN) connection.

The Acrobat Reader is distributed free of charge, and is commonly bundled, or delivered in conjunction with other software. You may already have a copy of the Reader, acquired through downloading other files from the Web. If not, you may download a free copy of the Reader, along with the *Alabama Medicaid Provider Manual*, from the Alabama Medicaid Home Page.

Online *Alabama Medicaid Provider Manual*

These instructions are written for Internet Explorer. Other browsers may require slightly different procedures. The instructions assume you know how to access the WWW and how to perform a search.

Perform the following steps from your browser to download the manual:

Step 1 Access the Alabama Medicaid home page by choosing the Open option from the File menu. The Open dialog box displays.

Step 2 Enter the following address in the text box: http://www.medicaid.alabama.gov

Step 4 Click on the word Billing located across the top of the home page. The Alabama Medicaid Billing page displays.

Step 5 Click on Manuals. The Alabama Medicaid Manuals page displays. Click on the most current version.

Step 6 If your PC is not equipped with Acrobat Reader version 4.05 or higher, click on the Download Acrobat Reader Icon. The Adobe Acrobat Download page displays. Follow the instructions on the Adobe site, then return to the Alabama Medicaid Manuals page.

Step 7 If your PC is already equipped with Adobe Acrobat Reader version 4.05 or higher, you are ready to download the manual.

Step 8 Click on the appropriate Alabama Medicaid Provider Manual link.

Step 9 If the File Download dialog box displays, choose the Save the File to Disk option to save the manual to your PC. (You should save the manual to your hard drive, to CD, or to ZIP disk. The manual is too large to fit on a standard 1.44 MB 3½ diskette.)

Step 10 When the file has finished downloading, open it by double clicking on the file in Windows Explorer.

1.2.2 Benefits of Using the Online Manual

Although a paper version of the manual is familiar and easy to use, consider how the following advantages save you and your office staff time and money in the billing process.

Maintenance-free and Always at Your Fingertips

The online manual takes up no desk space. It can never be misplaced, and if it is inadvertently deleted, you can download another version. You will never need to insert new pages and throw away old ones; merely download a new version each time you are notified of changes to the manual.

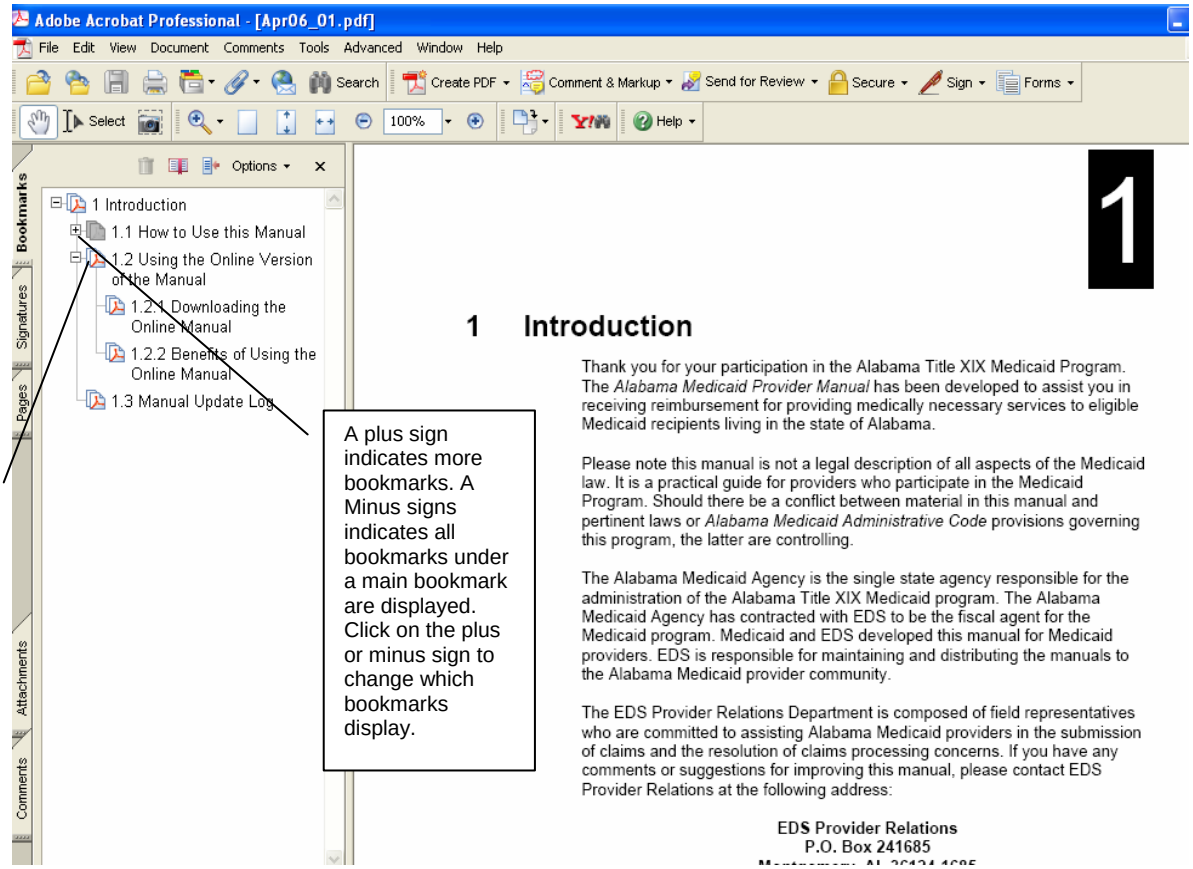
Customized Display Options

Although you cannot alter the contents of the online manual, you can modify how the manual displays online. Acrobat enables you to increase or reduce the font size, which can be helpful if you have vision problems. You may also customize other view options as available through the Acrobat Reader. The help feature resident in Acrobat Reader will guide you through using the Reader and customizing views.

Search and Browse Capabilities

The online manual features an online form of a table of contents that allows you point and click access to all the manual's sections. Acrobat calls each entry in this table of contents a bookmark. To view the bookmarks, select the Bookmark icon, the second icon from the left, on the Acrobat toolbar.

The bookmarks in the manual correspond to the section headings. Primary headings, such as the names of chapters, display as the first level of bookmarks. If a primary heading has secondary headings, a plus sign displays next to the heading.



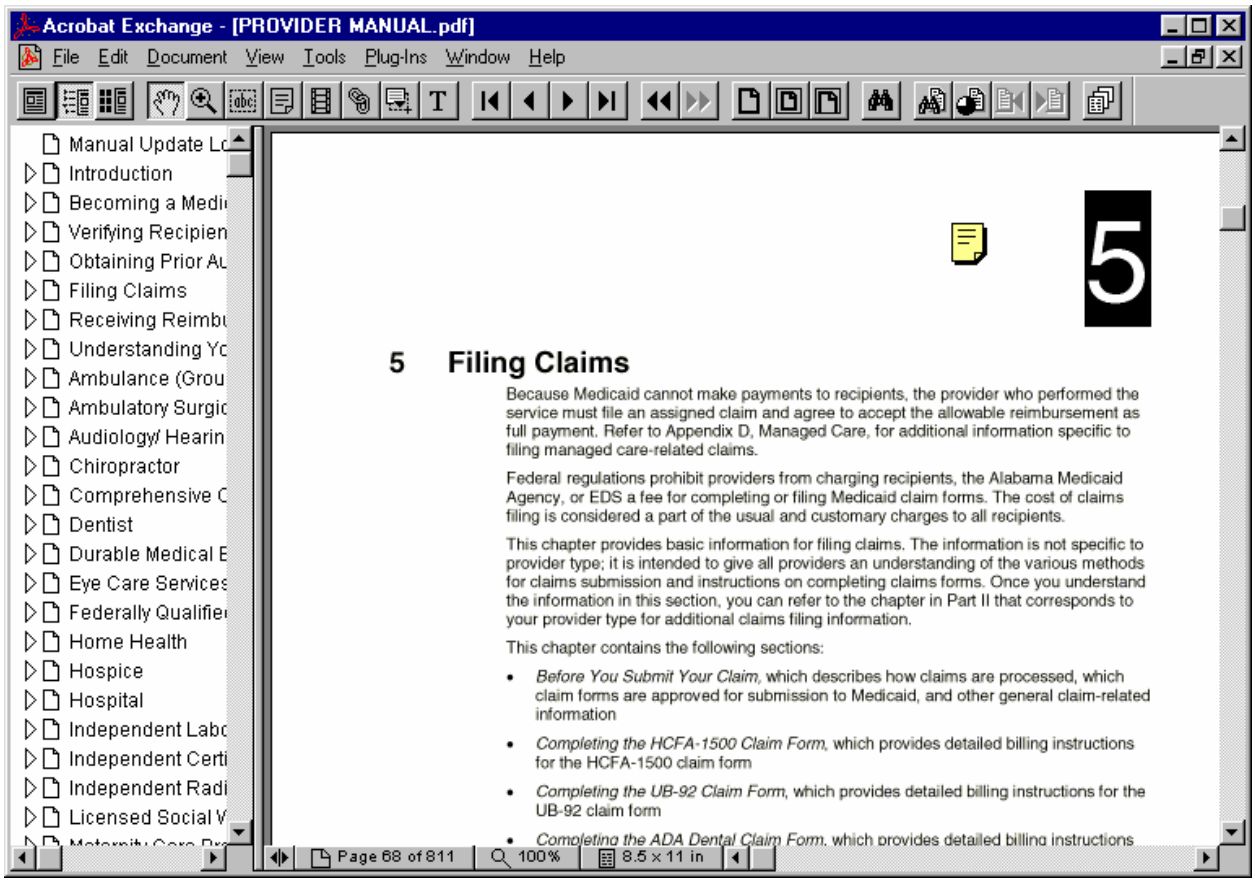
Click on a bookmark to go directly to a particular page in the document.

A plus sign indicates more bookmarks. A Minus signs indicates all bookmarks under a main bookmark are displayed. Click on the plus or minus sign to change which bookmarks display.

Simply click on the plus sign to view all headings beneath that heading level. To jump to a particular section of the manual, click on the corresponding bookmark.

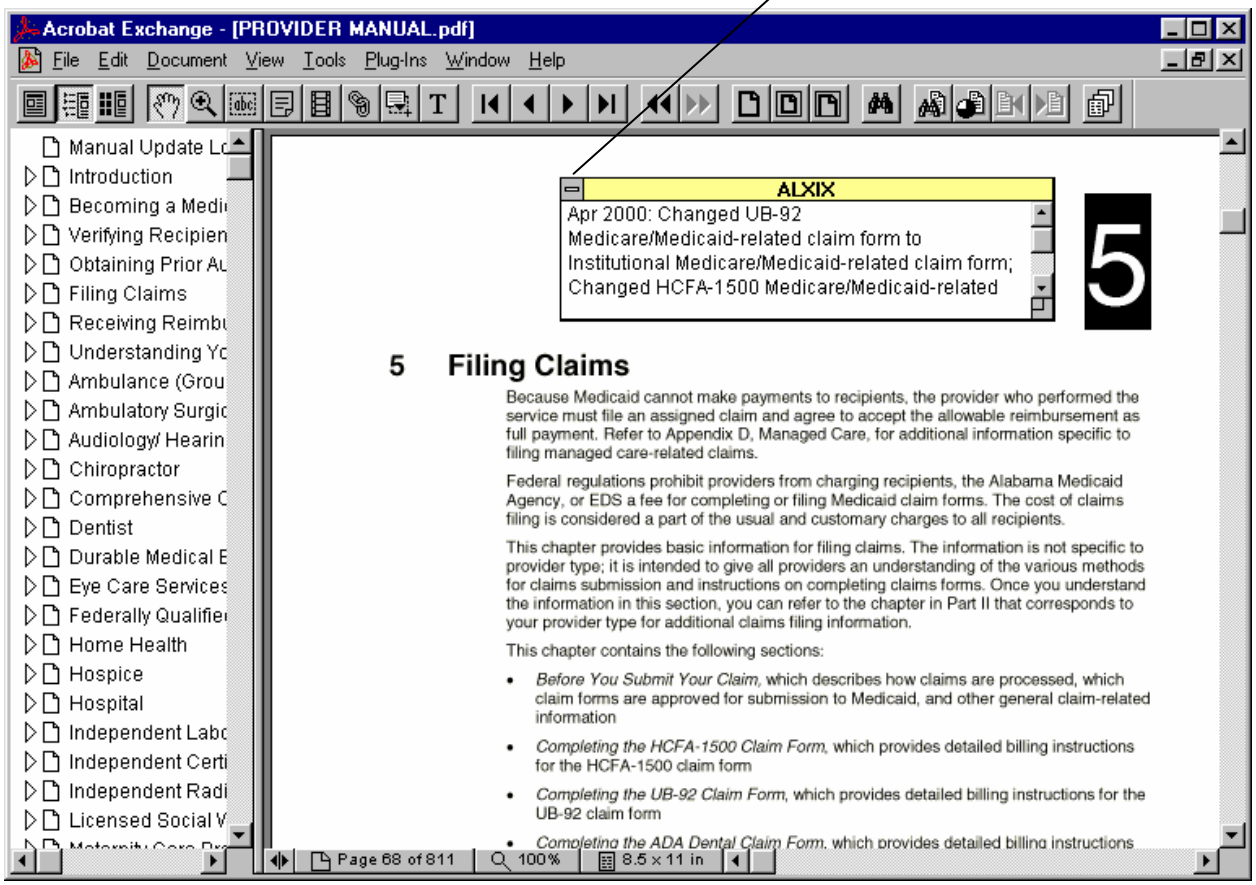
The online version of the manual also allows you to more thoroughly understand modifications to the provider manual. All updates are tracked in the update log, but are also indicated by the electronic notes feature.

For example, a note displays on the updated page.



When you double click the note, the update displays.

Click on the bar to close the note.



You can also access the powerful online search capabilities of Acrobat to quickly locate information by entering a keyword in the Find dialog box. Acrobat searches the entire manual and displays the first occurrence of the word. You can then search again to find the next occurrence.

Access the help functionality in the Acrobat Reader for further instructions on using Acrobat.

1.3 Manual Update Log

Periodically, EDS will make updates to this manual and mail updated pages to you. EDS also provides an updated Acrobat copy of the manual on the Alabama Medicaid home page (http://www.medicaid.alabama.gov).

The following Manual Update Log describes the updates and document pages that were added, modified, or deleted as a result of the updates. EDS sends a copy of this log with each paper copy of updated pages. The online copy of the manual also includes the manual update log, although the changed pages will already have been updated. Acrobat notes display on all individual page changes, or the beginning of each chapter or section replacement, in the online version of the manual. Please refer to Section 1.2.2, Benefits of Using the Online Manual, for more information about Acrobat's notes feature.

Affected Chapter	***Changes made on pages***
Chapter 1 Introduction	1-11, 1-12

NOTE:

Providers who maintain a paper copy of the manual should add or replace pages as updates occur. Providers who maintain the online version of the manual should download another copy. All providers will be notified by mail each time the manual is updated.

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2

2 Becoming a Medicaid Provider

EDS is responsible for enrolling providers in the Medicaid program and for maintaining provider information in the Alabama Medicaid Management Information System (AMMIS, usually referred to as the 'system' in this manual). Based on enrollment criteria defined by Medicaid, EDS receives and reviews all applications. Each application is approved, returned, or denied within five business days of receipt.

Most readers of this manual will be current Alabama Medicaid providers who have already completed the enrollment process; however, this chapter briefly discusses how to request an application, where to send a completed application, and how to track the progress of an application. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for a description of how to notify EDS of changes to provider enrollment information.

Only physicians who are fully licensed and possess a current license to practice medicine may enroll to become an Alabama Medicaid Provider.

Physicians who are participating in a Residency Training program may enroll and receive a pseudo Medicaid license number that must be used on prescriptions issued to Medicaid recipients. To request a pseudo license number, in-state providers who are not yet licensed by the Alabama Board of Medical Examiners must complete the Resident Certification Form and mail it to EDS at the address indicated in Section 2.1, Requesting and Receiving an Application. The form cannot be faxed due to the requirement of original signatures. Upon receipt of a Resident Certification Form, EDS Provider Enrollment staff reviews the information and makes the decision to assign or deny assignment of a pseudo license number. When a pseudo license number is assigned, the Residency Program to which the provider is associated will receive a copy of the form showing the pseudo number assigned. Pseudo license numbers are to be used only for the purpose of prescribing medications for Alabama Medicaid recipients. The pseudo license number is to be utilized only by the resident to which the pseudo number is assigned. The Resident Certification Form can be downloaded from the Alabama Medicaid Web site. Medicaid's web site address is indicated in the Note box on page 2-2.

Physicians participating in an approved Residency Training program may not bill for services performed as part of the Residency Training program.

Supervising physicians may bill for services rendered to Medicaid recipients by residents who are rendering services as part of (through) the Residency Training program. See Chapter 28 for more information.

2.1 Requesting and Receiving an Application

A provider of medical services (including an out-of-state provider) who wants to be eligible for Medicaid reimbursement must complete the required Medicaid provider enrollment application and enter into a written provider agreement with the Alabama Medicaid Agency. If a provider has more than one location, each location receives an individual provider number. If a group consists of more than one physician, each physician receives an individual provider number.

The EDS Provider Enrollment Department is responsible for supplying the application. To receive an application, providers may telephone, e-mail, or mail an application request to the address and phone number below:

EDS Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124-1685
1 (888) 223-3630
e-mail: enrollment@alxix.slg.eds.com

EDS will send an application within two business days of receipt of the request.

NOTE:

You can download an application from the Alabama Medicaid Web site at http://www.medicaid.alabama.gov . Follow the instructions provided in Section 1.2.1, Downloading the Online Manual. Both the online manual and the application are provided in Adobe® Acrobat™.

Effective October 1, 1999, Medicaid began using a new form for provider enrollment. It is important to file applications as soon as possible for new enrollments and changes in enrollment status. Physicians and other individual practitioners should not wait until they have obtained Medicare approval to file a Medicaid application. The provider will be assigned a Medicaid effective date which may change to the Medicare effective date when the provider has enrolled with Medicare.

2.2 Completing and Submitting the Application

Providers must complete the provider application and include any required attachments as directed in the accompanying instructions. Once the application is complete, providers should mail the application to EDS Provider Enrollment, at the address listed in Section 2.1, Requesting and Receiving an Application.

➢ To learn about enrollment requirements specific to your provider type, please refer to the appropriate chapter in Part II of this manual.

EDS reviews the application and approves, denies, or returns the application based on criteria set by Medicaid. Providers must correct and resubmit returned applications for approval prior to enrollment in the Alabama Medicaid Program.

A Medicaid provider number is issued when EDS, based upon the qualifications set forth by Medicaid, determines that a provider qualifies for participation.

Providers will not be reimbursed for claims submitted without a valid provider number.

NOTE:

A provider who does not submit claims within a consecutive 24-month period will be disenrolled from the Medicaid program. To return to an active status, the provider must re-enroll.

2.3 Tracking the Application

EDS tracks the status of each application as it moves from initial review to approval or denial. Upon receipt of the application, EDS date stamps the application and enters the provider name, contact name, contact phone number, and date received into a tracking system. A member of the EDS enrollment team reviews the application based on state-defined criteria and makes a determination within five business days.

- If the application is approved, EDS generates a letter with the new provider number and then mails the letter and a provider manual to the provider within two business days of approval.
- If the application is denied, EDS sends a letter to the provider listing the denial reason and providing a contact at Medicaid through which the provider may appeal the decision.
- If the application is incomplete, EDS returns it accompanied by a letter listing the necessary information EDS requires to complete the enrollment process.

When EDS returns an application to the provider, an enrollment representative logs the return date in the tracking system. When the provider corrects and returns the application, EDS logs the date returned.

Providers may determine the status of their applications by contacting EDS Provider Enrollment at 1 (888) 223-3630 (out of state providers call (334) 215-0111).

To check on the status of the application, the enrollment representative will ask for the provider's name, telephone number, and Social Security Number (SSN) or Federal Identification Number (FEIN).

EDS maintains applications and includes additional correspondence received from providers on file.

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3

3 Verifying Recipient Eligibility

The Alabama Medicaid Program is a medical assistance program that is jointly funded by the federal government and the State of Alabama to assist in providing medical care to individuals and families meeting eligibility requirements. Income, resources, and assets are considered when determining Medicaid eligibility.

Medicaid-eligible persons are referred to as recipients in the Alabama Medicaid Program. Medicaid reimburses providers for services rendered while the recipient is eligible for Medicaid benefits.

NOTE:

Providers who do not verify a recipient's eligibility prior to providing service risk a denial of reimbursement for those services. For this reason, it is important that every provider understand the terminology and processes associated with verifying recipient eligibility.

This chapter consists of three sections:

- *General Medicaid Eligibility*, which describes who determines eligibility and identifies the valid types of recipient identification
- *Confirming Eligibility*, which describes the various methods for verifying eligibility. *Please note that possession of a Recipient Identification (RID) card does not guarantee eligibility*
- *Understanding the Eligibility Response*, which provides explanations for the various programs and limitations that define recipient eligibility. **Providers should pay particular attention to this section, because there are several restrictions, limitations, and programs that may limit eligibility**

3.1 General Medicaid Eligibility

This section describes who grants eligibility, what constitutes Medicaid eligibility, and what identification recipients must provide.

3.1.1 Granting Eligibility

Medicaid eligibility is determined by policies established by and through the following agencies:

- Department of Human Resources
- Social Security Administration
- Alabama Medicaid

Names of eligible individuals and pertinent information are forwarded to Medicaid who, in turn, makes the information available to EDS. Any questions

concerning general or specific cases should be directed in writing to Medicaid or the appropriate certifying agency.

3.1.2 Eligibility Criteria

A person may be eligible for medical assistance through Medicaid if the following conditions are met:

- The applicant must be eligible for medical assistance for the date the service is provided. **Services cannot be paid under the Medicaid program if they are provided to the recipient before the effective date of his or her eligibility for Medicaid, or after the effective date of his or her termination of eligibility. Having an application in process for Medicaid eligibility is not a guarantee that the applicant will become eligible.**
- The service must be a benefit covered by Medicaid, determined medically necessary (exceptions are preventive family planning and EPSDT screenings) by the Medicaid program, and performed by an approved provider of the service.
- Applicants may be awarded retroactive eligibility to cover a time period prior to the application and award for eligibility. When applicants are awarded eligibility, they receive an award notice that includes the effective dates of coverage. The notice indicates whether retroactive eligibility has been awarded. Providers may contact the EDS Provider Assistance Center at 1(800) 688-7989 to verify retroactive eligibility dates.

Medicaid does not guarantee future eligibility. Providers should not assume future eligibility based on current eligibility. Providers who do not verify eligibility prior to providing a service risk claim denial due to ineligibility.

NOTE:

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. Please refer to Section 3.3, Understanding the Eligibility Response, for more information.

3.1.3 Valid Types of Recipient Identification

This section describes the unique number used to identify Alabama Medicaid recipients and the valid forms of identification required for verifying recipient eligibility. Providers should begin the verification process by asking the recipient to present one of the following forms of identification:

- Plastic Alabama Medicaid Program identification card
- Notification letter for unborn or newborn child
- Notification letter for a recipient without a social security number
- Notification letter (or system print) for a recipient with retroactive eligibility
- Eligibility notification (in the form of a report) for nursing home residents

In addition to those identifications listed above, photo identification, such as a driver's license, should be requested from adult recipients, especially those without one of the above forms of eligibility notification.

NOTE:

Providers are encouraged to check photo identification of adult recipients, even if they have a plastic card or notification letter. If the recipient does not have a photo ID, providers should verify that the date of birth, sex, and race seem appropriate for the recipient requesting the service. This helps guard against fraud: for example, when an adult attempts to use a child's card.

Providers are responsible for verifying the identity of the recipient before accepting the card. **If at any time you suspect that the person receiving the service is not the person to whom the card belongs, report the occurrence to the Medicaid Fraud Hotline at the Alabama Medicaid Agency. The toll free number is 1- 866-452-4930 and select the fraud option.**

Recipient Identification (RID) Number

Medicaid recipients are issued a unique, 13-digit Recipient ID number (RID). This number is composed of a twelve-digit number plus a check digit. The RID is used to verify eligibility, submit requests for prior authorization, and submit claims. The RID is maintained on the Medicaid system and all pertinent recipient information is associated with this unique number.

Although care is taken to ensure that recipients are issued only one RID, there are instances where multiple RIDs may be issued for the same recipient. This is especially likely when Medicaid issues a temporary RID for recipients who do not have a Social Security Number. When these recipients provide Medicaid with their SSN, they are issued a permanent plastic card and RID.

When you verify eligibility, the RID you enter and the ‘Current ID and check digit’ value returned by the system for the recipient may differ. When this occurs, it is often because a recipient was issued a temporary RID but has since been issued a permanent RID. Medicaid links all RIDs for a recipient and returns the most current RID as part of the eligibility verification process. Either the original RID or the current RID may be used to submit the claim or verify eligibility.

Plastic Identification Cards

Most Alabama Medicaid recipients have permanent plastic Medicaid cards. These cards are white, blue, and green and resemble a credit card. Each card is embossed on the front (with raised lettering) with the following:

- Recipient Identification (RID) number
- Name
- Date of birth
- Sex and race
- Two-digit card number

The magnetic stripe on the back of the card has been encoded with the RID for use with a point of service device or card swipe attached to a PC.

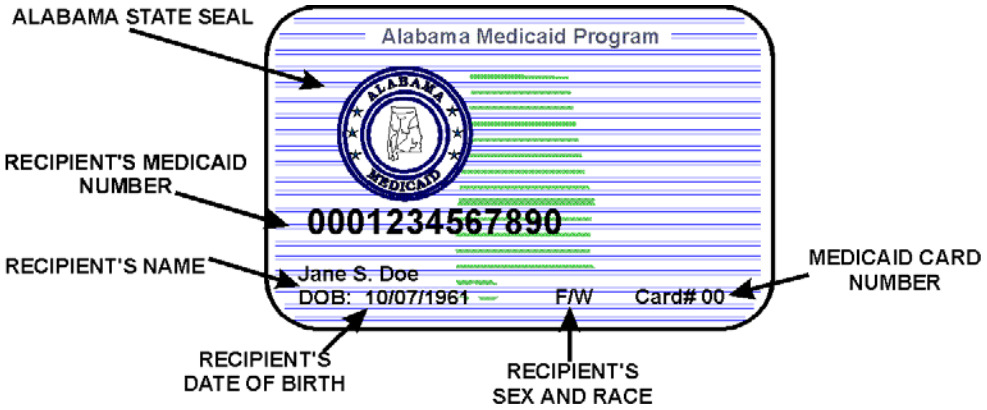
New recipients are issued permanent Medicaid cards within 10-14 working days of eligibility determination.

Providers should check the two-digit card number against the card number returned as part of the eligibility verification response. The first card issued has a number of ‘00’; the second, ‘01’; and so on. If the numbers do not match (for instance, if the plastic card number is ‘00’ but the eligibility response returns a card number of ‘01’) please notify the recipient they are using an old card and ask to see photo identification.

NOTE:

The Medicaid Agency has a Recipient Call Center available to assist recipients with questions regarding their Medicaid cards. The recipient Call Center may be reached at 1(800) 362-1504.

Below is a sample Medicaid card:



Notification Letters

Recipients may not have a permanent plastic card for some of the following reasons:

- Recipients without a Social Security Number (SSN), such as unborn children, newborns, foster children, or some children who have been adopted
- Recipients with retroactive eligibility, but not current eligibility
- Recipients residing in a nursing facility who are not certified as QMB only

Examples of notification letters for recipients who do not have permanent plastic cards follow on the next 4 pages.

Eligibility Notification Letter for Newborns/Unborns

Alabama Medicaid Agency

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

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

OCTOBER 1, 1999

PARENT/GUARDIAN OF
UNBORN C DOE
123 OAK LANE
MONTGOMERY, AL 12345-5555

MEDICAID: 000-555-05-5555-1

Dear UNBORN C DOE,

This is your unborn baby's Medicaid Eligibility card. Keep this letter and show it to the doctor's staff, the hospital staff, or whoever gives care to your baby. They will need to see this letter to make sure you are eligible to have Medicaid pay for your new baby's care. As soon as possible after your baby is born, give the baby's name and birth date to the agency that certified you for Medicaid. Once you receive the baby's Social Security Card, contact your worker to provide the number. Then you will get a plastic Medicaid card for your child. If you have any questions about your baby's Medicaid, call 1-800-362-1504. The call is free.

PROVIDER: To verify eligibility, call 1-800-727-7848.

Eligibility Notification Letter for Recipients without a Social Security Number

Alabama Medicaid Agency

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

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

DO NOT THROW AWAY THIS MEDICAID LETTER

OCTOBER 1, 1998

TEST A. RECORD
SHADY ACRES N H
123 EVERGREEN ST.
MONTGOMERY, AL 36103-0000 MEDICAID: 999-999-99-9999

Dear TEST A. RECORD,

This letter is to be used as a temporary Medicaid card until you give your social security number to the agency that certified you for Medicaid. Then you will get a permanent plastic card that you can use as long as you remain eligible for the program. If you have questions about your Medicaid, call 1-800-362-1504. The call is free.

PROVIDER: To verify eligibility, call 1-800-727-7848

Eligibility Notification for Recipients with Closed or Retroactive Eligibility

Alabama Medicaid Agency

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

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

OCTOBER 1, 1999

PARENT/GUARDIAN OF
JOHN R. DOE
123 MAIN STREET
MOBILE, AL 36606

MEDICAID NUMBER: 000-000-00-0000-0

The person named above was or is eligible for Medicaid for the most recent dates shown below:

04/97 – 05/97-Regular Medicaid	02/97 – 02/97-Regular Medicaid
06/95 – 08/96-Regular Medicaid	

Retroactive Eligibility Issued Within the Last 12 Months:

Date Issued	From To	Date Issued	From-To	Date Issued	From-To
05/02/97	02/97 02/97				

Pregnancy related services limited to:
Claims submitted one year beyond the date of service must be filed within one year of the date issued.

Eligibility Notification for Recipients in Nursing Homes

Nursing facility residents certified as QMB-only receive permanent plastic cards; however, other Medicaid-eligible nursing facility residents do not receive plastic cards. Each month, Medicaid sends nursing facilities a list of eligible recipients residing in that facility.

A sample list displays below:

Alabama Medicaid Agency

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

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

OCTOBER 1, 1999

STATE OF ALABAMA
ALABAMA MEDICAID AGENCY
501 DEXTER AVENUE

FACILITY: JOHN DOE MANOR INC.
123 MAIN STREET
MONTGOMERY, AL

THE PEOPLE LISTED BELOW, EXCEPT AS NOTED, ARE ELIGIBLE FOR MEDICAID FOR THE MONTH - JULY, 1999 PROVIDER #

ELIGIBLE PERSON	JANE SMITH	JANE H. JONES	ROBERT JOHNS	JILL. DOE
MEDICAID NUMBER	999-999-99-9999	111-111-11-1111	444-444-44-4444	777-777-77-7777
SEX	F	F	F	F
RACE	W	W	W	W
BIRTHDATE	07/06/23	12/23/20	08/30/13	09/04/10
NEW 1ST				
AWARD ELIG				
AGENCY CODE	51	51	51	51
AID CAT	1	1	1	1
QMB	QMB	QMB	QMB	QMB
MEDICARE NUMBER	111111111D	222222222A	333333333A	444444444A
MEDICARE TYPE	A&B	A&B	A&B	A&B
INS. CODE	T-P	T-P	Q	S-P

\# RESTRICTED TO HUMANA FOR INPATIENT HOSPITAL SERVICES UNLESS EMERGENCY OR HUMANA PRIOR APPROVED.

* CERTAIN NURSING HOME SERVICES ARE RESTRICTED FOR THIS INDIVIDUAL. THIS PERSON IS ELIGIBLE FOR OTHER MEDICAID.

NOTE:

Only the first position of the aid category appears on this report. In the future, the full two-position aid category will appear.

3.2 Confirming Eligibility

Whenever possible, providers should verify eligibility prior to providing service. To verify eligibility, providers should perform the following:

Step 1 Request to see the recipient's plastic card, or a copy of the eligibility notification letter.

Step 2 Ask to see a driver's license or other picture identification for adult recipients.

Step 3 Perform eligibility verification using one of the methods described in Section 3.2, Confirming Eligibility.

Step 4 Review the entire eligibility response, as applicable, to ensure the recipient is eligible for the service(s) in question. Please note that the eligibility response provides lock-in, third party, and managed care information. You need all the available information to determine whether the recipient is eligible for Medicaid.

Step 5 **Maintain a paper copy of the eligibility response in the patient's file to reference, should the claim deny for eligibility.**

If the claim denies for ineligibility, the provider may contact the EDS Provider Assistance Center to review the eligibility verification receipt and discuss the reasons the claim denied.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by EDS
- Automated Voice Response System (AVRS) at 1 (800) 727-7848
- Contacting the EDS Provider Assistance Center at 1 (800) 688-7989
- Web Server https://almedicalprogram.alabama-medicaid.com/secure.

Appendix B, Electronic Media Claims Guidelines, provides an overview of the EDS Provider Electronic Solutions software, which providers may use to verify recipient eligibility and submit claims. Instructions for requesting the software are also included in this appendix.

Providers who use a billing service may be able to verify eligibility through the billing service's software, providing the service obtained a copy of the vendor specification. Please refer to Appendix B for contact information.

Appendix L, AVRS Quick Reference Guide, provides instructions for using AVRS to verify recipient eligibility. Providers can obtain a faxed response verifying eligibility by following the instructions provided.

Web User Guide provides instructions for using web server to verify recipient eligibility. Instructions for accessing and login are also included in the guide.

NOTE:

Calling EDS is not the preferred method for verifying eligibility. The Provider Assistance Center is intended to assist providers with problem claims and issues requiring further research. You can verify eligibility more quickly and completely by using the Provider Electronic Solutions software, or AVRS.

3.3 Understanding the Eligibility Response

When you use Provider Electronic Solutions software, or AVRS to verify eligibility, the system returns a detailed eligibility response. You will receive confirmation of the information displayed on the recipient's plastic card, along with verification that the recipient is eligible or ineligible for services performed on the requested From Date of Service (FDOS). The eligibility response also returns the following information:

- Recipient's aid category
- Lock-in information
- Managed Care or Medicare affiliation, if applicable
- Third party information

This section provides a description of each as it applies to recipient eligibility.

3.3.1 Alabama Recipient Aid Categories

NOTE:

Programs such as Managed Care and Maternity Care, and restrictions such as lock-in, are not indicated by aid category. You must review and understand the entire eligibility response before determining the recipient is eligible for the proposed service.

There are many valid recipient aid categories. Below is a listing of aid categories that indicate restrictions. **Recipients with aid categories not identified in the following lists receive full Medicaid benefits.**

Partial Coverage

The following aid categories denote partial coverage:

5A Pregnancy-related services, family planning, and postpartum services only

5B Pregnancy-related services, postpartum, and family planning, plus Medicare deductibles and coinsurance for other services that Medicare covers

5C Pregnancy-related services, postpartum, and family planning, plus payment of the Medicare part B premiums

50 Family planning-related services only

58 Emergency Services for aliens, delivery/childbirth only

Medicare deductibles and coinsurance (cover services only if Medicare pays on the services) QMB-only (Category 1 recipients are described in Section 3.3.6, Medicare)

95 Medicare deductibles and coinsurance (cover services only if Medicare pays on the services) QMB-only (Category 1 recipients are described in Section 3.3.6, Medicare)

R2 Medicare deductible and coinsurance (cover services only if Medicare pays on the services) QMB-only (Category 1 recipients are described in Section 3.3.6, Medicare)

R4 Pregnancy-related services, family planning, and postpartum services only

R5 Pregnancy-related services, family planning, and postpartum services only (plus Medicare deductibles and coinsurance for other services that Medicare covers - retro)

R6 Emergency Services for aliens, delivery/childbirth only

Medicare Coverage

Category 2: See the description of Category 2 recipients in Section 3.3.5, Medicare.

The following aid categories denote full Medicaid coverage and ALL Medicare coinsurance and deductibles:

14	24	31	44	56	R3
15	25	33	45	57	R8*
17	27	35	47	59	
1E	2A	37	4A	5H	
	2E	3C	4E	5L	
		3D	4Q		
		3H	SQ		
		3K	TQ*		

Category 3: See the description of Category 3 recipients in Section 3.3.5, Medicare.

The following aid categories denote full Medicaid coverage, and coinsurance and deductibles ONLY for Medicaid-covered services up to Medicaid's benefit limit:

12	22	3E	42	5D
13	23	3F	43	5J
18	28		48	5M
1D	2B		4B	R7
	2D		4D	
			4L	
			SL	
			TL*	

*** These aid categories cover Private Duty Nursing.**

Special Coverage

The following aid categories denote full Medicaid coverage that includes private duty nursing services for adults.

Private Duty Nursing Service recipients are identified as adults who were formerly receiving private duty nursing services through the EPDST Program under the Medicaid State Plan, for whom private duty nursing services continue to be medically necessary based upon approved private duty nursing criteria. Waiver services provided are full Medicaid plus private duty nursing, personal care/attendant service, medical supplies, assistive technology, and targeted case management. Recipients may or may not also have Medicare. If they do have Medicare the eligibility verification will denote Medicare eligibility.

TT-R7 Full Medicaid plus private duty nursing services

TQ- R8 Full Medicaid coverage, all Medicare co-insurance and deductibles plus private duty nursing services

TL-R7 Full Medicaid coverage and co-insurance and deductibles only for Medicaid covered services up to Medicaid's benefit limit plus private duty nursing services

No Coverage

Recipients with aid categories 92, 93, 97 or R0 (zero) receive no Medicaid coverage.

3.3.2 Lock-in

The Alabama Medicaid Agency closely monitors program usage to identify recipients who may be potentially overusing or misusing Medicaid services and benefits. For those identified recipients, qualified Alabama Medicaid staff performs medical desk reviews to determine overuse or misuse of service. If the review indicates overuse and/or misuse of services, the recipient may be locked in to one physician and/or one pharmacy. Additional limitations may be placed on certain medications such as controlled drugs and/or other habit-forming drugs.

Recipients who are placed on lock-in status are notified by certified letter of the pending restriction. They are asked to contact the Recipient Review Unit at the Alabama Medicaid Agency with the names of their chosen physician and/or pharmacy. The physician and pharmacy are contacted by the Recipient Review Unit to determine if they will agree to serve as primary care physician/designated pharmacy while the recipient is restricted.

Referring Recipients with Lock-in Status

Physicians who serve as a restricted recipient's lock-in provider should use the Restricted Recipient Referral Form (SUR-1-92 or Form 192), provided by Medicaid to the lock-in physician, when referring the restricted recipient to another physician. The lock-in physician should retain the white copy in the recipient's file. The lock-in physician should mail the yellow copy to the referred physician or provide the copy to the restricted recipient. The referral may cover one visit or multiple visits so long as those visits are part of the plan of care and are medically necessary. No referral can last more than one year. Additional restricted recipient referral forms may be obtained by calling the Recipient Review Unit at the Alabama Medicaid Agency at 1 (334) 242-5430.

NOTE:

The message indicating the recipient is restricted is part of the general eligibility response provided AVRS or Provider Electronic Solutions software.

A copy of the Recipient Referral Form is shown on the next page.

ALABAMA MEDICAID AGENCY

Restricted Recipient Referral Form

Name of Referred Physician _____

Recipient's Name _____

Recipient's Medicaid Number _____

Date of Referral _____

Reason for Referral _____

_____

Primary Physician's Medicaid Provider Number _____

Signature of Primary Physician _____

When billing Alabama Medicaid, the referred physician should place the Primary Physician's Medicaid Provider Number in Block 17a of the CMS-1500 claim form to be paid for the services.

White copy should be retained in the primary physician's office.

Yellow copy should be retained in the referred physician's office.

SUR-1-92
Form 192 (Revised 4/24/96)

3.3.3 Managed Care

During the eligibility verification process, providers should be aware of the Managed Care information that Medicaid provides. AVRS and Provider Electronic Solutions software reports Managed Care enrollment status under two different managed care plans:

- Medicare Complete

Refer to Chapter 39, Patient 1st, for more detailed information about managed care programs.

Patient 1st

Patient 1st is a statewide Primary Care Case Management (PCCM) system. Medicaid recipients eligible for this program are assigned to a Primary Medical Provider (PMP) who is responsible for primary care services and authorization of referrals.

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is enrolled in Patient 1st:

Verification of the recipient's enrollment in Patient 1st

- PMP's provider number
- PMP's telephone number (and 24-hour phone number, if applicable)

The PMP must be contacted to authorize any service requiring a referral. Chapter 39, Patient 1st, provides information on referrals. Once the referral is obtained, the claim is filed directly to EDS for processing.

Maternity Care Program

The Maternity Care Program is a statewide program that covers maternity services. The state is divided into 14 districts with a Maternity Care Primary Contractor in each district. The primary contractor is responsible for the coordination of care for recipients enrolled in the program.

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is eligible for the Maternity Care Program:

- Primary contractor's provider number
- Primary contractor's telephone number

Claims for services covered under this program should be filed directly to the primary contractor. See Chapter, 24, Maternity Care, for more information on the maternity care program.

Medicaid's Medicare Advantage Managed Care Plan

There are currently four companies who contract with the Alabama Medicaid Agency and offer Medicare Advantage coverage in Alabama – HealthSpring's Seniors First, United HealthCare's Medicare Complete, Viva Health's VIVA Medicare Plus and Blue Cross/Blue Shield of Alabama's Blue Advantage. When one of these companies notifies Medicaid that a Medicaid recipient has enrolled in their Medicare Advantage Plan, Medicaid makes a premium payment to the applicable plan. This payment covers all Medicare coinsurance and deductibles. Therefore, neither Medicaid nor the recipient will pay any co-payments, coinsurance or deductibles for Medicare services incurred during the time that the individual is enrolled in Medicaid's Medicare Advantage Plan.

Claims can be submitted to Medicaid for copays, deductibles or coinsurances for dates of service that are prior to or after the dates that Medicaid has paid a premium to one of the four Plans listed above. These claims should be billed on a Medicare/Medicaid crossover claim and will be processed like any other Medicare paid claim. (See Section 5.7.1 for specific billing instructions)

There are several Medicare Advantage Plans that are servicing Medicaid recipients. However, the four Plans mentioned above are the only ones with whom Medicaid has a contract to pay premiums. Since Medicare Advantage Plans pay in place of Medicare, any secondary claims to Medicaid for copays, deductibles or coinsurance should be billed on a Medicare/Medicaid crossover claim and will be processed by Medicaid in the same manner as a Medicare paid claim. (See Section 5.7.1 for specific billing instructions)

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is enrolled in a Medicare Advantage Plan for which Medicaid is making a capitation payment:

- Verification of the recipient's enrollment in a Medicare Advantage Plan
- Plan telephone number

Claims for services covered under this plan must be filed directly to the applicable Medicare Advantage Plan.

3.3.4 Benefit Limits

The Alabama Medicaid Agency establishes annual benefit limits on certain covered services. Certain services are excluded, such as services rendered as a result of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. The EPSDT program covers recipients under 21 years of age. SOBRA pregnant women under 21 are not covered under EPSDT. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

NOTE:

Aid Categories 5A, 5B, 5C, 50, R4, R5, 58 and R6 are not covered under EPSDT.

The table below describes the benefit limitations documented as part of eligibility verification.

Benefit	***Limitation***
Inpatient hospital days	16 per year
Outpatient hospital days	3 per year
Physician office visits	14 per year
Eyeglass frames	1 every other year for recipients 21 years and older
Eyeglass lenses	1 every other year for recipients 21 years and older
Eyeglass fitting exams	1 exam every other year for recipients 21 years and older
Eyeglass exams	1 every other year for recipients 21 years and older
Home health visits	104 per year
Ambulatory surgery center	3 per year
Dialysis services	156 per year

NOTE:

Refer to specific program chapters for additional benefit limitation. To verify benefit limits, refer to Appendix B, Electronic Media Claims (EMC) Guidelines, or Appendix L, AVRS Quick Reference Guide.

3.3.5 Medicare

Medicare, the federal health insurance program for the aged and disabled, covers certain institutional (Part A) and medical (Part B) benefits for eligible beneficiaries. The Title XIX Medicaid Program pays the Part B Medicare monthly premiums for Medicaid/Medicare eligible recipients through a buy-in agreement with the Social Security Administration (SSA). As a result of the Medicare Catastrophic Coverage Act, there are three different categories of Medicare recipients for which Medicaid is responsible for the deductible and/or co-insurance:

Category	*Description*
Category 1 QMB-only Medicare recipients	QMB-only Medicare recipients are identified as QMB ONLY by using the Provider Electronic Solutions software, AVRS (Automated Voice Response System) or the Provider Assistance Center. These recipients are eligible only for crossover services and ARE NOT eligible for Medicaid only services. That is, if Medicare covers the service, Medicaid will consider for payment the deductible and/or co-insurance. Premiums and copayment will be considered for payment if the individual is enrolled in a Medicare Advantage Plan.
Category 2 QMB Medicare/Medicaid recipients	QMB Medicare/Medicaid recipients are identified as having Medicaid and QMB (QMB+) when eligibility is verified through the Provider Electronic Solutions software, AVRS, or the Provider Assistance Center. These recipients are eligible for the same benefits as QMB-only recipients (category 1) and Medicaid/Medicare recipients (category 3).
Category 3 Medicare/Medicaid recipients	Medicare/Medicaid recipients who do not qualify as QMB are identified as having part ‘A’, ‘B’, or ‘A & B’ when their eligibility is verified through the Provider Electronic Solutions software, AVRS, or the Provider Assistance Center. Medicare-related claims for Medicare/Medicaid recipients will be paid only if the services are covered under the Alabama Medicaid Program.

NOTE:

A QMB (Qualified Medicare Beneficiary) recipient is a Part A Medicare beneficiary whose verified income does not exceed certain levels.

Part A Medicare/Medicaid Claims - Medicaid will pay the Medicare co-insurance and deductible for services covered by Medicare for QMB recipients. For non-QMB recipients, Part A claims are limited to those services that are covered benefits under Medicaid and would have been paid had the recipient not been eligible for Medicare. Medicaid will not pay Medicare coinsurance and deductibles for individuals enrolled in Medicaid’s managed care program for Medicare Advantage enrollees. For these individuals, Medicaid’s premium payment covers Medicare coinsurance and deductibles.

Part B Medicare/Medicaid Claims – Effective for claims with date of service November 11, 1997 and after: For QMB recipients, Medicaid will pay Medicare coinsurance and deductibles only for services covered by Medicare and only to the extent of the lesser or lower of Medicaid and Medicare reimbursement. Ambulance providers will be paid the full deductible and coinsurance amounts. For non-QMB recipients, any Medicaid noncovered services will be denied. In no instance will total reimbursement to the provider (Medicare plus Medicaid) exceed the lesser of the total Medicaid allowed amount or the Medicare paid amount. If the amount allowed by Medicaid is less than or equal to the amount paid by Medicare, Medicaid will pay nothing for the procedure. Medicaid will not pay Medicare coinsurance and deductibles for individuals enrolled in Medicaid's Medicare Advantage premium program. For these individuals, Medicaid's premium payment covers Medicare coinsurance and deductibles.

3.3.6 Third Party Liability

Providers should verify whether a Medicaid recipient has other insurance prior to submitting a claim to Medicaid. Because federal Medicaid regulations require that any resources currently available to a recipient be considered in determining liability for payments of medical services, providers have an obligation to investigate and report the existence of other insurance or liability to Medicaid. Cooperation is essential to the functioning of the Alabama Medicaid Program.

NOTE:

Medicare Advantage Plans should not be reported as Third Party insurance since they are paying in place of Medicare. Medicaid's MMIS system will continue to edit claims for Medicare coverage when a recipient is enrolled in a Medicare Advantage Plan.

This section discusses the following:

- Verifying Other Insurance
- Submitting Claims to Other Insurance
- Submitting Paid and Partially Paid Claims to Medicaid
- Submitting Denied Claims to Medicaid
- Medicare Crossover Claims
- Duplicate Payment by a Third Party

NOTE:

Verifying third party resources reduces the risk of your claim denying because of additional third party insurance. This is especially true in situations where the recipient is enrolled in a plan that requires the recipient to use certain providers or meet plan restrictions, such as pre-certification or obtaining physician referrals. Medicaid payment may be denied or recouped retroactively if the recipient's health plan requirements are not met.

Verifying Other Insurance

Recipients may be covered through a variety of health insurance resources. Please ask the recipient about the following types of insurance coverage:

Insurance Coverage Scenarios	*Health Insurance Resources*
If the recipient is married or working	Request information about possible health insurance through the recipient's or spouse's employer
If the recipient is a minor	Request information about insurance the mother, father, or guardian may carry on the recipient
If the recipient is active or retired military personnel	Request information about CHAMPUS coverage and a Social Security number of the policyholder
If the recipient is over 65 or disabled	Request information about a Medicare HIC number; ask if the recipient has health insurance such as a Medicare supplement policy, cancer, accident, or indemnity policy, group health insurance, or individual insurance

If the recipient receives treatment for an injury, question the recipient to determine if there are potential third party resources. Examples include automobile and homeowner's insurance; malpractice insurance; retention of legal counsel; product liability; and workman's compensation coverage.

NOTE:

Medicaid copayment received from the recipient is not considered a third party resource and should not be recorded on the claim.

You can also verify other insurance while you verify recipient eligibility. EDS Provider Electronic Solutions software and AVRS provide third party information when you verify recipient eligibility. Please refer to Appendix B, Electronic Media Claims (EMC) Guidelines, and Appendix L, AVRS Quick Reference Guide, for more information.

NOTE:

If the other insurance data provided by AVRS/PES is incomplete, please check with the patient for further information. If the recipient has never been covered by the insurance listed or the policy is not in force, please contact the appropriate third party representative as listed below. Please provide, if possible, the month, day, and year the coverage ended.

Call the third party representative assigned to recipients whose last names begin with the letters indicated:

A-G (334) 242-5280

H-P (334) 242-5254

Q-Z (334) 242-5279

Submitting Claims to Other Insurance

When you identify a third party resource, you should submit the claim to that resource using the address from the recipient. When you identify a third party resource through eligibility verification, obtain the company code from the eligibility response. Then refer to Appendix K, Top 200 Third Party Carrier Codes for a list of company names (and addresses) that correspond to the carrier codes.

Claims filed to third party resources on behalf of a Medicaid recipient may fully pay, partially pay, or deny. Refer to Section 5.1.8, Submitting Paid and Partially Paid Claims to Medicaid, or Section 5.1.9, Submitting Denied Claims to Medicaid, for details.

Medicare Crossover Claims

Please refer to Section 5.6, Crossover Claim Filing, for information on filing Medicare crossover claims.

For claims retroactively identified as Medicare-related, EDS will withdraw Medicaid payment and the provider will be instructed to file the claim with Medicare. The provider may refile the claim with Medicaid for the balance of the allowed charges after the Medicare claim has been filed with Medicare.

Duplicate Payment by a Third Party

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts.

If providers receive duplicate payments from a third party and Medicaid, all duplicate third party payments must be refunded within 60 days. Providers must do **one** of the following:

- Send a refund of insurance payment to the Third Party Division, Medicaid
- Request an adjustment of Medicaid payment

If a provider releases medical records and/or information pertaining to a claim paid by Medicaid and, as a result of the release of that information, a third party makes payment to a source other than the provider or Medicaid, the provider is responsible for reimbursing Medicaid for its payment.

NOTE:

If you have reason to believe other insurance exists that is not on Medicaid's file, please call Third Party, Medicaid Agency at (334) 242-5269 to report other insurance.

4

4 Obtaining Prior Authorization

Prior authorization serves as a cost-monitoring, utilization review measure and quality assurance mechanism for the Alabama Medicaid program. Federal regulations permit the Alabama Medicaid Agency to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or recipients, or easily result in excessive, uncontrollable Medicaid costs.

This chapter describes the following:

- Identifying services requiring prior authorization
- Submitting a prior authorization request
- Receiving approval or denial of the request
- Using AVRS to review approved prior authorizations
- Submitting claims for prior authorized services

4.1 Identifying Services Requiring Prior Authorization

The Alabama Medicaid Agency is responsible for identifying services that require prior approval. Prior authorization is generally limited to specified non-emergency services. The following criteria may further limit or further define the conditions under which a particular service is authorized:

- Benefit limits (number of units or services billable for a recipient during a given amount of time)
- Age (whether the procedure, product, or service is generally provided to a recipient based on age)
- Sex (whether the procedure, product, or service is generally provided to a recipient based on gender)

To determine whether a procedure or service requires prior authorization, access the Automated Voice Response System (AVRS). Refer to Section L.6, Accessing Pricing Information, of the AVRS Quick Reference Guide (Appendix L) for more information.

The program services chapters in Part II of this manual may also provide program-specific prior authorization information.

NOTE:

When a recipient has third party insurance and Medicaid, prior authorization must be obtained from Medicaid if an item ordinarily requires prior authorization. This policy does not apply to Medicare/Medicaid recipients.

4.2 Submitting a Prior Authorization Request

To receive approval for a PA request, you must submit a complete request using one of the approved submission forms. This section describes how to submit online and paper PA requests, and includes the following sections:

- Submitting PAs (278 Health Care Services Review-Request for Review and Response) using Provider Electronic Solutions
- Submitting Paper PA Requests

NOTE:

PAs are approved only for eligible recipients. It is therefore recommended that provider verify recipient eligibility prior to submitting a PA request. Refer to Chapter 3, Verifying Recipient Eligibility, for more information.

In the case of a retroactive request (retroactive eligibility), the recipient must have been eligible on the date of service requested. The provider must submit the PA request within 90 calendar days of the retroactive eligibility award (issue) date. If a retroactive PA request is submitted and does not reference retroactive eligibility, the request will be denied.

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Beginning December 1, 1999, you can submit electronic PA requests using EDS Provider Electronic Solutions software, available to you at no charge. If you already use this software, you will be mailed an upgrade; if you do not currently use the software, but would like to order a copy, refer to Appendix B, Electronic Media Claims Guidelines, for contact information. The electronic 278 Health Care Services Review- Request for Review and Response claim is not limited to the use of the Provider Electronic Software. Providers may use other vendor's software to submit a 278 electronic claim.

Electronic PA Requests Requiring Attachments

If attachments are required for PA review the attachments must be sent to EDS to be scanned into the system. Do not fax this information to the Alabama Medicaid Agency unless a request is made for specific information by the agency reviewer. Attachments scanned can be located in the system and are linked by the PA number on the Prior Authorization response returned by the system. Refer to Chapter 15 of the *Provider Electronic Solutions Manual* for specific information. This chapter provides instructions for submitting electronic 278 requests. Please be aware that the need to link the attachments sent hard copy with a PA request submitted electronically has resulted in delays in PA processing. In an effort to expedite this process follow the instructions below taken from Chapter 15, *Submitting Prior Authorization Requests, Provider Electronic Solutions Manual.*

NOTE:

Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. Fax them to (334) 215-4298, Attn: PA Unit, or mail the attachments to:

Attn: PA Unit P. O. Box 244032 Montgomery, AL 36124

4.2.2 Submitting Paper PA Requests

In the absence of electronic applications, providers may submit requests for prior authorization using the Alabama Prior Review and Authorization Request Form. No other form or substitute will be accepted. Completed requests should be sent to the following address:

EDS Prior Authorization Unit
P.O. Box 244032
Montgomery, AL 36124-4032.

4.3 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit non-dental PAs on paper. These forms are available through the Medicaid Agency.

4.3.1 Blank Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )
Requesting Provider
License # or Provider # _____
Phone ( ) _____
Name _____

Recipient Medicaid #_____
Name _____
Address _____
City/State/Zip _____
EPSDT Screening Date _____ DOB _____
Prescription Date CCYYMMDD _____

Rendering Provider Medicaid # _____
Phone ( )_____
Fax ( )_____

Name _____

Address _____

City/State/Zip _____
Ambulance Transport Code_____
Ambulance Transport Reason Code _____
DME Equipment: _____ New _____Used

First Diagnosis _____._____ Second Diagnosis _____._____
Service Type _____ Patient Condition _____ Prognosis Code _____

(01) Medical Care	(48) Hospital Inpatient Stay*	(75) Prosthetic Device
(02) Surgical	(54) LTC Waiver	(A7) Psychiatric-Inpatient*
(12) DME-Purchase	(56) Ground Transportation	(AC) Targeted Case Management
(18) DME-Rental	(57) Air Transportation	(AD) Occupational Therapy
(35) Dental Care	(69) Maternity	(AE) Physical Therapy
(42) Home Health Care	(72) Inhalation Therapy	(AF) Speech Therapy
(44) Home Health Visits	(74) Private Duty Nursing	(AL) Vision-Optometry

DATES OF SERVICE							
Line Item	START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____
_____
_____
_____
_____
_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider_____ Date_____

FORWARD TO: EDS, P.O. Box 244032 Montgomery, Alabama 36124-4032

Form 342
Revised 08/30/05

Alabama Medicaid Agency

4.3.2 Instructions for completing the Alabama Prior Review and Authorization Request Form

Section 1: Requesting Provider Information (Required)

PMP	Check if the patient has been assigned to a Primary medical provider (PMP) under the Primary Care Case Management (PCCM) program, known as Patient 1st.
License # or Provider #	Enter the license number or the nine-digit Medicaid provider number of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting physician.
Name	Enter the name of the prescribing physician.

Section 2: Rendering Provider Information (Required)

Rendering Provider Medicaid Number	Enter the nine-digit Medicaid provider number of the provider rendering services.
Phone	Enter the current area code and telephone number for the provider rendering services.
Fax	Enter the current area code and fax number for the provider rendering services.
Name	Enter the name of the provider rendering services.
Address	Enter the physical address of the provider rendering services.
City/State/Zip	Enter the city, state, and zip code for the address of the provider rendering services.
Ambulance Transport Code	Enter code to specify the type of ambulance transportation. Refer to "Ambulance Transport Codes" in the section below for appropriate codes. **Used for ambulance services only**.
Ambulance Transport Reason Code	Enter code to specify the reason for ambulance transportation. Refer to "Ambulance Transport Reason Codes" in the section below for appropriate codes. **Used for ambulance services only**.
DME Equipment	Enter a check mark indicating if the DME Equipment is New or Used.

Section 3: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address.
City/State/Zip	Enter the city, state, and zip code for the address of the recipient.

Section 4: Other Information

EPSDT Screening Date CCYYMMDD	**Required field for all requests.** Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
DOB	Enter the date of birth of recipient.
Prescription Date CCYYMMDD	**Required field for all requests.** Enter the date of the prescription from the attending physician. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
First Diagnosis	**Required field for all requests.** Enter the primary diagnosis code.
Second Diagnosis	Enter the secondary diagnosis code.
Service Type	**Required field for all requests.** Outpatient hospitals requesting physical therapy must use Service type 01 (medical) and not Service Type AE (physical therapy.).

Patient Condition	Enter the code that best describes the patient's condition. Refer to "Patient Condition Codes" in the section below for appropriate codes. **Used for ambulance services and DME providers only.**
Prognosis Code	**Required field for Service Types: 42, 44, and 74.**

Section 5: Procedure Information (Required)

Dates of Service	Enter the line item (1, 2, 3, etc) along with start and stop dates requested. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
Place of Service	Enter a valid place of service (POS) code.
Procedure Code*	Enter the five-digit procedure code requiring prior authorization. If this PA is for inpatient stay, a procedure code is not required.
Modifier 1	Enter modifier, if applicable.
Units	Enter total number of units.
Cost/Dollars	Enter price in dollars.
Clinical Statement	Provide a clinical statement including the current prognosis and the rehabilitation potential as a result of this item or service. Be very specific.
Signature of requesting provider	After reading the provider certification, the provider signs the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.
Date	Enter the date of the signature.

NOTE:

Additional information may be required depending on the type of request.

Procedure Code Modifiers

Procedure code modifiers are not available with the current electronic 278 Health Care Services Review – Request for Review transaction. If procedure code modifiers are necessary for a claim to process correctly, providers may submit a paper PA form.

Ambulance Transport Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the type of trip for ambulance service requests.

Code	***Description***
I	Initial Trip
R	Return Trip
T	Transfer Trip
X	Round Trip

Ambulance Transport Reason Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the reason for the ambulance transport request.

Code	***Description***
A	Patient was transported to nearest facility for care of symptoms.
B	Patient was transported for the benefit of a preferred physician.
C	Patient was transported for the nearness of family member.
D	Patient was transported for the care of a specialist or for availability of specialized equipment.
E	Patient transferred to rehabilitation facility.

Patient Condition Codes

The table below lists condition codes which may be used in different programs. Some codes may not be appropriate for all provider types. Please refer to the provider specific chapter of the Alabama Medicaid Provider Manual for acceptable patient condition codes.

Code	*Description*
01	Patient was admitted to a hospital
02	Patient was bed confined before the ambulance service
03	Patient was bed confined after the ambulance service
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
10	Patient is ambulatory
11	Ambulation is impaired and walking aid is used for therapy or mobility
12	Patient is confined to a bed or chair
13	Patient is confined to a room or an area without bathroom facilities
14	Ambulation is impaired and walking aid is used for mobility
15	Patient condition requires positioning of the body or attachments which would not be feasible with the use of an ordinary bed
16	Patient needs a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons
17	Patient's ability to breathe is severely impaired
18	Patient condition requires frequent and/or immediate changes in body positions
19	Patient can operate controls
20	Side rails are to be attached to a hospital bed owned by the beneficiary
21	Patient owns equipment
22	Mattress or side rails are being used with prescribed medically necessary hospital bed owned by the beneficiary
23	Patient needs lift to get in our out of bed or to assist in transfer from bed to wheelchair
24	Patient has an orthopedic impairment requiring traction equipment which prevents ambulation during period of use
25	Item has been prescribed as part of a planned regimen of treatment in patient's home
26	Patient is highly susceptible to decubitus ulcers.
27	Patient or a caregiver has been instructed in use of equipment

Patient Service Type Codes

Use this table for the appropriate code to describe the service type provided to the patient.

Code	*Description*
01	Medical Care
02	Surgical
12	Durable Medical Equipment - Purchase
18	Durable Medical Equipment - Rental
35	Dental Care
42	Home Health Care
44	Home Health Visit
48	Hospital Inpatient Stay
54	Long Term Care Waiver Services

Code	Description
56	Medically Related (Ground) Transportation
57	Air Transportation
69	Maternity
72	Inhalation Therapy
74	Private Duty Nursing
75	Prosthetic Devices
A7	Psychiatric - Inpatient
AC	Targeted Case Management
AD	Occupational Therapy
AE	Physical Therapy
AF	Speech Therapy
AL	Vision - Optometry

Prognosis Codes (Home Health and Private Duty Nursing Services Only)

Use this table for the appropriate code to describe the patient's prognosis.

Code	Description
1 - 2	Good
4 - 6	Fair
7 - 8	Poor

4.4 Completing the Alabama Prior Review and Authorization Dental Request Form

Providers use this form to submit dental PAs on paper. These forms are available through the Alabama Medicaid Agency.

4.4.1 Blank Alabama Prior Review and Authorization Dental Request Form

Section I – Must be completed by a Medicaid provider.

Requesting Provider License No. _____

Phone( ) _____

Name_____

Address_____

City/State/Zip_____

Provider Medicaid Number _____

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required.)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number _____

Section III

DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

3. Brief Dental/Medical History:_____

_____

_____

NOTE :When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential." Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343 05/05 Alabama Medicaid Agency

4.4.2 Instructions for Completing the Alabama Prior Review and Authorization Dental Request Form

Section 1: Requesting Provider Information (Required)

License #	Enter the license number of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting dental provider.
Name	Enter the name of the dental provider.
Provider Medicaid Number	Enter the nine-digit Medicaid provider number of the requesting provider.

Section 2: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address.
City/State/Zip	Enter the city, state, and zip code for the address of the recipient.
Telephone Number	Enter the recipient's most current phone number.

Section 3: Procedure Information

Dates of Service	Enter the start and stop dates of service requested. Enter dates using the format CCYYMMDD. Use the date you complete the form and add six months. For example, 20050401 (April 1, 2005) through 20051001(October 1, 2005).
Place of Service	Circle the appropriate two-digit place of service.
Procedure Code	Enter the five digit procedure code requiring prior authorization. Use the correct CDT2005 procedure code.
Quantity Requested	Enter the number of times the procedure code will be used/billed.
Tooth Number	Enter the tooth number(s) or area of the mouth in relation to the procedure code requested.

Section 4: Medical Information

Complete Items 1-3 with the information requested. Documentation must be legible. If x-rays are sent, place them in a separate sealed envelope marked with recipient's name and Medicaid number.

Indicate whether the recipient has missing teeth and indicate the missing teeth with an X on the diagram.

After reading the provider certification, the provider signs and dates the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.

The completed form should be forwarded to EDS at the address given on the form.

4.5 Receiving Approval or Denial of the Request

Letters of approval will be sent to the provider on paper requests only, indicating the approved ten-digit PA number, dates of service, place of service, procedure code, modifiers, and authorized units or dollars. This information should be used when filing the claim form. All electronic claims (278) will generate a 278 Health Care Services Review – Response, to notify the requester that of the response. Once the State has made a decision on the request, which will trigger an electronic 278 response to the provider. The electronic 278 response will either contain the PA number, rejection code or cancellation code information.

Section 1: Decision Codes

Current Decision Codes:		HIPAA Decision Codes:	
A	Approved	X	Cancelled
P	Pending	Z	Rejected
D	Denied		
H	Pending Hearing/Appeal		
M	Modified PA Request		
C	Condition Approval		
R	Denial after Appeal		
S	Sent back for Corrections (Used by EDS in Paper Process only)		

Letters of denial will also be sent to the provider and recipient indicating the reason for denial, for paper claims only.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). The Alabama Medicaid Agency must receive this request for appeal within 30 days from the date of the denial letter, or the decision will be final and no further review will be available.

4.6 Using AVRS to Review Approved Prior Authorizations

AVRS allows the provider to access information about an approved prior authorization number to confirm start and stop dates, procedure code(s), total units, and dollar amount authorized.

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- The ten-digit prior authorization number, followed by the pound sign

AVRS performs a query and responds with the following information for the PA:

- Recipient number
- Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)
- Start and stop dates

- Units authorized
- Dollars Authorized
- Units used
- Dollars Used

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another Procedure Code or NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

4.7 Submitting Claims for Prior Authorized Services

Once the **approved** ten-digit PA has been received, providers must indicate that number on the claim form in the appropriate spaces. Claims for services that require a PA received by EDS without the ten-digit PA number are denied. Refer to Chapter 5, Filing Claims, for more information on completion of the claim form.

NOTE:

Providers must also have the appropriate Patient 1st referral for certain patients and/or services. Refer to Chapter 39.

5

5 Filing Claims

Because Medicaid cannot make payments to recipients, the provider who performed the service must file an assigned claim and agree to accept the allowable reimbursement as full payment.

Federal regulations prohibit providers from charging recipients, the Alabama Medicaid Agency, or EDS a fee for completing or filing Medicaid claim forms. The cost of claims filing is considered a part of the usual and customary charges to all recipients.

This chapter provides basic information for filing claims. The information is not specific to provider type; it is intended to give all providers an understanding of the various methods for claims submission and instructions on completing claims forms. Once you understand the information in this section, you can refer to the chapter in Part II that corresponds to your provider type for additional claims filing information.

This chapter contains the following sections:

- *Before You Submit Your Claim,* which describes how claims are processed, which claim forms are approved for submission to Medicaid, and other general claim-related information
- *Completing the CMS-1500 Claim Form*, which provides detailed billing instructions for the CMS-1500 claim form
- *Completing the UB-92 Claim Form*, which provides detailed billing instructions for the UB-92 claim form
- *Completing the ADA Dental Claim Form*, which provides detailed billing instructions for the ADA Dental claim form
- *Completing the Pharmacy Claim Form*, which provides detailed billing instructions for the Pharmacy claim form
- *Crossover Claim Filing*, which provides billing instructions for the medical and institutional crossover claim forms. **Please note that Alabama Medicaid requires paper crossovers to be submitted using the approved Medical and Institutional Medicaid/Medicare-related crossover claim forms.**
- *Required Attachments*, which lists and describes the Alabama Medicaid required attachments
- *Adjustments,* which provides instructions for submitting online and paper adjustments. **Please note that Alabama Medicaid requires paper adjustments to be submitted on the approved Adjustment form.**
- *Refunds,* which provides instructions on receiving refunds
- *Inquiring about Claim and Payment Status,* which describes various methods for contacting EDS to inquire about claim and payment status

5.1 Before You Submit Your Claim

This section discusses claim types, how EDS processes claims, and the various methods for submitting claims. It includes the following topics:

- Valid Alabama Medicaid claim types
- How claims are processed
- Methods for submitting claims with attachments
- Electronic claims submission
- Filing limits and approved exceptions
- Recipient signatures
- Provider signatures

5.1.1 Valid Alabama Medicaid Claim Types

Alabama Medicaid processes eight different claim types (Managed Care claims are described in Chapter 39, Patient 1st). The claims can be submitted on paper or in electronic format. Alabama recognizes two standard claim forms (UB-92 and CMS-1500) and four Medicaid non-standard claim forms (Pharmacy, Dental, and two Medicare/Medicaid-related claim forms) for the submission of these claims. The provider's provider type determines which claim type to bill, as illustrated in the table below.

Claim Type	***Claim Form***	***HIPAA Transaction***	***Providers Who Bill Using This Claim Type***
Medical	CMS-1500	837 Professional	• Physicians • Physician Employed Practitioners (CRNP and PA) • Independent Labs • Independent Radiology • Transportation • Prosthetic Services • DME • Podiatrists • Chiropractors • Psychologists • Audiologists • Therapists (Physical, Speech, Occupational) • Optometrists/Opticians • Optical Dispensing Contractor • Clinics • Rural Health Clinics (IRHC, PBRHC) • FQHC • County Health Departments • Targeted Case Management • Independent Nurse Practitioner • Hearing Aid Dealer • Waiver Services (Homebound, Elderly and Disabled, MR/DD) • Maternity Care • State Rehab Services (Mental Health Centers, DYS, DHR) • CRNA • Nurse Midwife

Claim Type	*Claim Form*	*HIPAA Transaction*	*Providers Who Bill Using This Claim Type*
Dental	2002,2004 ADA	837 Dental	Dentists/Oral Surgeons when billing CDT codes
Pharmacy	XIX-BC-10-93	NCPDP	Pharmacists
Inpatient	UB-92	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient	UB-92	837 Institutional	• Hospitals • Ambulatory Surgical Centers (straight Medicaid) • Hemodialysis • Private Duty Nursing • Hospice Facility • Home Health Services • Lithotripsy (ESWL)
Medical crossover	Medical Medicare/Medicaid-Related Claim	837 Professional	All providers listed under the medical claim type • Ambulatory Surgical Centers (crossover claims) **Exceptions** (these provider types are not covered for Medicare-related claims): • Nurse Midwife • Targeted Case Management • Maternity Care • Waiver Services
Inpatient crossover	Institutional Medicare/Medicaid-Related Claim	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient crossover	Institutional Medicare/Medicaid-Related Claim	837 Institutional	• Hospitals • Dialysis • CORF (Comprehensive Outpatient Rehabilitation Facility) • Nursing Facility (Therapy) • Home Health Services

5.1.2 How Claims are Processed

This section briefly describes claims processing, from assigning a unique tracking number to a claim, to generating and mailing the payment.

Internal Control Number

All claims entered into the EDS system for processing are assigned a unique 13-digit Internal Control Number (ICN). The ICN indicates when the claim was received and whether it was sent by paper or through electronic media. The ICN is used to track the claim throughout processing, on the Explanation of Payment (EOP), and in claims history.

For more information about the ICN numbering system used for claims processing, refer to Appendix F, Medicaid Internal Control Numbers.

Claims Processing

EDS verifies that the claim contains all of the information necessary for processing. The claim is processed using both clerical and automated procedures.

First, the system performs validation edits to ensure the claim is filled out correctly and contains sufficient information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met.

For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider.

Once claims pass through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policy and performs cost avoidance. Cost avoidance is a method that ensures Medicaid is responsible for paying for all services listed on the claim. Because Medicaid is the payer of last resort, the system confirms that a third party resource is not responsible for services on the claim.

The system then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compares them to Alabama Medicaid policy.

The system then prices the claim using a State-determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claims processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by EDS personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the checkwriting schedule published in the *Provider Insider*, the Alabama Medicaid provider bulletin produced by EDS. The check is sent to the provider's payee address with an Explanation of Payment (EOP), which also identifies all denied claims, pending claims, and adjustments. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider. EOPs are described in Chapter 6, Receiving Reimbursement.

5.1.3 Methods for Submitting Claims

EDS accepts claims in electronic or paper format. Paper claims must be submitted using the approved claim formats listed in the table in Section 5.1.1, Valid Alabama Medicaid Claim Types.

To improve hard copy claims processing, EDS now scans paper claims and performs Optical Character Recognition (OCR) to enter data from the claims into the Medicaid system. All CMS-1500 and UB-92 paper claims must be submitted using red dropout forms. The scanner drops any red or blue markings on the claim form, leaving only the data the provider entered on the claim form.

NOTE:

All claim forms must be completed in dark **BLACK** ink. Do not circle, underline, or highlight any information on the claim. **Send original claim forms only;** do not send copies.

Providers should submit typewritten or computer-generated paper claims whenever possible to speed up the data entry process. Keep in mind the following guidelines:

- Make sure typed information does not fall outside the specific boxes.
- Change printer ribbons often, since claims with print too light to be scanned will be returned.

Providers can obtain Medicaid/Medicare-related claim forms free of charge from EDS. Providers may purchase copies of CMS-1500 and Alabama Medicaid Pharmacy claim forms from EDS by writing or calling the EDS Provider Assistance Center:

EDS Provider Assistance Center
P.O. Box 244032
Montgomery, AL 36124-4032
1 (800) 688-7989

5.1.4 Electronic Claims Submission

Electronic claims may be submitted using a variety of methods:

- Provider Electronic Solutions software, provided at no charge to Alabama Medicaid providers
- Value Added Networks (VANs) or billing services on behalf of an Alabama Medicaid provider
- Tapes or other electronic media, as mutually agreed to by the Alabama Medicaid Agency and the vendor

The Alabama Medicaid Agency and EDS strongly encourage submitting claims electronically. Electronic Claims Submission (ECS) offers providers a faster and easier way to submit Medicaid claims. When you send your claims electronically, there is no need to complete paper Medicaid forms. Your claim information is submitted directly from your computer to EDS.

If filing claims using the PES software, please refer to the Provider Electronic Solutions User Manual for the appropriate claim filing instructions and values.

Electronic claims begin processing as soon as they are received by the system. Paper claims must go through lengthy processing procedures, which could result in delayed payment on the claims. An electronically submitted claim displays on the next Explanation of Payment (EOP) following the claim submission. Unless your claim suspends for medical policy reasons, it should finalize (pay or deny) in the checkwriting step.

All of the Electronic Claims Submission (ECS) options are provided free of charge. Providers also have the option of using software from a software vendor or programmer. EDS furnishes file specifications at no charge. **If you have further questions or wish to order software, contact the EDS Electronic Claims Submission (ECS) Help Desk at 1(800) 456-1242** (out of state providers call (334) 215-0111).

5.1.5 Filing Limits and Approved Exceptions

Generally, Medicaid requires all claims to be filed within one year of the date of service; however, some programs have different claims filing time limit limitations. Refer to your particular provider type program chapter for clarification.

Claims more than one year old may be processed under the following circumstances:

- Claims filed in a timely manner with Medicare or other third party payers may be processed if received by the fiscal agent within 120 days of the third party disposition date. This date **must** be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider and a copy of the dated insurance must be attached to the claim. Providers should state the disposition date in the following format: "TPL-12-1-99" or "TPL-Dec. 1, 1999."

  Medicare EOMBs are no longer a required attachment, except as described above when the service is past the one year filing limit and within 120 days of the Medicare EOMB date. Providers must use the appropriate Medicare/Medicaid-related form (Institutional or Medical). Refer to Appendix E, Medicaid Forms, for a sample. Providers are reminded that claims that are denied by a third party payer must be submitted with a copy of the dated denial sheet attached. Third party payer denials must still be attached with the appropriate claim form or Medicare/Medicaid-related form.

- Claims for services rendered to a recipient, during a retroactive eligibility period, may be processed if received by the fiscal agent **within one year** from the date of the retroactive award. **Providers should indicate in Block 19 on the CMS-1500 claim form or in Block 84 on the UB-92 claim form the retroactive eligibility award date and submit a copy of the award notice with the claim(s).**

- Claims for services that were previously paid by Medicaid and later taken back, either at Medicaid's request or the provider's request, may be processed if received by the fiscal agent **within 120 days** of the recoupment. This date must be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider in the following format: "Recouped Claim 11-01-02" or "Recouped Claim Nov. 1, 2002". A copy of the Medicaid Explanation of Payment (EOP), showing the recoupment and the date must be attached to the claim.

Submit claims more than one year old, that meet the above criteria, to the following address:

EDS Provider Assistance Center
P.O. Box 244032
Montgomery, AL 36124-4032

Claims for inpatient hospital services provided through Partnership Hospital Programs (PHP) must be filed by the last day of February for the previous year. For example, claims with dates of service 10-1-2002 through 9-30-2003 must be filed by 2-29-2004. Inpatient claims may not span calendar or fiscal years and must be split-billed.

NOTE:

Refer to Section 7.2.1, Administrative Review and Fair Hearings, for more information regarding administrative reviews.

5.1.6 Recipient Signatures

While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, (such as release forms or sign-in sheets) as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below:

- The recipient signature is not required when there is no personal contact between recipient and provider, as is usually the case for laboratory or radiology.
- Illiterate recipients may make their mark, for example, "X," witnessed by someone with his dated signature after the phrase "witnessed by."
- A representative may sign for a recipient who is not competent to sign because of age, mental, or physical impairment.
- The recipient signature is not required when a physician makes a home visit. The physician must provide documentation in the medical record that the services were rendered.
- For services rendered in a licensed facility setting other than the provider’s office, the recipient’s signature on file in the facility’s record is acceptable.

5.1.7 Provider Signatures

This section discusses the various requirements for provider signatures when filing electronic or hard copy claims.

Medical Claims

The provider's signature on a claim form/medical submission agreement certifies that the services filed were performed by the provider or supervised by the provider and were medically necessary.

Individual practitioners (not groups or clinics) may sign a medical claims submission agreement with Medicaid for the submission of paper claims instead of signing individual claim forms.

By signing the claim agreement, the provider agrees to keep any records necessary to enable the provider to perform the following responsibilities:

- Disclose the extent of services the provider furnishes to recipients
- Furnish Medicaid, the Secretary of HHS, or the state Medicaid Fraud Control Unit, upon request, any information regarding payments received by the provider for furnishing services
- Certify that the information on the claim is true, accurate, and complete, and the claim is unpaid
- Affirm the provider understands that the claim will be paid from federal and state funds, and any falsification or concealment of a material fact may be prosecuted under federal and state laws

Providers who have a completed Medical Claims Submission Agreement on file should place the words "**Agreement on File**" in block 31.

If an agreement is not signed, the individual practitioner must personally sign the claim form in the appropriate area or initial the claim form beside a typewritten or stamped signature. An individual practitioner's name or initials may be signed by another person who has power of attorney from the practitioner.

Tape Billers

Providers submitting claims through a tape biller must have a contract on file with EDS signed by the provider or the billing agent authorizing tape submission of claims.

Tapes that EDS receives must be accompanied by a transmittal form signed by the billing provider or the billing agent.

Electronic Billers

Providers billing electronically must have a contract signed by the provider on file with EDS. When applicable, the billing agent's signature must also appear on the contract.

Diskette Billers

Providers submitting claims on diskette to EDS must have a contract signed by the provider on file with EDS.

Computer Generated Claim Forms

Computer generated claim forms may be submitted with the provider's name generated on the form. In which case, the provider’s handwritten name or initials must accompany the name.

"Agreement on File" may also be printed on computer generated claim forms in lieu of the provider's signature, if a Medical Claim Submission Agreement is on file.

The policy provisions for provider signatures can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 1.

5.1.8 Submitting Paid and Partially Paid Claims to Medicaid

Providers may submit paid and partially paid third party claims to Medicaid using the approved paper or online filing methods as described in Chapter 5, Filing Claims. **The following third party-related information is required on the claim,** in addition to the other required claim data:

Claim Form	*Include the Following Third Party Information*	*In These Claim Fields*
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL paid dates • Amount paid	• Blocks 9-9d • Block 10 • Block 19 • Block 29
UB-92	• Other payer name • Prior payments • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL paid date	• Block 50 • Block 54 • Block 58 • Block 60 • Block 61 • Block 62 • Block 78 • Block 84
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#)/Policy Number • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code • Carrier Pays	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11 • Block 32 Other Fee(s)
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL payment	• TPL carrier information • TPL payment/denial information

NOTE:

Failure to list the third party payment in the appropriate space on the claim may cause the claim to deny.

If the claim is less than one year old, you may submit the claim electronically and Medicaid does not require the attachment of the third party Explanation of Payment (EOP). For claims more than one year old, you must submit the claim on paper and attach a copy of the third party EOP. You must submit claims more than one year old **within 120 days** of the third party payment.

Claims meeting the requirements for Medicaid payment will be paid in the following manner if a third party payment is indicated on the claim:

- The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference will be paid to the provider.
- Third Party contractual write-offs or discounts should not be billed to Medicaid. Medicaid should be billed for the recipient's liability only. Any contractual write-off or discount covered by the primary insurance should be included in the amount designated as paid by the primary insurance on the claim to Medicaid.

- Third party paid amounts exceeding the Medicaid allowed amount will receive no further payment from Medicaid. Medicaid will place a zero paid amount on the claim and include an explanatory EOB code on the Explanation of Payment (EOP). **Patients cannot be billed under this condition.**

5.1.9 Submitting Denied Claims to Medicaid

Providers may submit denied third party claims to Medicaid. **The following third party-related information is required on the claim,** in addition to the other required claim data:

Claim Form	***Include the Following Third Party Information***	***In These Claim Fields***
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL denied dates • Amount paid	• Blocks 9-9d • Block 10 • Block 19 • Block 29
UB-92	• Other payer name • Prior payments • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL denied date	• Block 50 • Block 54 • Block 58 • Block 60 • Block 61 • Block 62 • Block 78 • Block 84
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#) • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code • TPL Denial Date (with EOB ATTACHED)	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11 • Block 35 Remarks
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL denial	• TPL carrier information • TPL payment/denial information

All claims with a third party denial **must** be submitted on paper with a copy of the third party denial attached. Claims with a third party denial **cannot** be submitted electronically.

Providers must submit legible copies of third party denials when billing Medicaid for services denied by the third party. For claims with dates of service over one year to be considered for payment, the denial must be dated by the insurance company and the claim must be submitted within 120 days of third party denial.

NOTE:

Be sure to indicate on the claim form that it denied for TPL. The table above lists, by claim type and block number, the fields that must be filled out to submit a claim that denied for TPL.

5.2 Completing the CMS-1500 Claim Form

This section describes how to complete the CMS-1500 claim form for submission to EDS. For a list of providers who bill for services using the CMS-1500 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use by all providers who bill using this claim form. For program-specific billing information, please refer to the chapter in Part II that corresponds to your provider type.

CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500/837 Professional claims in approved formats. The 837 Professional transaction allows providers to bill up to 50 details per Professional (837 transaction) claim type.

Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the EDS Electronic Claims Submission Help Desk at 1(800) 456-1242.

CMS-1500 Claims Form Paper Billing

CMS-1500 forms may be purchased through EDS. Providers may also obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard CMS format using red dropout ink.

Claims must contain the billing provider's complete name, address, and Medicaid provider number. **Critical claim information includes:**

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Payee's nine-digit Medicaid provider number
- Rendering (performing) provider's nine-digit Medicaid provider number (on each line item)

A claim lacking any of the critical claim information cannot be processed. Also, each claim form must have a provider signature, initials, a stamped signature, or have an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

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5.2.1 CMS-1500 Blank Claim Form

APPROVED QMB-0938-0008

☐☐☐ PICA

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last name, first Name, Middle Initial)

3. PATIENTS BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐
Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? PLACE (state) ☐ YES ☐ NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d.

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) MM DD YY INJURY (Accident) MM DD YY PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E B LINE)
1. 3.
2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place Of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OF UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. Claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME , ADDRESS, ZIP CODE, & PHONE #
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) ***PLEASE PRINT OR TYPE*** FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500 CMS-1500-1 (Rev. 12-90)

SAMPLE

5.2.2 CMS-1500 Claim 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. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
2	Patient's name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID number you entered in Block 1.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
3	Patient's date of birth Patient's sex	Enter the month, day, and year (MM/DD/YY) the recipient was born. Indicate the recipient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (city, state, and ZIP code).
9-9d	Other insured's name	If the recipient has other health insurance coverage, enter all pertinent information. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid.**
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
17	Name of referring physician or other source	Enter one of the following, if applicable: • The name of the referring PMP provider • The EPSDT referring provider if the services are the result of an EPSDT screening • The referring lock-in physician if the eligibility verification response indicates the recipient has Lock-In status Please refer to Section 3.3, Understanding the Eligibility Response, for information on Lock-in or as they relate to recipient eligibility Appendix A, EPSDT, provides referral instructions for EPSDT.
17a	ID number of referring physician	Enter the nine-digit Medicaid provider number corresponding to the provider entered in Block 17, if applicable. Anesthesia providers must submit the UPIN number of the referring surgeon/physician.

Block No.	*Description*	*Guidelines*
19	Reserved for Local use	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • Home accident • Treatment due to disease • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date The substitute provider's name may also be indicated here.
21	Diagnosis or nature of illness or injury	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not include diagnosis descriptions. Do not use decimal points in the diagnosis code field.
23	Prior Authorization Number	If the service requires prior authorization, enter the ten-digit PA number provided on the prior authorization notice here. Do not include the PA notice with the claim. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type. **Do not use for any other number. Leave blank if this does not apply.**
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	Type of Service (TOS)	TOS is no longer a required field on the Medicaid claim form. The system automatically assigns TOS codes based on the procedure code billed.
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.

Block No.	*Description*	*Guidelines*
24h	EPSDT Family Planning	Enter one of the following values, if applicable: • "1" if the procedure billed is a result of an EPSDT referral • "2" if the procedure is related to Family Planning • "3" if the procedure is a Patient 1st (PMP) referral Effective April 1, 2005 the referral requirement for Patient 1st recipients was reinstated. • "4" if the procedure is EPSDT and PMP referral
24I	EMG	This block is used to indicate certain copayment exemptions, or Patient 1st referral exemption for Certified Emergency. Enter an "E" for emergency or "P" for pregnancy, if applicable. Do not enter Y or N. Effective April 1, 2005 the referral requirement for Patient 1st recipients was reinstated.
24k	Reserved for local use	Enter the rendering (performing) provider's nine-digit Medicaid provider number. The rendering (performing) provider is the one who performs the service.
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	Physician's or supplier's name, address, zip code, and telephone number PIN# GRP#	Enter the payee's name and address in the space provided. The payee name is printed in the upper right corner of the EOP. PIN# is not a required field. Do not enter PIN#. Enter the payee's nine-digit Medicaid provider number in the GRP# field. The payee number is the number printed in the upper left corner of the EOP. **NOTE: If the payee is a group or clinic, the rendering (performing) provider whose number is listed in Block 24k must be enrolled as a member of the group or clinic.**

5.3 Completing the UB-92 Claim Form

This section describes how to complete the UB-92 claim form for submission to EDS. For a list of providers who bill for services using the UB-92 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use by all providers who bill using this claim form. For program-specific billing information, please refer to the chapter that corresponds to your provider type.

UB-92 Electronic Billing

Electronic billers must submit UB-92/837 Institutional claims in approved formats. The 837 Institutional transaction allows providers to bill up to 999 details per Institutional (837 Institutional transaction) claim type. Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the EDS Electronic Claims Submission Help Desk at 1(800) 456-1242.

UB-92 Claims Form Paper Billing

EDS does not supply the UB-92 claim form. Providers may obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard UB-92 format using red dropout ink.

Claims must contain the billing provider's complete name, address, and Medicaid provider number. Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's eight-character Medicaid provider number

A claim lacking any of the critical claim information cannot be processed. Also, each claim form must have a provider signature, initials, a stamped signature, or have an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.3.1 UB-92 Blank Claim Form

APPROVED QMB NO. 0938-0279

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL

5. FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTH DATE | 15 SEX | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 CODE | OCCURRENCE SPAN FROM THROUGH | 37 A B C

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							

50 PAYER | 51 PROVIDER NO. | 52 REL. INFO | 53 ASG. BEN | 54. PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 | DUE FROM PATIENT

58 INSURED'S NAME | 59 P.REL | 60 CERT.-SSN-HIC.-ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E | 83 OTHER PHYS. ID A | OTHER PHYS. ID B

84 REMARKS | 85 PROVIDER SIGNATURE X | 86 DATE

UB-92 HCFA-1450

TITLE POSITION

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE

5.4 UB-92 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the UB-92 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.
2	Referring Provider number	Enter the referring physician's provider number for the following types of referrals: • EPSDT referrals • Patient 1st referrals • Lock-in Physician referrals The referring provider number should contain nine digits. A condition code of A1 is only required if the referral number is an EPSDT referral. If not applicable, leave blank.
3	Patient control number	**Optional**: Enter your internal medical record number. This may be an alpha or numeric string (limit 20 characters). If entered, the number appears on the provider's Explanation of Payment (EOP) to assist in patient identification.

Block No.	***Description***	***Guidelines***
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice	Enter the three-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 5-8 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.
7	Covered days	Enter the total days represented on this claim that are to be covered. This is not required for outpatient claims.
8	Non-covered days	Enter the total days represented on this claim that are not covered. This is not required for outpatient claims. **The sum of blocks 7 and 8 must equal the total days billed as reflected in block 46.**

Block No.	***Description***	***Guidelines***
12	Patient name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you entered in Block 60.** If a recipient has two initials instead of a first name, enter the first initial along with a 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.
17	Admission date	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.
18	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for outpatients (TOB 141) or home health claims (TOB 331).
19	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 20) 5 Trauma Center
20	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available 6 Transfer from another health care facility
21	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.

Block No.	***Description***	***Guidelines***
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. Refer to the UB-92 Billing Manual for the valid patient status codes. If status code 30, the total days in blocks 7 and 8 should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
23	Medical record number	Enter the patient's medical record number assigned by the hospital. This number will be referenced on the provider's EOP for patient identification. Up to twenty numeric characters may be entered into this field.
24-30	Condition Codes	The following UB-92 condition codes are valid for EPSDT referral and/or PMP referrals: A1 Denotes services rendered as the result of an EPSDT screening. Block 2 must also contain the screening provider's 9-digit Medicaid provider number. A4 Denotes family planning and will exempt the claim from the $3 copay. If A1 is entered here, a referring provider number must be indicated in block 2.
32	Occurrence Codes	Accident related occurrence codes are required for diagnoses between 80000-99499.
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed. Refer to the UB-92 Uniform Billing Manual published by the Alabama Hospital Association for valid codes. Revenue 001 (Total) must appear on every claim.
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.

Block No.	***Description***	***Guidelines***
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.
51	Medicaid no.	Enter the eight-character Medicaid provider number.
54	Prior payments	Enter any amounts paid by third party commercial insurance carrier(s). **Do not enter Medicaid copayment amount. Do not enter Medicare payment amount.**
58	Insured's name	If a third party carrier is involved, 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. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
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.
63	Treatment authorization code	Enter the ten-digit prior authorization number, if applicable. Do not include the PA notice with the claim. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type.
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.
68-75	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.
76	Admitting diagnosis	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.
78	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.**
80-81 a,b,c,d,e	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.
82	Attending physician ID	Enter the attending physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
83 a,b	Other physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Blocks 80-81, enter the surgeon's license number.

Block No.	***Description***	***Guidelines***
84	Remarks	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date
85	Provider representative signature	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
86	Date bill submitted	Enter the date the bill was signed.

5.5 Completing the ADA Dental Form

This section describes how to complete the 2002, 2004 ADA Dental form for submission to EDS. For a list of providers who bill for services using the ADA Dental form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use for all providers who bill using this claim form; for program-specific billing information, please refer to Chapter 13, Dental.

Only version 2002, 2004 ADA Dental form is acceptable. If you experience problems with EDS processing your forms, contact EDS for resolution.

ADA Dental Electronic Billing

Electronic billers must submit ADA Dental claims in approved formats. Providers may bill up to 50 details per dental (837 Dental transaction) claim type.

Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the EDS Electronic Claims Submission Help Desk at 1(800) 456-1242.

ADA Dental Claim Form Paper Billing

EDS does not supply the ADA Dental claim form. Providers may obtain copies of the claim form from a printer of their choice.

Claims must contain the billing provider's complete name, address, and Medicaid provider number. Critical claim information includes:

- Recipient's first and last name as it appears when verifying eligibility. NOTE: Recipient's Medicaid cards can have the name spelled differently that what is in our system.
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's nine-digit Medicaid provider number

A claim without the above information cannot be processed. Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

NOTE:

Because EDS uses a new scanning process, **do not use a blue pen to complete paper claims.** Do not circle, underline, write notes or highlight any information on the claim. **Send original claim forms only;** do not send copies.

Providers should submit typewritten or computer-generated paper claims whenever possible to speed up the data entry process. Keep in mind the following guidelines:

- Make sure typed information does not fall outside the specific boxes.
- Change printer ribbons often, since claims with print too light to be scanned will be returned.

5.5.1 ADA Dental Blank Claim Form

Please use the approved 2002, 2004 ADA Dental claim form printed using standard blue dropout ink.

5.5.2 ADA Dental Filing Instructions

The instructions describe information that is required to be entered in each of the block numbers on the ADA Dental Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by EDS.**

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
2	Preauthorization Number	Enter the 10 digit Prior Authorization Number (if applicable)
4-11	Other Coverage/Other Insurance Information (These blocks are only required if patient has other insurance.)	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Subscriber Identifier (SSN or ID#) Enter the Other Insurance Policy Number • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code
12	Primary Insured Information (Medicaid Recipient Information)	Enter name as Last, First. 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 enter in Block 15.** 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.
15	Subscriber Identifier (SSN/ID#)/Medicaid Number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
24	Procedure Date/Date of Service (MM/DD/CCYY)	Enter numerically (MM/DD/YY) the date of service for each procedure provided.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
25	Area of the Oral Cavity/Oral Cavity Designation	If applicable, enter the Oral Cavity Designation Code associated with the procedure being performed on a specific tooth. 00 —Full Mouth 01 —Upper Arch 02 —Lower Arch 09 —Other Area of Oral Cavity 10 —Upper Right Quadrant 20 —Upper Left Quadrant 30 —Lower Left Quadrant 40 —Lower Right Quadrant L —Left R—Right There are few procedures that require an oral cavity designation. Some of these include D4341, D4355, D4910, D7970 and D7971.
27	Tooth Number or Letter	Enter the appropriate tooth number for permanent teeth (01-32) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. Enter AS – TS for children and 51-82 for adults for all supernumerary teeth regardless of location in maxilla or mandible. When spacers or partials are required, mark the missing teeth with an "X" on the claim form.
28	Tooth Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL). The block is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. M – Mesial F – Facial; Labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal B —Buccal; Labial
29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure(s) (such as D0120).
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
32	Other Fees	**Enter the amount paid by the other insurance or other third party sources known at the time of submission of the claim.**
33	Total Fee	Enter the total of the charges on the claim. **DO NOT SUBTRACT** the amount the other insurance pays (if applicable).
35	Remarks	The only information that should be written in this section is “TPL Denial Attached” and the date of the third party (other insurance) denial. Make sure the EOB denial statement is attached. NO OTHER comments should be written in this section.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
38	Place of Treatment	Enter the following place of service codes in the appropriate box: office, hospital, or other: • 11 – Dental office • 21 – Inpatient hospital • 22 – Outpatient hospital • 31 – Skilled Nursing facility *****Use the "HOSP" box to indicate outpatient hospital or inpatient hospital.**
45-47	Treatment Results From	As applicable, indicate yes or no. If yes, provide date of accident and state (if auto accident).
48	Billing Dentist or Dental Entity	Enter the billing provider's name, street, city, state, and ZIP code. The billing (payee) name, address, Medicaid number is printed in the upper left corner of the Explanation of Payments (EOP). This information must be entered exactly as it reads on the EOP.
49	Provider ID	Enter the provider number of the **actual** dentist performing the service. Enter the rendering (performing) provider's number. NOTE: If the billing provider (payee) entered in the License Number field at the bottom of the form is a group provider, the rendering (performing) provider must be a member of the group.
50	License Number	This space is for the billing (payee) provider number. Enter the billing provider's nine-digit Alabama Medicaid provider number in the license number field. The billing (payee) number is the number printed in the upper left corner of the Explanation of Payments (EOP). The rendering (performing) provider number and the billing provider number may or may not be the same, but each number **must** be entered in the appropriate location.
52	Phone Number	Enter the office phone number should Medicaid staff need to contact staff for questions/information.
53	Treating Dentist Information	Each claim form must have a provider signature, initials by a stamped signature or an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.6 Completing the Pharmacy Claim Form

This section describes how to complete the pharmacy claim form for submission to EDS. For a list of providers who bill for services using the pharmacy claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use for all providers who bill using this claim form; for program-specific billing information, please refer to Chapter 27, Pharmacy.

Pharmacy Electronic Billing

Electronic billers must submit pharmacy claims in approved formats. Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the EDS Electronic Claims Submission Help Desk at 1(800) 456-1242.

Pharmacy Paper Billing

Medicaid pharmacy claim forms may be purchased through EDS. Providers may also obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed using red dropout ink.

Claims must contain the billing provider's complete name, address, and Medicaid provider number. **Critical claim information includes:**

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's nine-digit Medicaid provider number
- Rx number (cannot be more than 7 digits)

A claim without the above information cannot be processed. Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.6.1 Pharmacy Blank Claim Form

ALABAMA MEDICAID PHARMACY CLAIM XIX-DC-10-93

RECIPIENT NAME		ORIG RX DATE	TPL CARRIER INFORMATION	PHYSICIAN LICENSE NO.
MEDICAID NUMBER		1 / 2 / 3	CARRIER CODE/ CO. NAME POLICY NO.	

SUBMIT TO
EDS
P.O. BOX 244032
MONTGOMERY, ALABAMA 36124-4032

PHARMACY PROVIDER NO./NAME	DATE DISPENSED
PHARMACY ADDRESS	

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE CLAIM IS UNPAID. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PHARMACIST

	COPAY	PRIOR AUTHORIZATION NO.
1		
2		
3		

SAMPLE

	G CODE					EFILL(S)			
	LA R NO.	PRODUCT DE	S.	N	QU TY	S PLY	TH	NO.	AND CUSTOMARY / CENTS
2									
3									
								TOTAL	

	DOLLARS	CENTS	REASON CODE		DOLLARS	CENTS	REASON CODE		DOLLARS	CENTS	REASON CODE
1				2				3			

5.6.2 Pharmacy Filing Instructions

The instructions describe information that must be entered in each of the fields on the Pharmacy Form. **Fields not referenced in the table may be left blank. They are not required for claims processing by EDS.**

Field Description	*Guidelines*
Recipient name and Medicaid number	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 the Medicaid Number block.** For recipients who have two initials for their first name, enter the first initial with a long space, then the second initial and no periods. For example, A. B. Doe would be filed as Doe A B. For recipients who have an apostrophe in their first name, enter the first letter of the first name and the apostrophe. For example, D'Andre Doe would be filed as Doe D'Andre.
Orig. Rx Date	Enter the date of the original prescription
TPL Carrier Information	Complete this portion only if the recipient has other insurance. Carrier code/Co. name — The insurance company name or carrier code may be obtained from Appendix K of this manual or by calling the EDS Provider Assistance Center at 1 (800) 688-7989. Policy no. — The insured's insurance policy number
Physician's license no.	Enter the physician's state license number, which should display on the prescription
Pharmacy license no./name	Enter the nine-digit Medicaid pharmacy provider number and name
Date dispensed	Enter the date the prescription is dispensed to the recipient
Pharmacy address	Enter the pharmacy street address, city, state, and zip code.
Pharmacist	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
Received by	Obtain the recipient's signature or enter "Signature on file" if the provider has the recipient's signature on file (such as a sign in sheet) as verification that the recipient was present on the date of service for which the provider seeks payment.
Copay	Enter "P" if the recipient is pregnant to indicate copay exemptions.
Prior Authorization	For prior authorization requests approved by Medicaid, the prior authorization number will be automatically entered into the claims system by Medicaid's contractor. Enter the ten-digit prior authorization number (0000999527) only when using the 72 hour emergency supply prior authorization number.
Rx number	Enter the prescription number
Drug code	Enter the NDC code

Field Description	***Guidelines***
B/N	Brand Necessary. This field is also known as the "Dispense as Written (DAW)" field. Valid values are as follows: 0 No product selection indicated 1 Substitution not allowed by subscriber – Brand necessary 2 Substitution allowed – patient requested product dispensed 3 Substitution allowed – pharmacist selected product dispensed 4 Substitution allowed – generic drug not in stock 5 Substitution allowed – Brand drug dispensed as a generic 7 Substitution not allowed – Brand drug mandated by law 8 Substitution allowed – Generic drug not available in market place **Note: These "Dispense as Written" values are required for the DAW field for electronic pharmacy claims.**
Quantity	Enter the quantity or number of units dispensed. **Please note there are five (5) spaces on the claim form for quantity. All five spaces must be completed.** There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045. **If a product is supplied in fractional units (for instance, a 3.5gm tube of ointment), Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed. In this example, the quantity billed should be 0003.5**
Days supply	Enter the amount of time the medication dispensed should last. The days supply is limited to 34.
Refills	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.
Usual and customary	Enter the amount (dollars and cents) of your customary charge.
TPL payment/denial information	These fields are completed only if the recipient has other insurance. If the other insurance makes a payment, it should be indicated in the dollars/cents field. The appropriate NCPDP other coverage reason code must also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the NCPDP other coverage reason code must be included.

5.7 Crossover Claim Filing

Medical and inpatient institutional claims filed to Medicare (at BCBS Alabama) crossover directly to Medicaid weekly for claims processing. Providers should wait **at least 21 days** from the date of the Medicare Explanation of Medical Benefits (EOMB) before filing a medical or inpatient crossover claim to EDS either electronically or on hard copy. Outpatient institutional claims, out-of-state Medicare claims, and those medical and inpatient claims 21 days old or older must be submitted either electronically or on hard copy to EDS using the appropriate Medicare/Medicaid-related Claim Form.

Electronic billers must submit crossover claims in approved formats. *Provider Electronic Solutions* software allows crossover billing via the 837 Institutional transactions and is available from EDS free of charge for providers. Specifications are also available to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the EDS Electronic Claims Submission Help Desk at 1 (800) 456-1242.

5.7.1 Medical Medicaid/Medicare-related Claim Filing Instructions

For paper billing, the Medical Medicaid/Medicare-related claim form may be obtained from EDS at no charge. For scanning purposes, only those forms printed with red dropout ink will be accepted. Photocopies of this form will be returned.

A copy of the Medical Medicaid/Medicare-related claim form displays on the following page.

NOTE:

Providers must use the Medical Medicaid/Medicare-related claim form when billing Medicaid for Medicare Advantage plan copays. These claims will be processed by Medicaid in the same manner as a Medicare number in the HIC # field on the crossover claim rather than the Medicare Advantage Plan's assigned number. Medicare Advantage copays should be reported in the Medicare Coinsurance field.

Refer to Appendix L, AVRS Quick Reference Guide, for information on checking claim status.

Medical Medicaid/Medicare-related Blank Claim Form

Do not write in this space.

MEDICAL
MEDICAID/MEDICARE
RELATED CLAIM

Do not use red ink to complete this form.

RECIPIENT INFORMATION

Medicaid ID #	
First Name	
Last Name	
HIC #	
Patient Account #	

OTHER INSURANCE INFORMATION

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

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

Diagnosis Codes	1st DX		2ND DX		3RD DX		4TH DX	

Date of Service			Procedure				Medicare			
From	Thru	POS	Code	Mods	Units	Charges	Allowed	Coinsurance	Deductible	Paid
					TOTALS					

SAMPLE

Remarks

Enter IPE Denial (MMDDYY) in this block.

Performing Provider Number	
Performing Provider Name	

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

Submit completed claim to:

EDS
Post Office Box 244032
Montgomery, AL 36124-4032

Provider Mailing Address Required in block below.

Form 340 Revised 10/00

Alabama Medicaid Agency

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 no longer required.

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

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 EOP for patient identification). Up to 20 characters may be entered into this field.
Covered by other insurance?	Enter a "Y" here if recipient has a commercial insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other commercial insurance company (except Medicare).
Insurance company carrier code	Not used at this time.
If payment was received from other insurance, place that amount here.	Enter the amount the other insurance company paid in this block. Do not include Medicaid copayment amounts.
1st DX, 2nd DX, 3rd DX, 4th DX	Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.
Dates of service	Enter the from and through dates in MMDDYY format.
POS	Enter the two-digit place of service as filed to Medicare.
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	Enter the Medicare allowed amount for each line item. *FQHC, PBRHC, and IRHC should enter the per diem encounter rate 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.
Rendering (performing) provider Number	Enter the rendering (performing) provider's nine-digit Medicaid provider number. Do not place any alpha characters in this block.
Rendering (performing) provider Name	Enter the rendering (performing) provider's name.
Provider Mailing Address	Enter the billing address, city, state, and zip code for the rendering (performing) provider.
Remarks	Enter TPL Paid/Denial Date (MMDDYY).

5.7.2 Institutional Medicaid/Medicare-related Claim Filing Instructions

For paper billing, the Institutional Medicaid/Medicare related claim form may be obtained from EDS at no charge. For scanning purposes, only those forms printed with red dropout ink will be accepted. Photocopies of this form will be returned. A copy of the Institutional Medicaid/Medicare-related claim form displays on the following page.

Refer to Appendix L, AVRS Quick Reference Guide, for information on checking claim status.

Institutional Medicaid/Medicare-related Blank Claim Form

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

INSTITUTIONAL MEDICAID/MEDICARE RELATED CLAIM

PROVIDER INFORMATION

Provider Number	
Provider Name	

BILL TYPE

RECIPIENT INFORMATION

Medicaid ID #	
First Name	
Last Name	
HIC #	
Patient Account #	

OTHER INSURANCE INFORMATION

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

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

ADMISSION

Date	Hour	Type	STAT

STATEMENT COVERS PERIOD *See Remarks.

From	Through	COV D	N C D	C I D	L R.D

Rev	PC/Rate	Mods	Units	DOS	Charges	Non-Cov
001				TOTALS		

ADMIT DX	
Principal DX	
Other DX	
Other DX	
Other DX	

Rema

* Enter T **denied (MM/DD/YY)** in this block

Total Medicare Paid Paid	Paid
Total Medicare Allowed	
Total Medicare Coinsurance	
Total Medicare Deductible	

SAMPLE

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

Send completed claim to:

EDS
Post Office Box 244032
Montgomery, AL 36124-4032

Provider Mailing Address Required in block below.

Form 341 Revised 10-00

Alabama Medicaid Agency

Institutional Medicaid/Medicare-related Claim Filing Instructions

This form is required for all medical Medicare-related claims in lieu of the UB-92 claim form and the Medicare EOMB. **The ONLY required attachments are for third party denials.** The Medicare EOMB is no longer required.

Provider Information

Provider Number	Enter the 8-character Medicaid provider number.
Provider Name	Enter the provider name.

Recipient Information

Medicaid ID #	Recipient's 13-digit Medicaid I.D. number
First Name	Recipient's First Name
Last Name	Recipient's Last Name
HIC #	Recipient's HIC I.D. number
Patient Account #	Recipient's patient account number. Up to 20 alphanumeric characters may be entered into this field.

Other Insurance Information

Covered by other insurance?	Enter a "Y" here if recipient has insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other insurance company (except Medicare).
Insurance company carrier code	Not used at this time
If payment was received from other insurance, place that amount here.	Place the amount the other insurance company paid in this block. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**

Admission and Statement Covers Period

Date	Enter date of admission
Hour	Enter hour of admission (in military time format)
Type	Enter type of admission
STAT	Enter patient discharge status
From and through dates	Enter from and through dates of service
COVD	Enter number of covered days
NCD	Enter number of non-covered days, if any
CID	Enter number of coinsurance days if applicable
LRD	Enter number of life time reserve days if applicable

Service Data

Rev	Enter the revenue codes for each line item.
PC/Rate	Enter the 5-digit procedure code or the accommodation rate for the line item.
Modifiers	Enter the 2-character if applicable. Enter up to 4 modifiers.
Units	Enter the number of units of service.
DOS	Enter the first date of service
Charges	Enter the total line item charge
Non-Cov	Enter the non-covered part of the line item charge if applicable
TOTALS	Enter the column totals.

Diagnosis Codes

ADMIT, Principal, Other, Other, Other	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.

Remarks

Remarks	Enter the TPL Paid/Denied Date (MMDDYY)

Medicare Payment Information

Paid	Enter the amount Medicare paid on each line item.
Allowed	Enter the amount Medicare allowed on each line item.
Coinsurance	Enter the amount of Medicare coinsurance on each line item.
Deductible	Enter the amount of Medicare deductible on each line item.

Mailing Address

Provider mailing address	Enter the billing address for the rendering (performing) provider.

5.8 Required Attachments

Providers are required to submit attachments for particular services. The table below describes Alabama Medicaid required attachments.

Attachment	*Guidelines*
Third party denials other than Medicare	Providers must submit legible copies of third party denials when billing Medicaid services denied by a third party.

NOTE:

All third party denials must be attached with the claim and sent hard copy. Claims with third party denials may not be sent electronically.

5.9 Required Consent Forms

Consent forms are no longer required attachments with the claim form. The accompanying claim may be sent electronically however, the actual forms must be sent hard copy to the claims address. These forms are scanned and matched electronically with the related claims before processing.

Consent Form	*Guidelines*
Sterilization consent form	A sterilization consent form is required for tubal ligations and vasectomies.
Hysterectomy consent form	A hysterectomy consent form is required when seeking payment for reasons of medical necessity, and not for purpose of sterilization.
Abortion certification form	An abortion certification and documentation of abortion form are required for abortions. Medicaid will not pay for any abortion or services related to an abortion unless the life of the mother would be endangered if the fetus were carried to term.

5.10 Adjustments

Adjustments may be performed only on claims **paid** in error (for example, overpayments, underpayments, and payments for wrong procedure code, incorrect units, or other errors). The adjustment process allows the system to "take back" or cancel the incorrect payment and reprocess the claim as if it were a new claim. Providers may submit their adjustment requests electronically or on paper.

5.10.1 Online Adjustments

Providers can submit electronic adjustments using the EDS Provider Electronic Software or vendor-supplied software designed using specifications received from EDS. Through this process, providers can recoup previously paid claims with dates of service up to three years old. Claims within the timely filing limit may be adjusted for correction and resubmitted for accurate payment the same day the electronic adjustment is made.

To submit electronic online adjustments, providers must use accurate information relating to the previously paid claim. The EDS Provider Electronic Solutions software or provider's vendor system will require that provider submit a new (837) Professional, Institutional or Dental transaction, with *Original Internal Control Number (ICN)* field populated. This electronic adjustment claim will be assigned a new ICN number with a region of 52.

The adjustment claim will process accordingly, and result in a new (835) electronic Health Care Payment/Advice (EOP) and the original claim information will appear on the 835 (EOP) as a void, if processed within the same check write cycle.

Submitting Adjustments on Paper

Providers must use the Medicaid Adjustment Request form to submit paper adjustments. These forms can be ordered from EDS (see Appendix E). **This is the only approved form that will be accepted for paper adjustments.** The following instructions explain how this form should be completed.

NOTE:
Please do not attach a check with the Adjustment Request Form.

Completing the Adjustment Request Form

Section I - Provider Pay-to Information

Field Name	***Instructions for Completion***
Provider Number	Enter the Alabama Medicaid Provider Number under which payment is made.
Provider Name and Address	Complete this field with the same information used to bill Medicaid.

Section II- Paid Claims Information

Field Name	***Instructions for Completion***
ICN Number	Enter the 13-digit number exactly as it is printed on your EOP.
Recipient Number	Enter the 13-digit Medicaid identification number assigned to the recipient as it appears on your EOP.
Recipient Name	Enter the recipient's name exactly as it appears on your EOP.

Field Name	*Instructions for Completion*
Date(s) of Service	Enter the beginning and ending month, day and year of services rendered.
Billed Amount	Enter the exact amount you billed the Medicaid program for the services rendered.
Paid Amount	Enter the amount actually paid by Medicaid for services.

Section III- Reason for Recoupment or Adjustment

Field Name	*Instructions for Completion*
Description of Problem	Indicate the specific reason for the recoupment or adjustment request (from reasons listed on the form).
Signature, date, and telephone number	Enter the signature of the requestor, the date the request was prepared and the requestor's telephone number.

Adjustments appear in the *Adjusted Claims* section of the provider Explanation of Payment (EOP) and consist of two segments: **Credit** (Repaid at lower amount/denied) and **Debit** (Repaid at higher/same amount). The **Credit** segment lists the amount owed to EDS from the original paid claim. This amount will also display in the *Financial Items* section of the EOP as a deduction.

The **Debit** segment indicates there is a repayment of an original claim and provides a complete breakdown of corrected information. The paid amount is included in the total paid claims amount.

An Adjustment occasionally results in a denied claim. Denied Adjustments do not display in the *Adjusted Claims* section on the EOP; they are listed in the *Denied Claims* section. The amount is withheld from the current explanation of payment and listed in the *Financial Items* section.

Refer to Chapter 6, Receiving Reimbursement, for more information relating to adjustments as described in the EOP.

NOTE:

The filing deadline applies to any claim that must be resubmitted due to an adjustment.

5.11 Refunds

If you receive payment for a recipient who is not your patient or are paid more than once for the same service, it is your responsibility to refund the Alabama Medicaid Program.

Provide refunds to the Medicaid Program by using the Check Refund Form (a sample can be found in Appendix E) accompanied by a check for the refund amount. Make the check payable to:

EDS – Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Please provide the following information in the appropriate fields on the Check Refund Request exactly as it appears on your Explanation of Payment (EOP) for each refund you send to EDS:

- Provider Name and Medicaid ID number
- Your check number, check date, check amount
- 13 digit claim number or ICN (from EOP)
- Recipient's Medicaid ID number and name (from EOP)
- Dates of service
- Date of Medicaid payment
- Date of service being refunded
- Services being refunded
- Amount of refund
- Amount of insurance received, if applicable (third party source other than Medicare)
- Insurance name, address and policy number
- Reason for return (from codes listed on form)
- Signature, date and telephone number

This information will allow your refunds to be processed accurately and efficiently.

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts. **If providers receive duplicate payments from a third party and Medicaid, all duplicate party payments must be refunded within 60 days by**:

- Sending a refund of insurance payment to the Third Party Division, Medicaid; or
- Requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

Providers are responsible for ensuring that Medicaid is reimbursed from any third party payment made to a source other than Medicaid as a result of the provider releasing information to the recipient, the recipient's representative, or a third party.

5.12 Inquiring about Claim and Payment Status

Providers may use any of several options to inquire about claim and payment status:

- Call AVRS Provider Electronic Solutions Software
- Review the Explanation of Payment (EOP) for the corresponding checkwrite
- Contact the EDS Provider Assistance Center at 1(800) 688-7989
- Contact EDS Provider Relations in writing at **EDS Attn: Provider Relations P.O. Box 241685 Montgomery, AL 36124-1685.**
- Access the Alabama Medicaid Agency Interactive Services Website at https://almedicalprogram.alabama-medicaid.com/secure.

Calling AVRS

Please refer to Appendix L, AVRS Quick Reference Guide, for instructions on using AVRS to inquire about claim and payment status.

Contacting the EDS Provider Assistance Center

The EDS Provider Assistance Center (PAC) is available Monday through Friday, 8:00 a.m. – 5:00 p.m. at 1(800) 688-7989. An assistance center representative can answer your questions about claim status, eligibility, or other claims related issues. **It is recommended that you use AVRS, Provider Electronic Solutions Software or access the Alabama Medicaid Agency Interactive Services website before calling the EDS Provider Assistance Center. To ensure the Assistance Center is available to all providers, EDS must limit providers to three transactions per telephone call. Through AVRS, however, providers may perform up to ten inquiries, including prior authorization requirements, claim status inquiries, and multiple eligibility verification requests.**

When a provider calls the Provider Assistance Center, the PAC representative logs a "ticket" in the call tracking system, including the provider number, contact name and number, and a description of the problem, question, or issue. If the issue is resolved during the call, the PAC representative records the resolution and closes the ticket. If the issue requires research, the PAC representative records the issue and keeps the ticket in an open status. Other EDS and Medicaid personnel can review the open ticket and participate in the resolution of the issue. The ticket stays open in the call tracking system until the issue is resolved. This enables EDS to monitor its service to providers.

Contacting EDS in Writing

Providers may contact EDS in writing to resolve more complex billing issues. This correspondence will be reviewed by EDS Provider Relations, which is composed of field representatives who are expert in Medicaid billing policy. EDS will respond to written inquiries within seven (7) business days and telephone inquiries by the end of the next business day.

The difference in response time occurs because EDS' Provider Assistance Center is fully staffed during regular business hours, and can receive, resolve, or forward all billing and claim-related calls, ensuring they are answered in a timely fashion. Provider Representatives, who provide responses to written requests, travel on a regular basis, providing billing assistance to the Alabama Medicaid provider community. It is therefore recommended that providers contact the Provider Assistance Center to begin the inquiry process, and follow up with written correspondence as the need arises.

Accessing the Alabama Medicaid Agency Interactive Services Website

The Alabama Medicaid Agency Interactive Services secure website gives you the opportunity to view claim status and eligibility verification inquiries and to upload and download standard X12 and NCPDP transactions.

Contact EDS Helpdesk if you need a User ID and Password.

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6

6 Receiving Reimbursement

This chapter describes the Explanation of Payment (EOP) report and the reimbursement schedule for Medicaid fee-for-service claims.

NOTE:

Reimbursement information specific to managed care is described in Chapter 39, Patient 1st, of this manual.

6.1 Explanation of Payment (EOP) Report

It is the responsibility of each provider to follow up on claims submitted to EDS. The Explanation of Payment (EOP) is a vital tool for this process. The EOP indicates claims that have been adjudicated (paid or denied) and lists claims that are currently in process (suspended claims). Providers are urged to examine each EOP carefully and to maintain the document for future reference. Claims listed as claims in process are being processed and will appear on one of the next two EOPs as paid, denied, or still in process.

A provider has the choice of receiving an electronic copy of the EOP, in addition to the paper copy. The electronic copy is the 835 Health Care Claim Payment/Advice. Both the paper and the electronic media have been expanded to include more information. Providers wishing to receive the 835 must be assigned a 'submitter ID" and an indicator must be set in the system to generate the electronic report*. The Electronic Explanation of Payment Agreement Form is available on the Alabama Medicaid website.*

The EOB (Explanation of Benefit) code that displays next to a paid or denied claim explains the adjudication of the claim. A provider who wishes to question a paid or denied claim should do so by calling the EDS Provider Assistance Center at 1(800) 688-7989. To request an adjustment of a previously paid claim, refer to Section 5.8, Adjustments, for more information.

Any claim that does not appear on an EOP within forty-five working days from the time of submission should be resubmitted immediately. Before resubmitting, please verify that the claim has not been returned to you for correction or additional information.

Providers are required to maintain a copy of each claim submitted. The claim copies should be used for comparison if there are questions concerning the disposition of claims as shown on the EOP.

6.1.1 Provider Explanation of Payment (EOP)

Twice a month, providers are issued a single remittance check or Electronic Funds Transfer (EFT) transaction for all claims that have been processed for payment for that checkwrite's pay period. Providers who choose to have their payments deposited directly to their bank receive their Explanation of

Payment (EOP) a few days earlier than providers who receive a paper check. Paper checks are generated and mailed to providers with the EOP.

The EOP displays the paid or denied status of adjudicated (settled) claims, as well as lists claims currently in process, claims credited to the Medicaid Agency, and any refunds that are processed. The sections of the EOP are described in the following paragraphs.

Each page displays the payee provider's submitter ID, name, address, and Medicaid provider number printed as it currently appears on EDS' provider file. The EOP number and checkwrite date display on each page of the EOP as well.

The columns that display at the top of every page correspond to the information in the sections that list paid and denied claims.

SUBMITTER ID
STATE OF ALABAMA

MEDICAL ASSISTANCE EXPLANATION OF PAYMENT
ALABAMA MEDICAID INFORMATION SYSTEM
EXPLANATION OF PAYMENT

Anywhere Physicians Clinic
123 Main St.
Anywhere, USA 12345

PROVIDER NUMBER **520000000** CNTRL NUM 000000 REPORT SEQ NUMBER 4 EOP NUMBER 0000000 DATE 01/01/2000 PAGE 1

NAME RECIPIENT ID	SERVICE DATES FROM MM DD YY	TO MM DD YY	DAYS OR UNITS	PROC/ REVENUE/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PATIENT LIABILITY	DEDUCTED AMOUNTS	OTHER DEDUCTED AMOUNTS	PAID AMOUNTS

First Page

A "Mini-Message" from EDS appears on this page. The "Mini-Message" delivers information to the provider community and includes updates to current policies and procedures.

NOTE:

A single EOP issued for several providers (such as for a corporation or a group) lists each provider number in the group separately in numeric order.

Paid Claims

This section of the EOP lists a payment for each claim in alphabetical order by recipient last name.

Claims are grouped by claim type, with a total for each. A grand total of paid claims and paid amounts displays at the end of this section.

Paid claims may include an EOB code to provide more information about the payment amount. For example, a provider may bill an amount higher than Medicaid allows for a procedure. The EOB code next to this paid claim explains why the provider received a lower payment than he submitted.

The following table lists the fields in the paid claims section from left to right, top to bottom. Not all paid claims will display data in every field.

Note: The fields listed in the following tables are based on information available at the time of publication. The information is subject to change based on further review.

Field	***Description***
Recipient Name	Displays the recipient's last name, first name, and middle initial. Claims are displayed in alphabetical order by last name.
PCN	Displays the Patient Control Number assigned to the recipient by the provider. This is the patient account number.
RCC	This field is no longer populated.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
Perf Phys	Displays the provider number of the performing provider.
Recipient Medicaid ID	Displays the 13 digit recipient Medicaid ID number.
First date of service - last date of service	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.
Procedure/Revenue/ Drug Code and Description	Displays these codes as they were submitted on the claim, with a description of the procedure code. This displays for each line item billed, if applicable. Effective on the first Checkwrite in October 2003 the following fields will no longer display on the EOP: Place of Service and Type of Service.
Total Billed	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.
Total Allowed	Displays the amount of the billed amount that Medicaid will cover. This displays for each line item billed, if applicable.
Patient Liability	Effective on the first Checkwrite in October 2003 this field will no longer be populated on the EOP.
Other Deducted Charges	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. This displays for each line item billed, if applicable.
ARC/RRC Codes	Displays an Adjustment Reason Code and or a Remittance Remarks Code about claim adjudication. This displays for each line item billed, if applicable.
DED	This field is only used for adjusted claims.
TPL	Displays the amount paid by a third party insurance.
Total Billed	Displays the total billed for all line items on the claim.
Total Non Allowed	Displays the total payment that Medicaid will not cover for all line items on the claim.

Field	*Description*
Total Allowed	Displays the total allowed amount for all line items on the claim.
Total Patient Liability	Displays the total patient liability for all line items on the claim.
Total other deductible charges	Displays the total deductible charges for all line items on the claim.
Total Paid Amount	Displays the total amount of Medicaid payment for the claim.

Paid claims have been finalized. No additional action will be taken on them unless the provider or Medicaid requests an adjustment and makes appropriate corrections.

Managed Care Claims Paid

This section of the EOP lists all paid Managed Care claims in alphabetical order by recipient last name.

Denied Claims

This section of the EOP lists each denied claim in alphabetical order by recipient last name. An ARC/RRC appears beside each claim. Please reference the listing at the end of each EOP that defines the codes used on that EOP. For further explanation please refer to Appendix J of the provider manual.

Claims are grouped by claim type, with a total for each. A grand total of denied claims and billed amounts displays at the end of this section.

The following table lists the fields in the denied claims section from left to right, top to bottom. Not all denied claims display data in every field.

Field	*Description*
Recipient Name	Displays the recipient's last name, first name, and middle initial. Claims are displayed in alphabetical order by last name.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
PCN	Displays the Patient Control Number assigned to the recipient by the provider. This is the patient account number.
Perf Phys	Displays the provider number of the performing provider.
Recipient Medicaid ID	Displays the 13 digit recipient Medicaid ID number.
First date of service - last date of service	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.

Field	*Description*
Procedure/Revenue/ Drug Code and Description	Displays these codes as they were submitted on the claim, with a description of the procedure code. This displays for each line item billed, if applicable.
Total Billed	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.
Total Allowed	Displays the amount of the billed amount that Medicaid will cover. In the case of a denied claim, this amount is always $0.00. This displays for each line item billed, if applicable.
Patient Liability	Effective on the first Checkwrite in October 2003 this field will no longer display on the EOP.
Other Deducted Charges	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. In the case of a denied claim, this amount is always $0.00. This displays for each line item billed, if applicable.
ARC/RRC Codes	Displays an Adjustment Reason Code and/or a Remittance Remarks Code about claim adjudication. This displays for each line item billed, if applicable.
DED	This field is only used for adjusted claims.
TPL	Displays the amount paid by a third party insurance.
Total Billed	Displays the total billed for all line items on the claim.
Total Non Allowed	Displays the total payment that Medicaid will not cover for all line items on the claim.
Total Allowed	Displays the total allowed amount for all line items on the claim. In the case of a denied claim, this amount is always $0.00.
Total Patient Liability	Displays the total patient liability for all line items on the claim.
Total other deductible charges	Displays the total deductible charges for all line items on the claim.
Total Paid Amount	Displays the total amount of Medicaid payment for the claim. In the case of a denied claim, this amount is always $0.00.

Denied claims are finalized. No additional action will be taken on them unless the provider makes appropriate corrections and refiles the claim. This section also includes denied adjustments.

Managed Care Claims Denied

This section of the EOP lists all denied Managed Care claims in alphabetical order by recipient last name. Medicare-Related Claims Paid

This section of the EOP lists all paid Medicare-related claims in alphabetical order by recipient last name.

Medicaid-Related Claims Denied

This section of the EOP lists all denied Medicare-related claims in alphabetical order by recipient last name.

Adjusted Claims

This section of the EOP lists adjustments made to correct payment errors in alphabetical order by recipient last name. Adjustments consist of two sections*:* Debit (Repaid at Higher/Same Amount) and Credit (Repaid at Lower Amount/Denied).

The ***"Debit"*** section indicates changes made to the original claim or additional amounts EDS owes the provider. It lists information in reference to the original payment, including the original claims number, the paid date, and the original paid amount. Debit adjustments are grouped together with the description Adjusted Claims: Debit (Repaid at higher or same amount). This segment lists a complete breakdown of the corrected information. The repayment is included as a part of the total paid claims amount.

*"*The *"**Credit"*** section lists information in reference to the original payment, including the original claim number, the paid date, and the original paid amount. Credit adjustments are grouped together with the description Adjusted Claims: Credit (Repaid at lower amount or denied). This is the amount owed to EDS that will be deducted from current explanation of payment.

This section also includes paid crossover adjustments. An ARC/RRC code is assigned to each action that has taken place in the adjustment process. An explanation of these codes is listed after the Summary Page of the EOP.

The Net Adjustment is the difference between the original paid amount ("Credit"), and the repaid claim ("Debit") financial Items.

Refunds

This section of the EOP lists, in alphabetical order by recipient last name, those claims for which the provider has sent EDS a refund check.

NOTE:

Because EDS must correct claim payment history, the full payment amount must be credited for claims paid in error before the claim can be reprocessed correctly. If the provider has sent EDS a partial refund, the difference between the payment amount and the refund amount will be credited under the "Provider Refund Checks Processed" section of the summary page.

Claims In Process

The claims in process section of the EOP lists claims currently in process for the provider, in alphabetical order by recipient last name. Claims that appear in this section are paid, denied, or suspended as appropriate on a future EOP. Providers should not submit inquiries or resubmit suspended claims as long as they appear on the EOP as suspended. If a claim appears in this section for more than two remits, please contact the EDS Provider Assistance Center to verify the status of this claim.

Summary Page

This page of the EOP is divided into two sections. The first section contains *informational dat*a (for example, beginning credit balance, total claims considered for payment, total claims suspended, total denied claims, and refund/void adjustments processed) for the current checkwriting period. The refund/void adjustment section displays current and year-to-date totals.

The second section contains *payment data* (for example, total claims approved for payment, claims adjusted, total net adjustments, audit adjustments, and check amount) for the current checkwriting period. Each section displays current and year-to-date totals.

NOTE:

If a credit balance has been established at the end of the payroll, the last entry appears as “Credit Balance Carried Forward,” and the following EOP lists this amount in the “Credit Balance Brought Forward” section of the payment data. The last EOP issued for the calendar year notifies providers of the amount submitted to the Internal Revenue Service for tax reporting.

ARC/RRC/CSC Codes

Following the summary page is a listing of definitions for the EOB codes used on each statement. This section also contains Adjustment codes identifying adjustments. (Refer to Appendix J of this manual for a complete list of these codes).

Encounter Data

This section of the EOP contains encounter claim data and follows the same sequence as the main part of the EOP. The encounter data is for informational purposes only and does not show any dollar amounts paid. However, the provider should resubmit any correctable denied encounter data claims for payment. The plan code identifies the payer of these claims followed by the district. Example: PXX would be a Maternity Care claim processed by the Maternity Contractor in district XX and HXX would be a PHP claim processed by district XX.

6.2 Reimbursement Schedule

Claims that have been accepted for processing either through electronic submission or manually by EDS staff are processed on a weekly basis. Payment for these claims is disbursed based on the twice a month checkwriting schedule as approved by the Alabama Medicaid Agency.

Information regarding checkwriting schedules is listed in the bimonthly publication of the Alabama Medicaid Provider Bulletin and can also be obtained on the Medicaid website at www.medicaid.alabama.gov.

7

7 Understanding Your Rights and Responsibilities as a Provider

This chapter describes provider rights and responsibilities as mandated by the *Alabama Medicaid Agency Administrative Code*. The chapter contains the following sections:

- Provider Responsibilities
- Medicare/Medicaid Fraud and Abuse Policy
- Refunds

7.1 Provider Responsibilities

Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, (such as, epidurals or spinal anesthetic) these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. Medicaid covers these services. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery-related pain management services.

Providers, including those under contract, must be aware of participation requirements that may be imposed due to managed care systems operating in the medical community. In those areas operating under a managed care system, services offered by providers may be limited to certain eligibility groups or certain geographic locations.

This section describes provider responsibilities such as maintenance of provider information, retention of records, release of confidential information, compliance with federal legislation, billing recipients, and agreement to the certification statement described in the *Alabama Medicaid Agency Administrative Code.*

7.1.1 Maintenance of Provider Information

Providers must promptly advise the EDS Provider Enrollment Department in writing of changes in address (physical or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, rendering providers). Failure to notify EDS of changes affects accurate processing and timely claims payment.

Send change requests to EDS Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

7.1.2 Retention of Records

The provider must maintain and retain all necessary records, Explanation of Payments (EOPs), and claims to fully document the services and supplies provided to a recipient with Medicaid coverage. These must be available, upon request, for full disclosure to the Alabama Medicaid Agency. The *Alabama Medicaid Agency Administrative Code,* Chapter 1, states the following:

> *Alabama Medicaid providers will keep detailed records in Alabama, of such quality, sufficiency, and completeness except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.*

In the event of ongoing audits, litigation, or investigation, records must be retained until resolution of the ongoing action.

The provider must be able to provide, upon request and at no charge to Medicaid, related state or federal agencies, or the Alabama Medicaid fiscal agent, EDS, original records. These records may include, but are not limited to, documents relating to diagnostic tests, treatment, service, laboratory results, and x-rays.

Providers will make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, the Alabama Medicaid Agency, and other agencies of the State of Alabama. Provider records and operating facilities shall be made available for inspection during normal business hours.

Providers participating in the Alabama Medicaid program shall make available, free of charge, within ten (10) days, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated Medicaid representatives who, in the course of conducting reviews or investigations, have need of such documentation to determine fraud, abuse, and/or other deliberate misuse of the Medicaid program. Depending on the number of records requested, Medicaid may provide a reasonable extension.

Failure to supply requested records might result in recoupment of the paid claims in question and additional action as deemed necessary by Medicaid including referral to law enforcement agencies.

Information pertaining to a patient's charges or care may be released only as directed by the Medicaid Regulations (see the *Alabama Medicaid Agency Administrative Code*, Chapter 20, for information pertaining to Third Party).

7.1.3 Release of Confidential Information

Information about the diagnosis, evaluation, or treatment of a recipient with Medicaid coverage by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical, mental or emotional disorder, or drug abuse, is usually confidential information that the provider may disclose only to authorized people. Family planning information is sensitive, and confidentiality must be assured for all recipients.

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulations of the U.S. Department of Health and Human Services (HHS) or on the express authorization of the Commissioner of Social Security. The regulations of HHS regarding the confidentiality of records and information apply to both governmental and private agencies participating in the administration of the Program; to institutions, facilities, agencies, and persons providing services; and to those administrative services under an agreement with a provider of services. The rules governing release of private information and disclosure of classified information are contained in Chapters 20 and 27 of the *Alabama Medicaid Agency Administrative Code*, which is available to all Alabama Medicaid providers.

Information furnished specifically for purposes of establishing a claim under the Medicaid Program is subject to these rules. Such information includes the individual's Medical Assistance (Medicaid Title XIX) Identification (ID) Number, facts relating to entitlement to Medicaid benefits, other medical information obtained from state of Alabama agencies or the Medicaid Fiscal Agent, EDS.

7.1.4 Compliance with Federal Legislation

Participating providers of services under the Medicaid Program must comply with the requirements of Titles VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990.

Under the provisions of these Acts, a participating provider or vendor of services receiving federal funds is prohibited from making a distinction based on race, color, sex, creed, handicap, national origin, or age.

Once accepted, recipients must have access to all portions of the facility and to all services without discrimination. Recipients may not be segregated within any portion of the facility, provided a different quality of service, or restricted in privileges because of race, color, sex, creed, national origin, age, or handicap.

Medicaid is responsible for investigating complaints of noncompliance. Send written complaints of noncompliance to the following address:

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

7.1.5 Utilization Control – General Provisions

Title XIX of the Social Security Act, Sections 1902 and 1903, mandates utilization control of all Medicaid services under regulations found at Title 42, *Code of Federal Regulations*, Part 456. Utilization review activities required by the Medicaid program are completed through a series of monitoring systems developed to ensure services are necessary and in the appropriate quality and quantity. Both recipients and providers are subject to utilization review monitoring.

Utilization control procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by the Alabama Medicaid Agency. Most monitoring is performed using two systems: the Surveillance and Utilization Review (SUR) system, and the Codman Pandora Managed Care Information System (MCIS) product. However, utilization review may also involve an examination of particular claims or services not within the normal screening when a specific review is requested by the Alabama Medicaid Agency or any related state or federal agency.

All providers identified as a result of provider review are made available to the Provider Review Department of the Alabama Medicaid Agency.

The primary goal of utilization review is to identify providers with practice patterns inconsistent with the federal requirements and the Alabama Medicaid Program scope of benefits. This review relies on a number of parameters including comparison of resource utilization with that of the provider's peer group.

The principal approach to resolution of inappropriate use is education of the provider. The education may include a provider representative visit or letter to assist with the technical aspects of the program, and (or) a physician education visit or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service.

Depending on the intensity of the identified problem, the letter or visit may result in a review of claims before payment. This is indicated on the provider records maintained by EDS, and may refer to claims for similar services, or all claims submitted by a particular provider. All claims that match the review criteria determined by Medicaid will suspend for manual review. As part of the review process, providers may be required to submit supporting documentation (for example, the medical record extract) for billed services. The documentation is used to ascertain the medical necessity for the services rendered.

7.1.6 Provider Certification

The Medicaid Program is funded by both the state and the federal government. Therefore, the providers of medical services are required to certify compliance with, or agreement to, various provisions of both state and federal laws and regulations. The agreements required by the Medicaid Program are explained in the following paragraphs:

Payment for services is made on behalf of recipients to the provider of service in accordance with the limitations and procedures of each program.

Medicaid payment can never be made directly to recipients.

By submitting Medicaid claims, the provider agrees to abide by policies and procedures of the Program as reflected by the information and instructions in the *Alabama Medicaid Agency Administrative Code*. The provider also agrees to the following certification statement: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws." The requirements for this certification may be found in 42 Code of Federal Regulations §447.15.

Services must be reasonable and medically necessary.

Medicaid is continuously evaluating and updating medical necessity for claims payment. In an effort to ensure accurate coding and payment of claims, diagnosis/procedure code criteria is applied. The correct use of a CPT or ICD-9 code alone does not guarantee coverage of a service. All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.

7.1.7 Billing Recipients

When the provider of medical care and services files a claim with the Medicaid Program, the provider must agree to accept assignment. By accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that which is paid on allowed services.

NOTE:

Recipients may not be billed for claims rejected due to provider-correctable errors or failure to submit claims in a timely manner.

The recipient may be billed for services that are non-covered and for which Medicaid will not make any payment. Services that exceed the set limitation (for example, physician visits, hospital visits, or eyeglasses limit) are considered non-covered services. Providers are requested 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. The requirements for payment can be found in 42 Code of Federal Regulations §455.18.

Recipients under 21 may qualify for additional Medicaid covered services beyond the yearly benefit limit. If treatment is deemed medically necessary to correct or improve conditions identified through the EPSDT screening process, these services will not be considered in the normal benefit limitations.

7.2 Provider Rights

This section describes the fair hearings process, informal conferences, appeals, and EDS and Alabama Medicaid Agency responsibilities towards providers participating in the Alabama Medicaid Program.

Providers have freedom of choice to accept or deny Medicaid assignment for medically necessary services rendered during a particular visit. This is true for new or established recipients.

The provider (or their staff) must advise each recipient when Medicaid payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted **must be recorded** in the recipient's medical record.

7.2.1 Administrative Review and Fair Hearings

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code.*

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated**. In addition to a clean claim, the provider should send all relevant EOPs and previous correspondence with EDS or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

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

Include the program area in the address (for instance, write “Attn: System Support”).

NOTE:

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing

7.2.2 Informal Conferences

A provider who disagrees with the findings of a utilization review may request an informal conference. Providers must make the request in writing to the Alabama Medicaid Agency at the above address. The informal conference is the intermediate step between the Administrative Review and the Fair Hearing process.

7.2.3 EDS’ Responsibilities

The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. The present fiscal agent contract is with EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032. Their toll free telephone number is 1(800) 688-7989.

EDS provides current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. EDS prepares and distributes the *Alabama Medicaid Agency Provider Manual* to providers of Medicaid services. This manual is for guidance of providers in filing and preparing claims.

Providers with questions about claims should contact EDS. Only unsolved problems or provider dissatisfaction with the response of EDS should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, or by calling (334) 242-5000.

7.2.4 Alabama Medicaid Agency’s Responsibilities

The Alabama Medicaid Agency is responsible for mandating and enforcing Medicaid policy for the Alabama Medicaid Program.

7.3 Medicare/Medicaid Fraud and Abuse Policy

The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse and/or misuse in the Medicaid Program. This includes verifying that medical services are appropriate and rendered as billed, that services are provided by qualified providers to eligible recipients, that payments for those services are correct, and that all funds identified for collection are pursued.

Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The Alabama Medicaid Agency has designated the Program Integrity Division through its Provider Review, Recipient Review, and Investigations Units to perform this function. These units are responsible for detecting fraud and abuse within the Medicaid Program through reviewing paid claims history and conducting field reviews and investigations to determine provider/recipient abuse, deliberate misuse, and suspicion of fraud. In addition, these units are utilized to aid in program management and system improvement.

Cases of suspected recipient fraud are referred to local law enforcement authorities for prosecution upon completion of investigation. Cases of suspected provider fraud and patient abuse are referred to the Medicaid Fraud Control Unit in the Alabama Attorney General's Office. This office was established under Public Law 95-142 and Health and Human Services guidelines to investigate, for possible prosecution, alleged provider fraud and patient abuse in the Medicaid Program. The requirements can be found in 42 Code of Federal Regulations Part 455, Program Integrity: Medicaid.

7.4 Appeals

If eligibility of a provider has been terminated because of a criminal conviction for Medicaid fraud or abuse, or because of loss of required licensure, then no fair hearing need be given. A certified copy of the judgement of conviction or of the decision to revoke or suspend a provider's license shall be conclusive proof of ineligibility for further participation in the Medicaid Program. The pending status of an appeal for any such conviction or license revocation or suspension shall not abate the termination of Medicaid eligibility. If a conviction, license revocation, or suspension is reversed on appeal, the recipient or provider may apply for reinstatement to the Medicaid program. However, Medicaid will examine the reasons for the reversal and reinstatement will be at the sole discretion of the Commissioner.

7.5 Refunds

Medicaid Refunds

If you receive payment for a recipient who is not your patient, or are paid more than once for the same service, please complete the Check Refund form. Refer to Section 5.8, Refunds, for instructions on completing the form. Appendix E, Medicaid Forms, contains a sample of the form.

Medicaid Adjustments

If you wish to have an overpayment deducted from a future remittance, do not attach a check. Instead, state that you wish to have funds deducted from a future remittance. If you require an adjustment on a fully or partially paid claim, please use one of the following methods:

- Complete the Alabama Medicaid Adjustment form as described in Section 5.8, Adjustments.
- Complete an online adjustment using Provider Electronic Solutions software or approved vendor software as described in Section 5.8, Adjustments.

NOTE:

For large numbers of adjustments, please contact the Provider Assistance Center at 1(800) 688-7989.

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts.

If providers receive duplicate payments from a third party and Medicaid, all duplicate third party payments must be refunded within 60 days by:

- Sending a refund of insurance payment to the Third Party Division, Medicaid
- Requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

If the provider releases medical records and/or information pertaining to a claim paid by Medicaid and, as a result of the release of that information, a third party makes payment to a source other than the provider or Medicaid, the provider is responsible for reimbursing Medicaid for its payment.

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8 Ambulance (Ground & Air)

Medicaid covers transportation costs to and from medical care facilities for eligible recipients. The approved plan includes the following services:

- Reimbursement of ambulance service for emergency and non-emergency situations
- Reimbursement of non-emergency transportation coordinated by the Alabama Medicaid Agency (See Appendix G, Non-Emergency Transportation (NET Program)

The policy provisions for transportation providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 18.

8.1 Enrollment

EDS enrolls transportation providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

For ambulance providers, Medicaid requires a new service contract in the following instances:

- Expiration of state license and issuance of new license
- Change of ownership

EDS is responsible for enrolling any qualified ambulance service that wishes to enroll in the Medicaid Transportation Program.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a transportation provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for transportation-related claims.

NOTE:

All nine digits are required when filing a claim.

Transportation providers are assigned a provider type of 15 (Transportation).

Valid specialties for transportation providers include the following:

- Emergency Ground Ambulance (A1)
- Helicopter (TA)
- Fixed Wing (TB)

Enrollment Policy for Transportation Providers

To participate in the Alabama Medicaid Program, transportation providers must meet the following requirements:

- Must be certified for Medicare Title XVIII
- Must maintain a disclosure of the extent and cost of services, equipment, and supplies furnished to eligible recipients
- Must be licensed in the state of Alabama and/or the state in which services are provided

8.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Please refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid reimburses a maximum of one round trip per date of service per recipient. A round trip consists of the transport from home base (home, nursing home, etc) to the destination (physician's office, hospital, etc) and transport from the destination back to home base on the same date of service.

All transportation must be medically necessary and reasonable. Documentation must state the condition(s) that necessitate ambulance service and indicate why the recipient cannot be transported by another mode of transportation. Medicaid will not reimburse ambulance service if some other means of transportation could have been used without endangering the recipient's health.

8.2.1 Non-Emergency Transportation (NET) Program Services

To eliminate transportation barriers for recipients, Medicaid operates the Non-Emergency Transportation Program (NET). The NET Program ensures that necessary non-ambulance transportation services are available to recipients. See Appendix G, Non-Emergency Transportation (NET) Program, for specifics about the program.

All payments for NET services require authorization.

8.2.2 Non-Emergency Ambulance Services

Medicaid reimburses non-emergency ambulance services provided to eligible recipients for the following origins and destinations:

- Hospital to home following hospital admission
- Home to hospitals or specialized clinics for diagnostic tests or procedures for non-ambulatory recipients

- Home to treatment facility for recipients designated on Home Health Care Program who are confined as "bedfast" recipients
- Nursing facility to hospital or specialized clinic for diagnostic tests within the state when medically necessary and out of state with Alabama Medicaid determined placement only.
- Nursing facility to nursing facility
- Hospital to hospital
- Hospital to nursing facility following hospital admission
- Ambulance services to a physician's office is a covered service only when prior authorized by Medicaid.

8.2.3 Emergency Ambulance Services

Medicaid reimburses emergency ambulance services provided to eligible recipients for the following origins and destinations:

- Location of emergency to a local hospital
- Nursing facility to a local hospital
- Hospital to hospital

Medicaid reimburses emergency ambulance services if the recipient expires during transport, but not if the recipient was pronounced dead by authorized medical personnel before transport.

If more than one recipient is transferred in the same ambulance at the same time, please file a separate claim form for each recipient.

8.2.4 Air Transportation Services

Medicaid reimburses air transportation services for all Medicaid recipients with prior authorization approval only. Air transportation for adults is reimbursed at the ground ambulance rate.

Air transportation may be rendered only when basic and advanced life support land ambulance services are not appropriate. Medical necessity applies when transport by land or the instability or inaccessibility to land transportation threatens survival or seriously endangers the recipient's health. Medicaid may authorize air transportation in certain cases when the time required to transport by land as opposed to air endangers the recipient's life or health. Medicaid will not reimburse air transportation when provided for convenience.

Medicaid requires that the recipient be taken to the nearest hospital that has appropriate facilities, physicians, or physician specialists needed to treat the recipient's condition. The hospital must have a bed or specialized treatment unit immediately available. If the recipient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick-up point to the nearest appropriate hospital.

NOTE:

Medicaid does not consider trips of less than 75 loaded miles to be appropriate unless extreme, extenuating circumstances are present and documented.

NOTE:

If more than one recipient is transferred in the same air transport trip, only one recipients transport will be reimbursed.

If Medicaid determines that land ambulance service would have been more appropriate, payment for air transportation will be based on the amount payable for land transportation.

8.3 Prior Authorization and Referral Requirements

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).

When requesting prior authorization, please give the recipient's name, RID number, address, diagnosis, attending physician, reason for movement (from and to), and the name of the ambulance provider who will be used. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

In the case of Retroactive Eligibility, the provider has 90 days after the date on which the award of retroactive eligibility was made to submit their request for prior approval. It is the provider's responsibility to submit a copy of the retroactive eligibility determination along with the prior approval request to Medicaid.

NOTE:

"Clean" Prior Authorization (PA) requests must be received by our Fiscal Agent (EDS) within thirty (30) business days from the date of service. A"Clean" PA request is one where valid information is submitted on both the provider and the recipient regarding services that were rendered on a specific date of service and without any RTPs (Return To Provider) which would create a delay for your request.

Prior Authorization for Non-Emergency Transportation (30 miles or greater)

All non-emergency ambulance services 30 miles or greater one way requires prior authorization. However, the provider has thirty (30) business days from the date the service was rendered to obtain the prior authorization (PA).

Prior Authorization for Repeat Non-Emergency Transportation (Less than 30 miles)

Medicaid reimburses for four (4) non-emergency trips less than 30 miles in the same calendar month without prior authorization, with the exception of trips to a physician's office, which always require prior authorization. The fifth non-emergency trip less than 30 miles in the same calendar month requires prior authorization.

When submitting Prior Authorization requests for non-emergency ground ambulance transport, the following condition codes are the only ones recognized by Alabama Medicaid:

Condition Code	***Description***
02	Bed confined before the ambulance service
04	Moved by stretcher
05	Unconscious or in shock
07	Physically restrained
08	Visible hemorrhaging

NOTE:

Renal Dialysis, Chemotherapy, Radiation Therapy Transport

Due to the necessity of multiple trips, for renal dialysis recipients, prior authorizations are approved for sixty (60) days at a time. A maximum of fifty-four (54) round trips may be provided with one sixty (60) day prior authorization. For chemotherapy recipients, prior authorizations are approved for ninety (90) days at a time with a maximum of twenty-five (25) round trips provided per ninety (90) day prior authorization. For radiation therapy recipients, prior authorizations are approved for sixty (60) days at a time with a maximum of thirty-five (35) round trips provided per sixty (60) day prior authorization.

Authorization for Air Transportation

All payments for air transportation services require authorization from Medicaid.

The following steps must be followed for air ambulance providers to receive reimbursement:

1. Medicaid's Fiscal Agent must receive authorization requests no later than the thirtieth (30th) business day after the service was rendered. **Please include the following:**
   - Copy of the EPSDT referral form (no longer required for dates of service after 6/1/02)
   - Air versus ground time and/or distance
   - Age of recipient
   - Diagnosis and severity of condition
   - Any other pertinent medical data as deemed necessary to document air transportation
2. The provider must supply the above documentation for any service requiring immediate transportation. The documentation must also include a copy of the flight record, progress notes from institution that requested air transport, and documentation of reason why ground transport is not feasible.
3. Medicaid's Fiscal Agent assigns a prior authorization number and forwards the request to the Medicaid Prior Approval Program for review.

4. The Prior Approval Program reviews the request and forwards it to the Medicaid's Medical Director for approval/denial.
5. If the Medical Director determines that air transportation is not medically necessary and the criteria are met for ground transportation, the request is approved at the emergency ground rate. The provider will bill authorized amount and be reimbursed at the emergency ground rate.
6. Providers who are dissatisfied with the decision of the Medical Director must request an informal review of medical information. The request must be in writing and received by Medicaid within thirty days of the modified approval letter. If additional information is not submitted for review, the decision will be final and no further review will be available.
7. Provider is instructed to submit claim to Medicaid's Fiscal Agent for payment with the assigned prior authorization number.
8. Prior authorization requests will be accepted from newly enrolled providers for dates retroactive to the first day of the month preceding the month of the effective date provider is added to the Medicaid system.

NOTE:

In the event an air transport provider is unable to verify a recipient's eligibility prior to or at the time of the transport due to the patient being unconscious or disoriented and no family member being available, the provider's prior authorization request will be reviewed on a case by case basis. The request must include documentation detailing the reason eligibility was not verified prior to transport.

NOTE:

Prior authorization requests may be submitted to Medicaid's Fiscal Agent per FAX or regular mail. Providers are instructed to follow-up with the fiscal agent within four to five days to be certain request was received, and again in two weeks, if no reply has been received.

8.4 Cost Sharing (Copayment)

The copayment does not apply to services provided by transportation providers.

8.5 Billing Recipients

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

By filing a claim with the Medicaid Program, a provider is agreeing to accept assignment and by accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount (copay) to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that, if any, which is paid on an allowed service.

8.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Transportation providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

8.6.1 Time Limit for Filing Claims

Medicaid requires all claims for transportation to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

8.6.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

Ground transportation providers must use a valid diagnosis code. Ground transportation providers may use more than one diagnosis code from the approved list per claim.

NOTE:

Air transportation providers should only bill diagnosis code used on the prior authorization.

Diagnosis codes for ground transportation are listed below. If you bill a diagnosis code that is not on this list, your claim will deny.

Covered

* An asterisk indicates additional digits are required. See the ICD-9 manual for appropriate digit(s).

NOTE: This chart displays diagnosis codes with the decimal point to facilitate code lookup in the ICD-9 manual. Do not include the decimal point when entering a diagnosis code on the claim form.

040.82	296.90	416.8	426.89	434.1*	484.3	638.5	666.0*	747.21	768.5	779.2	801.4*
0664	296.99	416.9	426.9	434.9*	484.5	638.6	666.1*	747.22	768.6	779.4	801.5*
250.1*	297.0	417.0	427.0	435.0	484.6	639.1	666.2*	747.29	768.9	779.5	801.6*
250.2*	297.1	417.1	427.1	435.1	484.7	639.3	666.3*	747.3	769	779.8	801.7*
250.3*	297.2	417.8	427.2	435.2	484.8	639.5	707.0*	747.40	770.1	779.81	801.8*
251.0	297.3	417.9	427.31	435.3	485	639.6	741.0*	747.41	770.2	779.82	801.9*
277.02	297.8	420.0	427.32	435.8	486	639.8	741.9*	747.42	770.3	779.83	802.0
277.03	297.9	420.90	427.41	435.9	487.0	640.0*	742.0	747.49	770.4	779.84	802.1
277.09	298.0	420.91	427.42	436	487.1	640.8*	742.1	747.5	770.5	779.85	802.20
282.62	298.1	420.99	427.5	437.0	487.8	640.9*	742.2	747.60	770.6	779.86	802.21
290.3	298.2	421.0	427.60	437.1	506*	641.0*	742.3	747.61	770.7	779.87	802.22
290.40	298.3	421.1	427.61	437.2	511.0	641.1*	742.4	747.62	770.8	779.88	802.23
290.41	298.4	421.9	427.69	437.3	511.1	641.2*	742.51	747.63	770.81	779.89	802.24
290.42	298.8	422.0	427.81	437.4	511.8	641.3*	742.53	747.64	770.82	780.0*	802.25
290.43	298.9	422.90	427.89	437.5	511.9	641.8*	742.59	747.69	770.83	780.1	802.26
291.0	299.0*	422.91	427.9	437.6	512.0	641.9*	742.8	747.81	770.84	780.2	802.27
291.2	299.1*	422.92	428.0	437.7	512.1	642.5*	742.9	747.82	770.85	780.31	802.28
291.3	299.8*	422.93	428.1	437.8	512.8	642.6*	745.0	747.89	770.89	780.39	802.29
291.4	299.9*	422.99	428.20	437.9	518.0	644.0*	745.10	747.9	771.7	785.50	802.30
291.5	345.1*	423.0	428.21	443.21	518.1	644.1*	745.11	748.0	771.8	785.51	802.31
291.8	345.2	423.1	428.22	443.22	518.2	644.2*	745.12	748.3	771.81	785.52	802.32
291.9	345.3	423.2	428.23	443.23	518.3	645*	745.19	748.8	771.82	785.59	802.33
292.0	345.4*	423.8	428.30	443.24	518.4	652.00	745.2	750.3	771.83	786.00	802.34
292.11	345.5*	423.9	428.31	443.29	518.5	652.01	745.3	751.1	771.86	786.01	802.35
292.12	357.81	424.0	428.32	444.0	518.81	652.03	745.4	751.2	771.87	786.02	802.36
292.2	357.82	424.1	428.33	444.1	518.82	652.10	745.5	756.6	771.88	786.09	802.37
292.81	357.83	424.2	428.40	444.2*	518.89	652.11	745.60	759.4	771.89	786.1	802.38
292.82	357.89	424.3	428.41	444.8	519.0*	652.13	745.61	759.7	772.0	786.50	802.39
292.83	359.81	424.90	428.42	444.9	537.84	652.20	745.69	760.2	772.1*	786.51	802.4
292.84	410.0*	424.91	428.43	445.01	569.86	652.21	745.7	760.70	772.2	786.52	802.5
292.89	410.1*	424.99	428.9	445.02	578.0	652.23	745.8	760.71	772.3	786.59	802.6
292.9	410.2*	425.0	429.0	445.81	578.1	652.30	745.9	760.72	772.4	789.0*	802.7
293.0	410.3*	425.1	429.1	445.89	578.9	652.31	746.00	760.73	773.0	790.1	802.8
293.1	410.4*	425.2	429.2	453.9	585*	652.33	746.01	760.75	773.1	790.2	802.9
295.0*	410.5*	425.3	429.3	480.0	633.0*	652.40	746.02	761.5	773.2	790.3	803.0*
295.1*	410.6*	425.4	429.4	480.1	634.1*	652.41	746.09	762.1	773.3	799.0	803.1*
295.2*	410.7*	425.5	429.5	480.2	634.3*	652.43	746.1	762.2	773.4	799.1	803.2*
295.3*	410.8*	425.7	429.6	480.3	634.5*	652.50	742.2	762.5	773.5	799.2	803.3*
295.4*	410.9*	425.8	429.71	480.8	634.6*	652.51	746.3	763.5	774.4	799.3	803.4*
295.5*	411.0	425.9	429.79	480.9	634.90	652.53	746.4	765.0*	775.1	799.4	803.5*
295.6*	411.1	426.0	429.81	481	634.91	652.60	746.5	765.1*	775.2	799.8*	803.6*
295.7*	411.81	426.10	429.82	482.0	634.92	652.61	746.6	765.20	775.3	799.9	803.7*
295.8*	411.89	426.11	429.89	482.1	635.1*	652.63	746.7	765.21	775.5	800.0*	803.8*
295.9*	413.1	426.12	429.9	482.2	635.3*	652.70	746.81	765.22	775.6	800.1*	803.9*
296.0*	413.9	416.13	430	482.30	635.5*	652.71	746.82	765.23	776.2	800.2*	804.0*
296.1*	414.0*	426.2	431	482.31	635.6*	652.73	746.83	765.24	776.4	800.3*	804.1*
296.2*	414.10	426.3	432.0	482.32	636.1*	652.80	746.84	765.25	776.5	800.4*	804.2*
296.3*	414.11	426.4	432.1	482.39	636.3*	652.81	746.85	765.26	777.1	800.5*	804.3*
296.4*	414.12	426.50	432.9	482.4*	636.5*	652.83	746.86	765.27	777.2	800.6*	804.4*
296.5*	414.19	426.51	433.0*	482.81	636.6*	652.90	746.87	765.28	777.3	800.7*	804.5*
296.6*	414.8	426.52	433.1*	482.82	637.1*	652.91	746.89	765.29	777.4	800.8*	804.6*
296.7	414.9	426.53	433.2*	482.83	637.3*	652.93	746.9	767.0	777.5	800.9*	804.7*
296.80	415.0	426.54	433.3*	482.89	637.5*	658.2*	747.0	767.4	777.6	801.0*	804.8*
296.81	415.19	426.6	433.8*	482.9	637.6*	660.00	747.10	767.8	777.8	801.1*	804.9*
296.82	416.0	426.7	433.9*	483*	638.1	661.3*	747.11	767.9	777.9	801.2*	805.0*
296.89	416.1	426.81	434.0*	484.1	638.3	663.00	747.20	768.4	778.4	801.3*	805.1*

805.2	808.3	819.0	836.51	861.31	870.0	873.75	890.1	902.51	940*	957*	967.2
805.3	808.41	819.1	836.52	861.32	870.1	873.79	890.2	902.52	941.2*	958.0	967.3
805.4	808.42	820.0*	836.53	862.0	870.2	873.8	891.0	902.53	941.3*	958.1	967.4
805.5	808.43	820.01	836.54	862.1	870.3	873.9	891.1	902.54	941.4*	958.2	967.5
805.6	808.49	820.02	836.59	862.21	870.4	874.00	891.2	902.55	941.5*	958.4	967.6
805.7	808.51	820.03	836.60	862.22	870.8	874.01	892.0	902.56	942.2*	960.0	967.8
805.8	808.52	820.09	836.61	862.29	870.9	874.02	892.1	902.59	942.3*	960.1	967.9
805.9	808.53	820.10	836.62	862.31	871.0	874.10	892.2	902.81	942.4*	960.2	968.0
806.00	808.59	820.11	836.63	862.32	871.1	874.11	893.0	902.82	942.5*	960.3	968.1
806.01	808.8	820.12	836.64	862.39	871.2	874.12	893.1	902.87	943.2*	960.4	968.2
806.02	808.9	820.13	836.69	862.8	871.3	874.2	893.2	902.89	943.3*	960.5	968.3
806.03	809.1	820.19	837.0	862.9	871.4	874.3	894.0	902.9	943.4*	960.6	968.4
806.04	810.1*	820.20	837.1	863.0	871.5	874.4	894.1	903.0*	943.5*	960.7	968.5
806.05	811.1*	820.21	843.0	863.1	871.6	874.5	894.2	903.1	944.2*	960.8	968.6
806.06	812.10	820.22	843.1	863.20	871.7	874.8	895.0	903.2	944.3*	960.9	968.7
806.07	812.11	820.30	843.8	863.21	871.9	874.9	895.1	903.3	944.4*	961.0	968.9
806.08	812.12	820.31	843.9	863.29	872.00	875.0	896.0	903.4	944.5*	961.1	969.0
806.09	812.13	820.32	844.0	863.30	872.01	875.1	896.1	903.5	945.2*	961.2	969.1
806.10	812.19	820.8	844.1	863.31	872.02	876.0	896.2	903.8	945.3*	961.3	969.2
806.11	812.20	820.9	844.2	863.39	872.10	876.1	896.3	903.9	945.4*	961.4	969.3
806.12	812.21	821.00	844.3	863.40	872.11	877.0	897.0	904.0	945.5*	961.5	969.4
806.13	812.30	821.01	844.8	863.41	872.12	877.1	897.1	904.1	946.2	961.6	969.5
806.14	812.31	821.10	844.9	863.42	872.61	878.0	897.2	904.2	946.3	961.7	969.6
806.15	812.40	821.11	850.0	863.43	872.62	878.1	897.3	904.3	946.4	961.8	969.7
806.16	812.41	821.20	850.1	863.44	872.63	878.2	897.4	904.40	946.5	961.9	969.8
806.17	812.42	821.21	850.2	863.45	872.64	878.3	897.5	904.41	947.0	962.0	969.9
806.18	812.43	821.22	850.3	863.46	872.69	878.4	897.6	904.42	947.1	962.1	970.0
806.19	812.44	821.23	850.4	863.49	872.71	878.5	897.7	904.50	947.2	962.2	970.1
806.20	812.49	821.29	850.5	863.50	872.72	878.6	900.00	904.51	947.3	962.3	970.8
806.21	812.50	821.30	850.9	863.51	872.73	878.7	900.01	904.52	947.4	962.4	970.9
806.22	812.51	821.31	850.11	863.52	872.74	878.8	900.02	904.53	947.8	962.5	971.0
806.23	812.52	821.32	850.12	863.53	872.79	878.9	900.03	904.54	947.9	962.6	971.1
806.24	812.53	821.33	851.0*	863.54	872.8	879.0	900.1	904.6	948.10	962.7	971.2
806.25	812.54	821.39	851.1*	863.55	872.9	879.1	900.81	904.7	948.11	962.8	971.3
806.26	812.59	822.0*	851.2*	863.56	873.0	879.2	900.82	904.8	948.20	962.9	971.9
806.27	813.10	822.1*	851.3*	863.59	873.1	879.3	900.89	904.9	948.21	963.0	972.0
806.28	813.11	823.0*	851.4*	863.80	873.20	879.4	900.9	925.1	948.22	963.1	972.1
806.29	813.12	823.40	851.5*	863.81	873.21	879.5	901.1	925.2	948.3*	963.2	972.2
806.30	813.13	823.41	851.6*	863.82	873.22	879.6	901.2	926.0	948.4*	963.3	972.3
806.31	813.14	823.42	851.7*	863.83	873.23	879.7	901.3	926.11	948.5*	963.4	972.4
806.32	813.15	823.1*	851.8*	863.84	873.29	879.8	901.40	926.12	948.6*	963.5	972.5
806.33	813.16	823.2*	851.9*	863.85	873.30	879.9	901.41	926.19	948.7*	963.8	972.6
806.34	813.17	823.3*	852.0*	863.89	873.31	880.0*	901.42	926.8	948.8*	963.9	972.7
806.35	813.18	823.8*	852.1*	863.90	873.32	880.1*	901.81	926.9	948.9*	964.0	972.8
806.36	813.20	823.9*	852.2*	863.91	873.33	880.2*	901.82	927.00	949.2	964.1	972.9
806.37	813.21	824.0	852.3*	863.92	873.39	881.0*	901.83	927.01	949.3	964.2	973.0
806.38	813.22	824.1	852.4*	863.93	873.40	881.1*	901.89	927.02	949.4	964.3	973.1
806.39	813.23	824.2	852.5*	863.94	873.41	881.2*	901.9	927.03	949.5	964.4	973.2
806.4	813.30	824.3	853.0*	863.95	873.42	882.0	902.0	927.09	950*	964.5	973.3
806.5	813.31	824.4	853.1*	863.99	873.43	882.1	902.10	927.10	951*	964.6	973.4
806.60	813.33	824.5	854.0*	864.0*	873.44	882.2	902.11	927.11	952.00	964.7	973.5
806.61	813.40	824.6	854.1*	864.1*	873.49	883.0	902.19	927.8	952.01	964.8	973.6
806.62	813.41	824.7	860.0	865.0*	873.50	883.1	902.20	927.9	952.02	964.9	973.8
806.69	813.42	824.8	860.1	865.1*	873.51	883.2	902.21	928.00	952.03	965.00	973.9
806.70	813.43	824.9	860.2	866.0*	873.52	884.0	902.22	928.01	952.04	965.01	974.0
806.71	813.44	827.0	860.3	866.1*	873.53	884.1	902.23	928.10	952.05	965.02	974.1
806.72	813.50	827.1	860.4	867.0	873.54	884.2	902.24	928.11	952.06	965.09	974.2
806.79	813.51	828.0	860.5	867.1	873.59	885.0	902.25	928.20	952.07	965.1	974.3
806.8	813.52	828.1	861.00	867.2	873.60	885.1	902.26	928.21	952.08	965.4	974.4
806.9	813.53	835.0*	861.01	867.3	873.61	886.0	902.27	928.3	952.09	965.5	974.5
807.0*	813.54	835.10	861.02	867.4	873.62	886.1	902.29	928.8	952.1*	965.7	974.6
807.1*	813.80	835.11	861.03	867.5	873.63	887.0	902.31	928.9	952.2	965.8	974.7
807.2	813.81	835.12	861.10	867.6	873.64	887.1	902.33	929.0	952.3	965.9	975.0
807.3	813.82	835.13	861.11	867.7	873.65	887.2	902.34	933.0	952.4	966.0	975.1
807.4	813.83	836.0	861.12	867.8	873.69	887.3	902.39	933.1	952.8	966.1	975.2
807.5	813.90	836.1	861.13	867.9	873.70	887.4	902.40	934.0	952.9	966.2	975.3
807.6	813.91	836.2	861.20	868.0*	873.71	887.5	902.41	934.1	953*	966.3	975.4
808.0	813.92	836.3	861.21	868.1*	873.72	887.6	902.42	934.8	954*	966.4	975.5
808.1	813.93	836.4	861.22	869.0	873.73	887.7	902.49	934.9	955*	967.0	975.6
808.2	818.1	836.50	861.30	869.1	873.74	890.0	902.50	935.1	956*	967.1	975.7

975.8	977.2	978.9	992.1	994.8	998.32	E880.0	E890*	E895	E960	E979.3	V23.41
976.0	977.3	979.0	992.2	995.0	999.1	E880.1	E890.8	E896	E961	E979.4	V23.49
976.1	977.4	979.1	992.3	996.73	999.4	E880.9	E890.9	E897	E962	E979.5	V44.0
976.2	977.8	979.2	992.4	997.1	E810*	E881.0	E891*	E898.0	E963	E979.6	V44.1
976.3	977.9	979.3	992.5	997.3	E811*	E881.1	E891.0	E898.1	E964	E979.7	V46.2
976.4	978.0	979.4	992.6	997.71	E812*	E882	E891.1	E899	E965	E979.8	V49.89
976.5	978.1	979.5	992.7	997.72	E813*	E883*	E891.2	E900.0	E966	E979.9	V55.0
976.6	978.2	979.6	992.8	997.79	E814*	E884*	E891.3	E900.1	E967	E985.7	V55.1
976.7	978.3	979.7	992.9	998.0	E815*	E885*	E891.8	E900.9	E968	E999.0	V71.82
976.8	978.4	979.9	993.3	998.1*	E816*	E886.0	E891.9	E905.0	E969	E999.1	V71.83
976.9	978.5	990	994.0	998.2	E817*	E886.9	E892	E905.1	E979.0	V01.81	
977.0	978.6	991.6	994.1	998.3	E818*	E887	E893*	E911	E979.1	V13.21	
977.1	978.8	992.0	994.7	998.31	E819*	E888*	E894	E955.7	E979.2	V13.29	

8.6.3 Procedure Codes and Modifiers

Transportation providers use the following procedure codes and modifiers. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Ambulance services billed will be commensurate with services actually performed. Services rendered are independent of the type of call received or the type staff / equipped ambulance service responding.

Procedure Codes for Basic Life Support (BLS) Services

Basic Life Support Service (BLS) is an ambulance service which includes equipment and staff to render basic services such as control of bleeding, splinting fractures, treating shock, performing cardiopulmonary resuscitation (CPR), delivery of babies, use of horizontal immobilizers, restraints for combative recipients, and use of gauze pads/bandages.

Procedure Code	***Description***
A0429	Ambulance Service, basic life support, emergency transport (BLS - Emergency)
A0380	BLS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002
A0425	Ground Mileage, per mile (30 miles or more requires prior authorization) Effective 4/1/2002

Procedure Codes for Advanced Life Support (ALS) Services

An ALS ambulance has similar equipment, crew, and certification requirements under Medicare as a basic ambulance, except the ALS ambulance has complex specialized life-sustaining equipment. It is ordinarily equipped for radio-telephone contact with a hospital or physician. A typical ALS ambulance may be a mobile coronary care unit or other vehicle appropriately equipped and staffed by personnel authorized to initiate and administer IV fluids, establish and maintain a recipient's airway, defibrillate the heart, relieve pneumothorax conditions, administer cardiopulmonary resuscitation (CPR), provide anti-shock therapy ,administer life sustaining drugs, venous blood draws, cardiac monitoring (EKG), administer pacing nebulizer and perform other advanced life support procedures or services to recipients during the transport. Documentation must support need for ALS services.

Added: A0225

Procedure Code	***Description***
A0225	Neonatal Emergency Transport, transport of a critically ill neontate, a level of interfacility service provided beyond the scope of the Paramedic. This service should be billed only for the transport of a neonate.

Procedure Code	Description
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ALS1) Must provide medically necessary supplies and services, including the provision of an ALS assessment or at least one ALS intervention.
A0433	Advanced Life Support Level 2 (ALS2). The administration of at least three different medications and the provision of one or more of the following ALS procedures: Manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line.
A0434	Specialty Care Transport (SCT), in a critically injured or ill patient, a level of interfacility service provided beyond the scope of the Paramedic. This service is necessary when a patient's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).
A0390	ALS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002

Procedure Codes for Non-emergency Services

Procedure Code	Description
A0426	Ambulance service, advanced life support, Level 1 (ALS1, Must provide medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention), non-emergency transport, (cannot be billed with A0422)
A0428	Ambulance service, basic life support, (BLS), non-emergency transport
A0380	BLS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002
A0390	ALS mileage, per mile (30 miles or more requires prior authorization) Deleted 6/1/2002
A0425	Ground Mileage, per mile (30 miles or more requires prior authorization) Effective 4/1/2002
Q3019	Ambulance service, ALS vehicle used, emergency transport. No ALS level service furnished. Effective 4/1/2002 Deleted 12/31/2005
Q3020	Ambulance service, ALS vehicle used, non-emergency transport. No ALS level service furnished. Effective 4/1/2002 Deleted 12/31/2005

Miscellaneous Procedure Codes

Procedure Code	Description
A0382	BLS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground Mileage, per mile (30 miles or more requires prior authorization) Effective 4/1/2002
A0999	Unlisted ambulance service

Services Not Covered by Medicare That Are Covered by Medicaid

Some non-emergency ambulance services are non-covered by Medicare but are covered by Medicaid if billed in conjunction with the modifiers below. Prior Authorization is required when billing these codes. These claims should be filed on a medical claim either electronically or on paper. A Medicare EOMB is not required.

- A0324-A0326, A0360, (The preceding codes are no longer valid effective January 1, 2001), A0380-A0390, (The preceding codes are no longer valid effective June 1, 2002), A0422, A0425, A0426, A0428, Q3020
- Modifiers DD, DG, DJ, DN, DP, DR, EP, GD, HD, HP, ND, NP, NP, PD, PE, PH, PN, PR, RD, or RP

Procedure Codes for Medicare Crossovers Only

Medicaid will reimburse providers for only the coinsurance and deductible for the following procedure codes:

Procedure Code	***Description***
A0432	Paramedic ALS intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers

Procedure Codes for Air Transportation

Procedures not included in this list are not covered by Medicaid.

Procedure Code	***Modifier***	***Description***
A0435		Air mileage, fixed wing, per statute mile
A0436		Air mileage, rotary wing, per statute mile
A0430		Ambulance service, conventional air services, transport, one way (fixed wing)
A0431		Ambulance service, conventional air services, transport, one way (rotary wing)
A0070		Ambulance service, oxygen, administration and supplies, life sustaining situation, limited to 1 unit per trip
A0215		Miscellaneous disposable supplies, limited to 1 unit per claim

First Modifier

The first place alpha code is the origin; the second place alpha code is the destination. **The valid origin/destination modifiers and their explanations are listed below:**

Modifier	***Description***
AS	Ambulance trip to an out-of-state hospital Deleted 12/31/2005
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.) (Note: Bed-bound recipients only, NET Program prior authorization required)
R	Residence
S	Scene of accident or acute event
UC	Unclassified ambulance service Deleted 08/01/2005

For example, when a recipient is picked up at the residence (origin code R) and taken to the hospital (destination code H) for an ALS emergency transport (procedure code A0427), the claim is coded as **A0427RH.**

The following are all of the valid combinations for the first modifier fields:

AS	DN	EH	GE	HG	HR	JH	NG	RD	RN
DD	DR	EJ	GH	HH	IH	JN	NH	RE	SH
DG	ED	EN	GN	HI	IN	JR	NJ	RG	SI
DH	EE	ER	GR	HJ	JD	ND	NN	RH	
DJ	EG	GD	HE	HN	JE	NE	NR	RJ	

NOTE:

For ground ambulance transport from a residence to an airport or helicopter site the ground provider should use the modifier combination "SI" since the reason for transport would be an accident or "acute event".

Second Modifier (These are not required by Medicaid)

Modifier	*Description*
1A	Bedridden Deleted 03/31/03
2A	Accidental injury home/nursing home
3A	Accidental injury
4A	Recipient in shock
5A	Oxygen used and/or heart monitor Deleted 03/31/03
6A	Transported by stretcher
7A	Fracture to hip, leg, knee, trunk (same day as ambulance trip) Deleted 03/31/03
8A	Hospital lacks facility (recipient admitted to second hospital)
9A	Rectal bleeding
1B	Myocardial infarction Deleted 03/31/03
2B	Possible cerebral vascular incident (CVA) Deleted 03/31/03
3B	Blacked out, passed out Deleted 03/31/03
4B	Laceration of head Deleted 03/31/03
5B	Dead on arrival (DOA) at hospital
6B	Died en route to hospital
7B	Unresponsive or coma Deleted 03/31/03
8B	Quadriplegia Deleted 03/31/03
9B	Stroke (same day as ambulance service) Deleted 03/31/03
1C	Paralysis Deleted 03/31/03
2C	Mentally retarded Deleted 03/31/03

Repeat Trip

The following modifiers are used in the second modifier position to indicate a repeat trip for the same recipient on the same day:

Local Code Modifier thru 12/31/03	*HCPCS Modifier(s) Beginning 01/01/04*	*Description*
Y2	TS	Follow-up Service
Y3	TS	Follow-up Service
Y4	TS	Follow-up Service
Y5	TS	Follow-up Service

When a recipient is picked up at a hospital (origin code H), taken to another hospital (destination code H), and returned to the original hospital, bill the procedure code with a TS modifier for Follow-up Service.

8.6.4 Place of Service Codes

The following place of service codes apply when filing claims for transportation services:

POS	***Description***
41	Ambulance – Land
42	Ambulance – Air or Water

8.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

8.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
NET Program	Appendix G

9

9 Ambulatory Surgical Centers (ASC)

The policy provisions for ASC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 38.

Ambulatory surgical services are procedures typically performed on an inpatient basis that can be performed safely on an outpatient or ambulatory surgical center (ASC) basis.

9.1 Enrollment

EDS enrolls ASC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an ASC provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for ASC-related claims.

NOTE:
All eight characters are required when filing a claim.

ASC Providers are assigned a provider type of 28 (ASC). Valid specialties for ASC providers include the following:

- Ambulatory Surgical Center (A4)
- Lithotripsy (L2)

Enrollment Policy for Ambulatory Surgical Center Providers

To participate in the Alabama Medicaid Program ASC providers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authorities
- Possess a copy of a transfer agreement with an acute care facility (refer to the *Alabama Medicaid Agency Administrative Code* rule no. 560-X-38-05 for details)

9.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

ASC services are items and services furnished by an outpatient ambulatory surgical center in connection with a covered surgical procedure.

Rates of reimbursement for ASC services include, but are not limited to:

- Nursing, technician and related services
- Use of an ambulatory surgical center
- Lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administrative, record keeping, and housekeeping items and services
- Materials for anesthesia

NOTE:

Outpatient dental care (procedure code D9420) must be prior approved and is covered only for recipients under the age of 21. The dentist is responsible for obtaining prior approval from the Alabama Medicaid Agency Dental Program at (334) 242-5997. Dental services provided to SOBRA adult females are non-covered.

ASC services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:

- Physician services
- Lab and x-ray not directly related to the surgical procedure
- Diagnostic procedures (other than those directly related to performance of the surgical procedure)
- Prosthetic devices (except intraocular lens implant)
- Ambulance services
- Leg, arm, back, and neck braces
- Artificial limbs
- Durable medical equipment for use in the patient's home

ASC services are reimbursed by means of a predetermined fee established by Medicaid. All ASC procedures will be reimbursed at the lesser of the predetermined rate for the procedure or the provider's submitted charge less the copay amount.

NOTE:

Ambulatory surgical center services are limited to three encounters each calendar year.

Medicaid pays for a surgical procedure performed on an outpatient basis for a Medicaid recipient only if the procedure is on the approved surgical list found in Appendix I.

Covered Surgical Procedures

Covered surgical procedures are procedures that meet the following criteria:

- Surgical procedures commonly performed on an inpatient basis in hospitals but may be safely performed in an ambulatory surgical center setting
- Surgical procedures limited to those requiring a dedicated operating room and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room
- Surgical procedures not otherwise excluded under 42 C.F.R. § 416.65 or other regulatory requirement
- Procedure codes within the range of 10000-69XXX

Medicaid maintains a listing of the covered surgical procedures in Appendix I, ASC Procedures List. This list is reviewed and updated on a quarterly basis. Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Ambulatory Surgical Center Transfer Procedures

The ambulatory surgical centers must have an effective procedure for the immediate transfer to a hospital of recipients requiring emergency medical care beyond the capabilities of the center. The hospital will have a provider contract with Medicaid. The center must have a written transfer agreement with said hospital, and each physician performing surgery in the center must have admitting privileges at said hospital. Changes in this submitted information will be made available to the EDS as they occur.

Surgical Procedures Groups

The surgical procedures are classified into separate payment groups. All procedures within the same payment group are reimbursed at a single rate. These rates are subject to adjustment by Medicaid.

If one covered surgical procedure is furnished to a Medicaid recipient in an operative session, Medicaid pays either the submitted charges minus the copayment amount or the predetermined rate for the procedure minus the copayment, whichever is lowest.

If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, Medicaid pays the lesser of either the submitted charges or the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges or at 50 percent of the predetermined rate for each of the other procedures, whichever is lowest.

9.3 Prior Authorization and Referral Requirements

Certain procedures require prior authorization. Please refer to the ASC Procedures List in Appendix I. A “Y” in the PA column on the list indicates surgical procedures that require prior approval. Payment will not be made for these procedures unless authorized prior to the service being rendered.

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).

All requests for prior approval must document medical necessity and be signed by the physician. Requests should be sent to EDS, Attention Prior Authorization, P.O. Box 244032, Montgomery, Alabama 36124-4032.

The prior authorization number issued must be listed on the UB-92 claim form when billing for the prior authorization service.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center.

9.3.1 Patient 1st Referrals

By verifying eligibility, providers can get information regarding whether a recipient is enrolled in the Patient 1st program. If the recipient is enrolled in Patient 1st, the provider must document information regarding the recipient’s primary medical provider (PMP) and obtain a referral for services prior to rendering services. A Patient 1st referral form is available; however, any method of documenting the required information is acceptable. The referral form must identify the PMP, the reason for the referral, authorized dates of service, and name of staff member giving referral.

As a specialty provider, ASCs are required to obtain a referral from the recipient’s PMP before rendering services. Without a referral from the PMP, reimbursement cannot be made. Refer to Chapter 5, Filing Claims, for specifics on completing the UB-92 claim form with this referral information.

9.3.2 EPSDT Referrals

Children under 21 years of age can receive medically necessary health care diagnosis, treatment and/or other services to correct or improve conditions identified during or as a result of an EPSDT screening. Refer to Appendix A, EPSDT, for more specifics on obtaining these referrals.

9.4 Cost Sharing (Copayment)

The copayment amount for an ASC encounter is $3.00 per encounter. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, family planning, and crossovers.

9.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

ASC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

For straight Medicaid claims, ASCs should bill Medicaid on the UB-92 claim form. Medicare-related claims should be filed using the Medical Medicaid/Medicare Related Claim Form.

9.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ambulatory surgical center providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

9.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits).

9.5.3 Procedure Codes and Modifiers

ASC providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four procedure code modifiers.

Only procedures listed in the ASC Procedures List are reimbursable in the ambulatory surgical setting. The list of covered outpatient procedures is located in Appendix I.

NOTE:

Procedures not listed on the ASC Procedures List may be covered under special circumstances. Approval must be obtained prior to the surgery. Refer to Section 9.3, Prior Authorization and Referral Requirements, for more information. Prior to providing services, providers should inform recipients of their responsibilities for payment of services not covered by Medicaid.

9.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

9.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

9.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
ASC Procedures List	Appendix I

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10

10 Audiology/Hearing Services

Audiological function tests and hearing aids are limited to Medicaid recipients who are eligible for treatment under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Hearing aids are provided through hearing aid dealers who are contracted to participate in the Alabama Medicaid Hearing Aid Program.

An eligible recipient with hearing problems may be referred to a private physician or to a Children's Specialty Clinic for medical evaluation.

The policy provisions for audiology and hearing services providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 19.

10.1 Enrollment

EDS enrolls hearing services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Only in-state and bordering out-of-state (within 30 miles of the Alabama state line) audiology and hearing aid providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid program.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hearing services provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hearing-related claims.

NOTE:

All nine digits are required when filing a claim.

Hearing service providers are assigned a provider type of 66 (Hearing Aids) and/or 20 (Audiology/Hearing Services). The valid specialty for Hearing Aid providers is Hearing Aid Dealer (H1). The valid specialty for Audiology is 64.

Enrollment Policy for Audiology Providers

Audiologists must hold a valid State license issued by the state in which they practice.

EDS is responsible for enrollment of audiologists. Licensed audiologists desiring to participate in the Alabama Medicaid Program must furnish the following information to EDS as part of the required enrollment application:

- Name
- Address
- Specialty provider type
- Social Security Number
- Tax ID Number
- Copy of current State license

Hearing Aid Dealers

Dealers must hold a valid license issued by the Alabama Board of Hearing Aid Dealers, as issued by the state in which the business is located.

10.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

10.3 Prior Authorization and Referral Requirements

Hearing services procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

10.4 Cost Sharing (Copayment)

Copayment does not apply to hearing services.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

10.5 Completing the Claim Form

NOTE:

An audiologist employed by a physician cannot file a claim for the same services billed by that physician for the same patient, on the same date of service.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hearing services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

10.5.1 Time Limit for Filing Claims

Medicaid requires all claims for hearing services to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

10.5.2 Diagnosis Codes

Hearing aid dealers must bill diagnosis code V729 on all claims.

Audiologists are required to use a valid ICD-9 diagnosis code. The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

10.5.3 Cochlear, Auditory Brain Stem and Osseointegrated Implants

Cochlear Implants

Cochlear Implants are covered on an inpatient basis only. Prior authorization for the preoperative evaluation and the implantation must be requested by a Medicaid-approved *cochlear implant team surgeon,* using the Authorization for Cochlear Implants Form (PHY-96-11).

Medicaid may reimburse for cochlear implant services for recipients who meet the following criteria:

1. EPSDT referral

2. Chronological age 2 through 20 years of age
3. Profound (>90 dBHL) sensorineural hearing loss bilaterally and minimal speech perception under best aided conditions
4. Minimal or no benefit obtained from a hearing (a vibrotacile) aid as demonstrated by failure to improve on age appropriate closed-set work identification task. Appropriate amplification and rehabilitation for a minimum six-month trial period is required to assess the potential for aided benefit. Benefits may be extended to candidates with severe hearing impairment and open-set sentence discrimination that is less than or equal to 30 percent in the best aided conditions.
5. No medical or radiological contraindications, and otologically stable and free of active middle ear disease prior to cochlear implantation.
6. Families/caregivers and possible candidates well-motivated. Education must be conducted to ensure parental understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the child's therapeutic program and the ability to adequately care for the external equipment.

Effective June 1, 2002, Medicaid will reimburse for a personal FM system for use by a cochlear implant recipient when prior authorized by Medicaid and not available by any other source. The replacement of lost or damaged external components (when not covered under the manufacturer's warranty) will be a covered service when prior authorized by Medicaid.

Reimbursements for manufacturer's upgrades will not be made within the first three years following initial implantation.

Prior Authorization Procedures are as follows:

1. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

2. The prior authorization number issued for the cochlear implant must be indicated in the clinical statement section of form 342.

3. Additional medical documentation supporting medical necessity for FM system (V5273) or replacement external components should be attached.

Auditory Brain Stem Implants (ABI)

An ABI is covered on an inpatient basis only and requires prior authorization. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for ABI services for recipients who meet the following criteria:

1. Must be 12-20 years of age
2. Physician notes must indicate the diagnosis of Neurofibromatosis Type II
3. Medical assessment to ensure candidate is able to tolerate surgery
4. Documentation of anticipatory guidance to child/parents concerning expected outcomes, complications, and possible aural rehabilitation

Osseointegrated Implant (BAHA)

An Osseointegrated Implant (BAHA) is covered on an inpatient basis only and requires prior authorization. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for osseointegrated implant services for recipients who meet the following criteria:

1. Must be 5-20 years of age; and
2. Congenital or surgically induced malformations of the external ear canal or middle ear; or
3. Chronic external otitis or otitis media when a conventional hearing aid cannot be worn; or
4. Tumors of the external canal.
5. Must all meet audiologic criteria of : pure tone average bone conduction threshold of up to 70 dB and speech discrimination score better than 60%.

For Single Sided Deafness (SSD), criteria are as follows:

1. Must be 5-20 years of age; and
2. Bone conduction of 35-40 dB or better in the contralateral ear.

10.5.4 Procedure Codes and Modifiers

Audiological function tests must be referred by the attending physician before testing begins. The (837) Professional electronic claim has been modified to accept up to four Procedure Code Modifiers.

Audiology Tests

The following CPT codes represent comprehensive audiological tests that may be performed each calendar year. Additional exams may be performed as needed when medically necessary to diagnose and test hearing defects.

Procedure Code	***Description***
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	Optokinetic nystagmus
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	Optokinetic nystagmus test, bi-directional, foreal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Torsion swing test, with recording
92547	Use of vertical electrodes in any or all of above vestibular function tests counts as one additional test
92557	Basic comprehensive audiometry (92553 & 92556 combined)
92582	Conditioning play audiometry (for children up to 5 years old)
92585	Brainstem evoked response recording (evoked response (EEG) audiometry)

NOTE:

Procedure codes 92531-92547 are normally performed on adults; however, children are occasionally tested.

The following procedure codes are not included in the annual limitations.

Procedure Code	*Description*
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry; threshold only
92556	Speech audiometry; threshold and discrimination
92560	Bekesy audiometry; screening
92561	Bekesy audiometry; diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry
92568	Acoustic reflex testing
92569	Acoustic reflex decay test
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test (Deleted 1/1/07)
92575	Sensorineural activity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92583	Select picture audiometry
92584	Electrocochleography
92585	Brainstem evoked response recording
92587	Evoked otoacocestic emissions
92588	Comprehensive/diagnostic evaluation
92590	Hearing aid examination and selection; monaural
92591	Hearing aid examination and selection; binaural
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630	Auditory Rehabilitation; pre-lingual hearing loss
92633	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour

Added to 92573: (Deleted 1/1/07)

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Cochlear & Auditory Brain Stem Implants (ABI) and BAHA System

Procedure Code	*Description*
69930*	Cochlear Device Implantation (See NOTE below)
L8619*	Processor repair/replacement- Will be reimbursed at invoice price
S2235****	Implantation of Auditory Brain Stem Implant
V5299**	Hearing service, miscellaneous (for non lithium processor batteries, cords, etc)
92601	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; with programming.

Procedure Code	Description
92602	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; subsequent reprogramming.
92603	Diagnostic analysis of Cochlear Implant, age 7 years or older, with programming.
92604	Diagnostic analysis of Cochlear Implant, age 7 years of age or older; subsequent reprogramming.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Group, two or more individuals
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630***	Auditory Rehabilitation; pre-lingual hearing loss
92633***	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour
V5273**	Assistive listening device, includes FM receiver and transmitter for use with Cochlear Implant
V5299**	Hearing service, miscellaneous code for repair done for V5273
69714****	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715****	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
69717****	Replacement, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718****	Replacement, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
L8691*	Auditory osseointegrated device, external sound processor, replacement – Will be reimbursed at invoice price

Deleted: ~~92510~~

* Requires the ten-digit prior authorization number initially assigned for the cochlear implant, ABI or Ossoeintegrated (BAHA) Implant

** Submit additional medical documentation providing the ten-digit prior authorization number approved for CPT 69930

***Cannot bill 92507 on the same day as 92630 or 92633

****Requires Prior Authorization

NOTE:

The Cochlear, ABI and BAHA Device is purchased at contract price established by hospital and supplier and covered through the hospital per diem.

Hearing Aid Monaural

Procedure Code	Description
V5030	Hearing aid, monaural, body worn, air conduction
V5040	Hearing aid, monaural, body worn, bone conduction
V5050	Hearing aid, monaural, in the ear
V5060	Hearing aid, monaural, behind the ear
V5070	Glasses, air conduction
V5080	Glasses, bone conduction
V5244	Hearing aid, digitally programmable analog, monaural, completely in the ear canal
V5245	Hearing aid, digitally programmable analog, monaural, in the canal

Procedure Code	*Description*
V5246	Hearing aid, digitally programmable analog, monaural, in the ear
V5247	Hearing aid, digitally programmable analog, monaural, behind the ear
V5254	Hearing aid, digital, monaural, completely in the ear canal
V5255	Hearing aid, digital, monaural, in the canal
V5256	Hearing aid, digital, monaural, in the ear
V5257	Hearing aid, digital, monaural, behind the ear

Hearing Aid Binaural

Binaural aids should be billed with one unit.

Procedure Code	*Description*
V5100	Hearing Aid, bilateral, body worn
V5120	Binaural, body
V5130	Binaural, in the Ear
V5140	Binaural, behind the Ear
V5150	Binaural, glasses
V5210	Hearing aid, bicros, in the Ear
V5220	Hearing aid, bicros, behind the Ear
V5250	Hearing aid, digitally programmable analog, binaural, completely in the ear canal
V5251	Hearing aid, digitally programmable analog, binaural, in the canal
V5252	Hearing aid, digitally programmable analog, binaural, in the ear
V5253	Hearing aid, digitally programmable analog, binaural, behind the ear
V5258	Hearing aid, digital, binaural, completely in the ear canal
V5259	Hearing aid, digital, binaural, in the canal
V5260	Hearing aid, digital, binaural, in the ear
V5261	Hearing aid, digital, binaural, behind the ear

(Extra ear mold is a billable expense in connection with binaural aids.)

Hearing Aid Accessories

Procedure Code	*Description*
V5298	Stethoscope (1 every 2 years)
V5298	Harness (Huggies)
V5266	Batteries (1 package every 2 months for use with monaural aid)
V5298	Battery Cover
V5266	Batteries (2 packages every 2 months for use with binaural aids)
V5298	Receiver
V5264	Ear mold (1 every 4 months for use with monaural aid)
V5298	Garment Bag
V5298	Cords
V5298	Ear Hook
V5014	Factory Repair of Aid (out of warranty) (1 every 6 months for use with monaural aid)
V5264	Ear Mold (2 every 4 months for use with binaural aids)
V5014	Factory Repair of Aids (out of warranty) (2 every 6 months for use with binaural aids)
V5267	Hearing aid supplies/accessories

10.5.5 Place of Service Codes

The following place of service codes apply when filing claims for hearing services:

POS Code	Description
11	Office

10.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

10.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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11

11 Chiropractor

Chiropractors are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

The policy provisions for chiropractors can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

11.1 Enrollment

EDS enrolls chiropractors and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a chiropractor is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for chiropractic-related claims.

NOTE:
All nine digits are required when filing a claim.

Chiropractors are assigned a provider type of 18 (Chiropractor). Valid specialties for chiropractors include the following:

- Chiropractor (35)
- QMB/EPSDT (EQ)

Enrollment Policy for Chiropractors

To participate in the Medicaid program, chiropractors must have a current certification and/or be licensed to practice and operate within the scope of practice established by the state's Board of Chiropractic Examiners.

11.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Chiropractic services are only covered for QMB recipients or for recipients referred directly as a result of an EPSDT screening.

For more information about the EPSDT program, refer to Appendix A, EPSDT.

11.3 Prior Authorization and Referral Requirements

Chiropractic services generally do not require prior authorization since services are limited to QMB recipients and EPSDT referrals. Some codes may require prior authorization before services are rendered. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines on determining if a prior authorization is needed and how to obtain the information.

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

11.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

11.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Chiropractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

11.5.1 Time Limit for Filing Claims

Medicaid requires all claims for chiropractors to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

11.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

11.5.3 Procedure Codes and Modifiers

Chiropractors use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

11.5.4 Place of Service Codes

The following place of service codes apply when filing claims for chiropractic services:

POS Code	*Description*
11	Office

11.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

11.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

12

12 Comprehensive Outpatient Rehabilitation Facility (CORF)

Rehabilitative services are specialized services for the restoration of people with chronic physical or disabling conditions to useful activity. These services will be provided to recipients on the basis of medical necessity.

12.1 Enrollment

CORFs are enrolled only for services provided to QMB eligible recipients (crossover claims).

EDS enrolls CORF providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a CORF provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for rehabilitation-related claims.

NOTE:

All eight characters are required when filing a claim.

CORF providers are assigned a provider type of 26 (Rehabilitation Center). The valid specialty for CORF providers is Rehabilitation Hospital (R1).

12.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

CORF providers are limited to Medicare-related claims billed on the UB-92 claim form.

12.3 Prior Authorization and Referral Requirements

CORF procedures do not require prior authorization or referrals since they are limited to Medicare crossovers only.

12.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by CORF providers.

12.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

CORF providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

12.5.1 Time Limit for Filing Claims

Medicaid requires all claims for CORF to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

12.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

12.5.3 Revenue Codes

CORF providers use the revenue codes identified by Medicare.

12.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

12.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy Institutional Medicaid/Medicare-related claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

12.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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13

13 Dentist

Certain dental health care services are available for eligible children under age 21 through Medicaid as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Dental services are any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individual.

NOTE:

A dental consultant is available for clinical consultation regarding coverage for unusual services and may be contacted through the Dental Program Manager at (334) 242-5472.

The policy provisions for dental providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 15.

13.1 Enrollment

EDS enrolls dental providers who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a dental provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for dental-related claims.

NOTE:

All nine digits are required when filing a claim.

Dental providers are assigned a provider type of 08 (Dentist). Valid specialties for dental providers include the following:

- General Dentistry (V2)

- Oral and Maxillofacial Surgery (SE)

Oral Surgeons are assigned a provider type of 79 or 01, depending on the source of the licensure information sent to the EDS provider enrollment unit. The valid specialty for Oral Surgeons is Oral and Maxillofacial Surgery (SE).

Oral Surgeons billing medical procedures or CPT procedure codes should refer to Chapter 28, Physician. Only dental procedures (CDT-2005 procedure codes) should be billed on the ADA dental claim form—Version ADA 2002, 2004.

Enrollment Policy for Dental Providers

To participate in the Alabama Medicaid Program, dental providers must be licensed to practice in the state where care is provided. Each dental provider **must** enroll with EDS, who assigns a provider number for each office location. You must have a different Medicaid provider number for each specific office location. This also applies for reimbursement for preventive services and must be performed at a fixed physical office location. Screenings at other sites are encouraged, but are not billable to Medicaid. Each claim filed constitutes a contract with the Alabama Medicaid Agency. Dental providers are required to complete and sign a coding sheet (often referred to as a “super bill”) listing all procedure codes/ descriptions performed on each date of service for each Medicaid recipient. For audit purposes, these coding sheets are required to be maintained on file for a period of three (3) years from the date of service.

Dentists who perform anesthesia or IV sedation services must submit a copy of their GA/IV certification to EDS with their provider enrollment application.

Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency, please refer to Chapter 2 - Becoming a Medicaid Provider. All program policies apply regardless of where care is provided.

13.2 Informed Consent

Effective July 1, 2003, informed consent shall be documented in the record for all patients for whom comprehensive treatment is to be provided. This informed consent shall include all diagnoses, an explanation of any treatment, therapies, reasonable alternative therapies, their risks, and prognosis.

All informed consents shall be signed by the patient or parent (guardian). If a blanket informed consent is used, a note that such a form was reviewed should be made in the progress notes.

Consistent violation of the informed consent requirement can result in further investigation and appropriate action.

13.3 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT Program.

13.3.1 Examinations

Only one of the following four examinations may be billed at a single appointment, when applicable and considering program limitations.

Periodic Oral Examination (D0120)

A periodic oral examination is an evaluation on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This examination is limited to once every six months for eligible Medicaid recipients.

Limited Oral Examination (Problem Focused) (D0140)

A limited oral examination is an evaluation or re-evaluation limited to specific health problems. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same day. Typically, recipients receiving this type of evaluation have been referred for a specific problem or are presented with dental emergencies, such as acute infection. Providers using this procedure code must report the tooth number or area of the oral cavity, symptom(s), diagnosis, and emergency treatment in the dental record where the specific problem is suspected. This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations. Limited to one per provider/provider group per year.

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

This code is intended to be for the first visit to a dental office for a patient under three years of age, for evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication and counseling with the child’s parent or guardian. This 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).

Comprehensive Oral Examination (D0150) once per provider

A comprehensive oral examination is used by a general dentist or specialist when evaluating a recipient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This must include the evaluation and recording of: dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (Complete periodontal charting is required if there are signs of periodontal disease or the recipient is ages 16 through 20), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. This examination is limited to once per recipient, per provider or provider group.

13.3.2 Dental Sealants

Sealant (per tooth) is limited to one per permanent molar only and is non-covered for children less than 5 or greater than 13 years of age. Teeth to be sealed must be free of proximal caries, and there can be no previous restorations on the surface to be sealed. Sealant material must be ADA approved opaque or tinted.

13.3.3 Orthodontic Services

Medicaid provides medically necessary orthodontic services for eligible and qualified recipients. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service at 1(800) 846-3697or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. All medically necessary orthodontic treatment must be prior authorized by Medicaid before services are provided.

Requests for orthodontic services must include the recommendations of the multidisciplinary team, photos and x-rays.

Criteria for coverage include the following diagnoses when medical necessity exists:

- Cleft palate or cleft lip deformities
- Cleft lip with alveolar process involvement
- Velopharyngeal incompetence
- Short palate
- Submucous cleft
- Alveolar notch
- Craniofacial anomalies included but not limited to
- Hemifacial microsomia
- Craniosynostosis syndromes
- Cleidocranial dysplasia
- Arthrogryposis
- Marfan's syndrome
- Apert's syndrome
- Crouzon’s Syndrome
- Other syndromes by review
- Trauma, diseases, or dysplasias resulting in significant facial growth impact or jaw deformity.

Specific **non-covered services** include the following diagnoses:

- Dento-facial Anomaly, NOS
- Orofacial Anomaly, NOS
- Severe Malocclusion

13.3.4 Radiology

Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated.

A full series consisting of at least 14 periapical and bitewing films OR a panoramic film are permitted every three years if professional judgment dictates. Effective July 1, 2003, panoramic films are limited to age 5 and above. A full series (D0210) uses the panoramic film (D0330) *once every three years* benefit and visa versa.

Posterior bitewing and single anterior films may be taken every six months as part of an examination, if medically necessary, subject to the annual limits. All periapical films are limited to a maximum of five per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).

13.3.5 Non-Covered Services

The following dental services are non-covered except where noted. Non-covered dental services include but are not limited to the following:

- Procedures which are not necessary or do not meet accepted standards of dental practice based on scientific literature
- Surgical periodontal treatment (Exceptions require prior authorization: Pharmaceutically induced hyperplasia and idiopathic juvenile periodontosis)
- Orthodontic treatment (Exception: medically necessary orthodontic services when prior authorized by Medicaid)
- Prosthetic treatment, such as fixed or removable bridgework, or full or partial dentures (Exceptions require prior authorization: prosthesis for closure of a space created by the removal of a lesion or due to congenital defects)
- Panoramic films on recipients under age 5
- Dental transplants
- Dental implants
- Prosthetic implants
- Esthetic veneers
- Silicate restorations
- Pulp caps on primary teeth
- Pulpotomies on permanent teeth
- Space maintainers for premature loss of primary incisors or as “pedo bridges”
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- Extraction of exfoliating primary teeth without a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the record
- Acrylic, plastic restorations (class III or V)

- Acrylic, plastic restorations (class IV)
- Plastic crowns (acrylic)
- Porcelain/ceramic substrate crowns
- Permanent crowns, core buildups, and post & cores on recipients under the age of 15
- Adult Dental Care

Palliative (emergency) treatment cannot be billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures. Only single restorations code can be billed per date of service per tooth.

13.4 Prior Authorization (PA) and Referral Requirements

Prior authorization from Medicaid is required for the following services:

- Periodontal treatment (scaling and root planing, full mouth debridement, periodontal maintenance procedures)
- Excision of hyperplastic tissue
- Inpatient and Outpatient hospitalizations for dental care for children 5 and above on date(s) of Alabama hospital service. (not required for any out-of state hospitalizations)
- Inpatient and outpatient hospitalization and anesthesia charges for adults when hospitalization is required because (1) the individual's underlying medical condition and status is currently exacerbated by the dental condition, or (2) the dental condition is so severe that it has caused a medical condition (for example, acute infection has caused an increased white blood count, sepsis, or bacterial endocarditis in a susceptible patient)
- Space maintainers (after the first two)
- Apicoectomy/periradicular surgery
- Removal of completely bony impactions
- Home visits or treatment of any recipient under age 21 in a licensed medical institution (nursing facility)
- Diagnostic models (when requested by Medicaid)
- Oral/Facial Images (e.g., photographs or slides when requested by Medicaid)
- Therapeutic drug injection (by report)

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

13.4.1 Obtaining Prior Authorization for Dental Services

Providers must use the Prior Review and Authorization Dental Request Form (form 343) to request prior authorization for any of the above procedures. All sections of this form must be completed. The form should be forwarded to EDS, P.O. Box 244032, Montgomery, AL 36124-4032. Refer to Chapter 4, Section 4.4, Obtaining Prior Authorization, of the Alabama Medicaid Provider

Manual for instructions on obtaining prior authorization and completion of the form.

Prior authorization requests take approximately two to three weeks for processing. Providers should call the Provider Assistance Center (PAC) at 1(800) 688-7989 to verify request is in the system if approval/denial is not received within this time frame.

Emergency Prior Authorizations

In an emergency situation where the delay for written request of prior authorization would endanger the health of the recipient, initiate prior authorization by contacting the Alabama Medicaid Agency's Dental Program at (334) 242-5995 or (334) 353-4771. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message will be accepted. The voice mail message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- Provider number of dentist
- Phone number of dentist, including area code
- Nature of emergency
- Contact person, if other than dentist for follow-up

An Alabama Prior Review and Authorization Dental Request Form (form 343) must be received by the fiscal agent within ten calendar days of the telephone/voice message request. If the request is not received within ten calendar days of the telephone call, the authorization will be denied. The request must meet established guidelines and criteria.

13.4.2 Criteria for Prior Authorization

This section discusses specific criteria for prior authorization for certain periodontal, preventive anesthetic and inpatient/outpatient procedures. There are additional dental procedures that require prior authorization as indicated in Section 13.5.3, Procedure Codes and Modifiers.

- For treatment in the dental office:

  When completing the Alabama Prior Review and Authorization Dental Request (form 343), **ONLY** list those procedures that require prior authorization.

- For treatment in outpatient/inpatient hospital or nursing facility:

  When completing the Alabama Prior Review and Authorization Dental Request (form 343), list **ALL** procedures planned even if they do not normally require prior authorization.

Additional dental prior authorization criteria will be provided to all Medicaid dental providers, as they become available.

Inpatient/Outpatient Hospitalization

Effective January 1, 2005, for prior authorization for patients five years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization; The mere extent of caries or large quantity of teeth to be treated, or preference to provide all treatment in one appointment, or need for premedication, are not, by themselves, qualifying reasons for hospitalization.
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder (requires an additional report described in a. – k. below)

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. On children ages 3 and 4, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting.

If Criteria number 4 above (without a physical or mental disability) is cited as the justification for treatment in a hospital setting, it additionally requires a report of at least one active failed attempt to treat in the office. This report must include (if applicable):

a. recipient's behavior preoperatively
b. type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
c. recipient's behavior during the procedure
d. the use, amount, and type of local anesthetic agent
e. use and dosage of premedication, if attempted
f. use and dosage (%, flow rate and duration) of nitrous oxide analgesia used
g. procedure(s) attempted
h. reason for failed attempt
i. start and end times of the procedure(s) attempted
j. name(s) of dental assistant(s) present in the treatment room
k. presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

Documentation Necessary for Hospital Cases Requiring Dental Prior Authorization (For recipients age 5 or older)

Hospital dental cases may be divided into three categories depending on the documentation obtained in the office. If criteria 4 above is cited as justification for hospital treatment, a report containing information as described in a. through k. above is also required.

1. **Child is cooperative for x-rays and treatment plan only:** treatment plan (by tooth #, by procedure code) and radiographs were obtained in the office.

Submit Prior Authorization request (form 343) **with informed consent, treatment plan and radiographs** through EDS for review. Failure to attach required information may delay your request.

2. **Child is partially uncooperative:** treatment plan (by tooth #, by procedure code) was obtained but child would not cooperate for radiographs in the office.

Submit Prior Authorization request (form 343) listing the codes on form **with treatment plan and informed consent** along with the explanation that the child would not cooperate for films in Section IV paragraph 3 of form 343. If the Prior Authorization is approved, the approval letter will generally approve **only one procedure code** (usually a radiograph code) and a statement to the effect: "Outpatient/Inpatient Hospital Approved; all other procedures **CONTINGENT UPON**: preoperative radiographs *(type will be specified)* being taken at the hospital and submitted with list of actual treatment procedures directly to Medicaid Agency for review and treatment meeting criteria."

Depending on the extent of the treatment, the preoperative radiographs required in the contingency statement above may vary from bitewings to a panoramic view to a **full mouth series** of radiographs which consists of **14 periapicals and bitewings**. Pay close attention to this contingency statement, as these requirements must be submitted before any review to decide whether requested codes will be added to the Prior Authorization File.

3. **Child is totally uncooperative:** neither the treatment plan nor radiographs could be obtained in the office.

The procedure, approval letter contingencies, and requirements are the same as in # 2 above except that the explanation in Section IV paragraph 3 of Form 343 will include that no films or treatment plan could be obtained in the office.

Outpatient/ASC Admission

Prior authorization is not required for children under 5 years on date of service (dos), unless the planned procedure code itself requires a Prior Authorization (e.g. scaling and root planing D4341)

Adult Anesthesia and Facility Fees

Coverage may be available for facility and anesthesia charges through the prior authorization process for medically compromised adults whose dental problems have exacerbated their underlying medical condition. This code covers Anesthesia and Facility fee only and does not cover any dental procedures.

Criteria for coverage of adult anesthesia and facility fees include the following conditions:

- Uncontrolled diabetes
- Hemophilia
- Cardiovascular problems (for example, CHF, prosthetic heart valves, acute endocarditis)
- When an existing qualifying medical condition is presently exacerbated by the dental condition or when the dental condition is so severe that it has caused a medical condition (for example, acute dental infection has caused an increased white blood cell count, sepsis, or bacterial endocarditis in a susceptible patient)

Documentation by the patient's primary care physician must be included with the completed Alabama Prior Review and Authorization Dental request form, which confirms the medical compromise indicated.

13.4.3 Referral Requirements

Dental care is available as a result of EPSDT referral or if the recipient seeking treatment.

EPSDT Referral

If the EPSDT screening provider determines a recipient requires dental care or if the recipient is 3 years of age or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and/or treatment. **Medicaid does recommend children be enrolled and under the care of a dentist at one year of age**. After the recipient's dental care is initiated, the Consultant's portion of the EPSDT Referral For Services Form must be completed by the dentist and the appropriate copy must be returned to the screening provider.

Recipient Seeking Treatment

If a recipient who has not been screened through the EPSDT Program requests dental care, care may be provided without having an EPSDT Referral Form. Dental care, provided upon recipient's request, is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT provider to obtain a complete medical assessment.

Patient 1st Referrals

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).

Case Management Care Coordination
Alabama's Patient 1st program requires that Medicaid recipients understand the importance of dental care and how to use the dental health care system. Now, professional case managers in the patient's county of residence can complement the dental services of your practice by working with patients you identify as needing additional assistance.

Examples of Case Management Services:

- Home visits or community follow-up
- Patient education or support
- Tracking and follow-up of children who frequently miss appointments
- Coordinating services for patients with multiple providers and/or complex needs
- Crisis intervention
- Resource assistance

If You Are Concerned About a Patient Because of:

- Non-compliance with dental treatment protocol
- Inappropriate behavior in the dental office
- Need for additional training reinforcement or education
- Missed appointments
- Lack of ability to follow a plan of care
- Language or educational barriers, or
- Risk taking behavior,

then refer this patient to the targeted case manager in the patient's county of residence for further screening, support, counseling, monitoring and education. For a list of managers in your area, call the Dental Program at (334) 242-5997 or visit the Alabama Medicaid Agency's website at www.medicaid.alabama.gov.

13.5 Cost Sharing (Copayment)

Copayment does not apply to services provided by dental providers.

13.6 Completing the Claim Form

Only ADA-approved forms are acceptable. If you experience problems with EDS processing your forms, contact EDS for resolution. Refer to Section 5.4, Completing the ADA Dental Form, for complete instructions on filling out the ADA Dental Form.

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Dental providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

13.6.1 Time Limit for Filing Claims

Medicaid requires all claims for Dental providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

13.6.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

13.6.3 Procedure Codes and Modifiers

Use the code numbers and procedure descriptions as they appear in this section when filling out the ADA dental form. The listing of a procedure in this section does not imply unlimited coverage. **Certain procedures require prior authorization as noted in the PA Required column.**

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Diagnostic Clinical Oral Examinations

Limited oral exam – problem-focused (D0140) must document the tooth number or area of the mouth treated, symptom(s), diagnosis, and emergency treatment in the dental record. This procedure cannot be billed in conjunction with a periodic or comprehensive oral examination.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0120	Periodic oral examination (limited to once every 6 months)	No
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 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. This 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).	No
D0140	Limited oral evaluation – problem focused (emergency treatment) Provider must report the tooth number or area of the oral cavity, symptom(s), diagnosis, and emergency treatment in the dental record. Cannot be billed in conjunction with periodic or comprehensive exams. (Limited to one per provider/provider group per year)	No
D0150	Effective January 1, 2004 this must include the evaluation and recording of: dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting if there are signs of periodontal disease OR age 16 and older), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. (Once per recipient's lifetime per provider or provider group)	No

Radiographs

In order to be reimbursed, all films must be of diagnostic quality suitable for interpretation, mounted in proper x-ray mounts marked Right and Left, and identified by type, date taken, recipient's name, and name of dentist. When billing Intraoral - Periapical, first film, and Periapical, each additional film (D0230) a tooth number/letter is required in tooth number column on electronic or paper claim. Any combination of periapical films with or without bitewings taken on the same date of service which exceed the maximum allowed, must be billed as a Complete Intraoral Series (D0210). Periapical films must have a valid indication documented in the record (e.g. aid in diagnosing an emergency, endodontic obturation evaluation, etc.) Routine use of periapical radiographs(s) at periodic/comprehensive evaluations or treatment appointments without valid documented indications are not allowable.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0210	Intraoral – Complete series, including bitewings, consists of 14 periapicals and bitewings (Limit once every 3 years) A complete series uses the benefit of a panoramic film. Any combination of D0220, D0230, D0272, or D0274 taken on the same date of service, which exceeds the maximum allowed fee for D0210 must be billed as D0210	No
D0220	Intraoral – Periapical, first film Not allowed on the same date of service as D0210	No
D0230	Intraoral – Periapical, each additional film Not allowed on the same date of service as D0210	No
D0240	Intraoral – Occlusal film (requires code 01 or 02 in tooth # field on claim indicating maxillary or mandibular arches)	No
D0250	Extraoral – first film	No
D0260	Extraoral – each additional film	No
D0272	Bitewings – two films (Limit 1 every six months) Not allowed on same the date of service as D0274	No
D0274	Bitewings - four films (Limit 1 every six months, effective July 1, 2003 procedure restricted to age 13 or older) Not allowed on same the date of service as D0272	No
D0330	Panoramic film (Cannot be billed in addition to D0210, and limited to once per recipient every three years, effective July 1, 2003 procedure restricted to age 5 or older) A panoramic film uses the benefit of a complete series (D0210)	No
D0350	Oral/facial images (traditional photos and intraoral camera images) *Oral/facial images are authorized only when required by Medicaid*	Yes

Tests and Laboratory Examinations

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0470	Diagnostic casts, per model. Models must be trimmed and able to be articulated and must include bases. *Diagnostic casts are authorized only when required by Medicaid.*	Yes

Preventive Services

Dental prophylaxis includes scaling and/or polishing utilizing a dental prophy cup. Providers should not bill for a “tooth brush prophy”. When billing for prophylaxis and fluoride treatment provided on the same date of service for a recipient, use of only the combined code is appropriate.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1110	Prophylaxis - Adult (over 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D4341, D4355, or D4910	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1120	Prophylaxis - Child (up to and including 12 years of age) (limited once every 6 months) Not allowed on the same date of service as D4341, D4355, or D4910	No
D1203	Topical application of fluoride (excluding prophylaxis) – Child (up to and including 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D1206	No
D1204	Topical application of fluoride (excluding prophylaxis) – Adult (over 12 years of age) (limited once every 6 months) Not allowed on the same date of service as: D1206	No
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);	No
D1351	Sealant, per tooth only covered for teeth: 02,03,14,15,18,19,30,31, on children aged 5 through 13 years) Limit one per tooth per lifetime	No

Space Maintainers

Effective July 1, 2003, space maintainers are covered on the following missing teeth ONLY:

1. Premature loss of second primary molar (A,J,K,T)
2. Premature loss of first primary molar (B,I,L,S) except in mixed dentition with normal class I occlusion
3. Premature loss of primary canines (C,H,M,R)

Space maintainers are NON-COVERED in the following instances:

- For premature loss of primary incisor teeth or as "pedo bridges"
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- More than once per recipient’s lifetime for a given space(tooth) to be maintained
- Space maintainers for the loss of permanent teeth

Space maintainers, when indicated, should be placed as soon as possible after early primary tooth loss, but no later than 180 days after extraction or loss. The claim or prior authorization form must indicate the primary tooth letter that has been prematurely lost/extracted. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. The first two space maintainer procedure codes billed regardless of tooth do not require prior authorization, but must meet coverage requirements. Prior authorization with justification is required for the billing of each additional space maintainer procedure code after the first two.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1510	Space maintainer- fixed, unilateral	Yes (See above)
D1515	Space maintainer- fixed, bilateral	Yes (See above)
D1520	Space maintainer – removable, unilateral	Yes (See above)
D1525	Space maintainer- removable, bilateral	Yes (See above)
D1550	Re-cement space maintainer	Yes (See above)

Restorative Services

Fee for restorative service includes: all adhesives including amalgam or resin bonding agents, lining or base, restoration, and local anesthesia or analgesia, if necessary. Amalgam or resin restorations are not covered on a tooth receiving any of the following procedures: stainless steel crowns (D2930, D2931), resin crowns (D2932), core buildups (D2950), post & cores (D2952, D2953, D2954, D2957), or crowns (D2750, D2751, D2752, or D2792).

Amalgam or resin codes (D2140 – D2394) may not be billed in substitution for a core buildup (D2950). Primary tooth restorations are not allowed when normal exfoliation is imminent. Multiple restorations with at least one surface touching each other will be considered one restoration. All cervical restorations will be considered as a single surface restoration. Effective July 1, 2005 restorations (D2140 – D2394) on primary teeth are not covered unless there is greater than one-third of the original root length remaining.

Amalgam Restorations (Including Polishing)

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2140	Amalgam – one surface, primary or permanent	No
D2150	Amalgam – two surfaces, primary or permanent	No
D2160	Amalgam – three surfaces, primary or permanent	No
D2161	Amalgam – four or more surfaces, primary or permanent	No

Composite Restorations

Resins are not allowed for preventive procedures or cosmetic purposes (e.g. diastema closure, discolored teeth, correction of developmental anomaly, etc.). Composite restorations are now authorized for all surfaces including occlusal surfaces. Preventive resins (resins placed on any surface without documented caries into dentin) are not covered.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2330	Resin – one surface, anterior	No
D2331	Resin – two surfaces, anterior	No
D2332	Resin – three surfaces, anterior	No
D2335	Resin – four or more surfaces or involving incisal (anterior) angle	No
D2391	Resin - one surface, posterior	No
D2392	Resin - two surfaces, posterior	No
D2393	Resin - three surfaces, posterior	No
D2394	Resin - four or more surfaces, posterior	No

Crowns, Single Restorations Only

Medicaid covers crowns, post & cores, and core buildups **only** following root canal therapy (D3310, D3320, D3330) which must qualify for Medicaid coverage. Effective July 1, 2003, crowns (excluding stainless steel or resin crowns), core buildups and post & cores are limited to the permanent teeth on eligible recipients age 15 years or older following root canal therapy. Limited to one per tooth per lifetime. Crowns, post & cores, and buildups on 3rd molars are not covered.

Effective April 1, 2006, permanent, stainless steel or resin crowns are limited to 6 per date of service individually or in combination when performed in an office setting. These procedure codes include D2750, D2751, D2752, D2792, D2930, D2931,and D2932.

Amalgam or resin restorations or sedative fillings are not authorized on teeth being crowned with or without a core buildup or post and core.

*No prior authorization is required for crowns, core buildups, or post & cores. If no root canal is in Medicaid's history, send a diagnostic postoperative periapical x-ray (bitewings are not acceptable) of completed root canal with completed claim form directly to: AL Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36103-5624.

Effective January 1, 2005 reimbursement fees for crown (D2750 – D2792) procedures include any: crown follow up appointments, equilibration, or recementation within 6 months of insertion.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2750	Crown – porcelain fused to high noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2751	Crown – porcelain fused to predominantly base metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2752	Crown – porcelain fused to noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2792	Crown – full cast metal (limited to age 15 or older, on endodontically treated teeth only)	No*

Incomplete Procedures

Effective July 1, 2003 for multiple appointment procedures, payment will be made to the provider that started the procedure. Documentation that several attempts were made to complete the procedure (i.e. phone calls, certified letters) must be supported in the medical record. Billing should only occur after documentation of failed attempts is complete. If the recipient is treated by a subsequent provider for the same procedure, same tooth, the services are considered non-covered.

Other Restorative Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2920	Re-cement crown - Limit 2 per lifetime per tooth and none allowed within the first six months of placement	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2930	Prefabricated stainless steel crown, primary tooth The following are indications for placement of stainless steel crowns (prefabricated crown forms) for fitting on individual teeth: • For the restoration of primary and permanent teeth with caries, cervical decalcification, and/or development defects (hypoplasia and hypocalcification) • When the failure of other restorative materials is likely with interproximal caries extended beyond line angles • Following pulpotomy or pulpectomy • For restoring a primary tooth being used as an abutment for a space maintainer, or • For restoring fractured teeth when the tooth cannot be restored with other restorative materials. Effective July 1, 2003 amalgam or resin restorations, sedative (temporary) fillings, core buildups, pin retention, or post and cores are not authorized on primary or permanent teeth receiving a stainless steel crown.	No
D2931	Prefabricated stainless steel crown, permanent tooth. See indications and limitations listed under D2930 above.	No
D2932	Prefabricated resin crown Amalgam or resin restorations, sedative (temporary) fillings, core buildups, pin retention, or post and cores are not authorized on primary or permanent teeth receiving a prefabricated resin crown. Allowable on anterior teeth only.	No
D2940	Sedative fillings - temporary restoration intended to relieve pain. not to be used as liners or bases under restorations). Not allowable with: amalgam or resin restoration, endodontically treated teeth, core buildups, posts and cores, done on same tooth, same DOS. Limit one per tooth.	No
D2950	Core buildup, including any pins. Not covered on primary teeth. (limited to age 15 or older) Not allowable on the same tooth with: • Amalgam or resins (D2140 – D2394) • Posts & Cores (D2952, D2953, D2954, D2957) Sedative (temporary) fillings (D2940) Pins (D2951)	No**
D2951	Pin retention – per tooth in addition to restoration. Not allowable with D2950	No
D2952	Post and core in addition to crown, indirectly fabricated - Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**
D2953	Each additional indirectly fabricated post – same tooth - (maximum of 2) Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**
D2954	Prefabricated post and core in addition to crown - (maximum of 1) Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-	No**

Procedure Code	Description of Procedure	Prior Authorization Required
	half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	
D2957	Each additional prefabricated post – same tooth – (maximum of 1) Not billable with D2950 (limited to age 15 or older) Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No**

Effective April 1, 2006, core buildups (D2950) and post and cores (D2952, D2954) are limited to 6 per date of service individually or in combination when performed in an office setting. Post and cores, each additional (D2953, D2957) are limited to 2 per date of service individually or in combination when performed in an office setting.

Effective July 1, 2003, the following codes require at a minimum a diagnostic pre-treatment periapical radiograph be taken and maintained on file: D2750, D2751, D2752, D2792, D2952, D2953, D2954, and D2957.

Effective July 1, 2004, to qualify for coverage: posts must be radiographically visible and distinct from the obturation material. "So-called Posts" made in the office solely by flowing or compacting materials into the canal(s), such as resins, polymers, acrylics, amalgams, etc., are not covered. In order to qualify for coverage, posts must be fitted and cemented within the prepared root canal, and be attached to the core in order to retain the core. Posts which do not meet criteria for coverage will not be covered as core buildups. Core buildups and posts & cores are only covered on teeth which are receiving crowns and are limited to once per eligible tooth per lifetime.

Endodontics

Pulp Capping

Bases and sedative fillings do not qualify as pulp caps. Pulp caps without a protective restoration are not covered.

Procedure Code	Description of Procedure	Prior Authorization Required
D3110	Pulp cap, Direct (excluding final restoration) Covered for permanent teeth only. Pulp cap must cover a documented exposed pulp. (limit one per tooth)	No
D3120	Pulp cap, Indirect (excluding final restoration) Covered for permanent teeth only. Effective January 1, 2005, indirect pulp caps are only covered for documented treatment of **deep** carious lesions near the dental pulp with a protective dressing over the remaining carious dentin to prevent operative pulp exposure. (limit one per tooth)	No

Pulpotomy/Pulpectomy

Only the single most appropriate endodontic code should be billed. It is not appropriate to bill pulpotomy/pulpectomy (D3220) and pulpal therapy on primary teeth (D3230 or D3240) for the same tooth. D3220 must not be billed with D3310, D3320, D3330 or D3332 for the same tooth, as these four codes

already include a pulpotomy or pulpectomy. Pulpotomies are not covered for permanent teeth effective July 1, 2003.

Effective April 1, 2006, the following limitations apply for endodontic procedures when performed in an office setting. Pulpotomies (D3220) and Pulpal Therapy (D3230, D3240) are limited to 6 per date of service individually or in combination.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3220	Therapeutic pulpotomy (Covered for primary teeth only, excluding final restoration)	No

Primary Endodontics

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3230	Pulpal therapy, anterior primary tooth	No
D3240	Pulpal therapy, posterior primary tooth	No

D3230 and D3240 would be covered ONLY when all of the following documented indications exist: the primary tooth is restorable and must be saved until the permanent tooth erupts, the pulp is non-vital with no radiographic signs of internal or external root resorption, and a succedaneous tooth is present. These procedures require a complete pulpectomy, diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file. These radiographs must show successful filling of canals with a resorbable filling material without gross overextension or underfilling. Follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Endodontics on Permanent Teeth

Root canal therapy applies to permanent teeth only. Therapy includes treatment plan, clinical procedures, radiographs, temporary fillings, and follow-up care. Endodontics on third molars is not a covered procedure. Effective April 1, 2006, Root canal treatment on anterior (D3310) and premolars (D3320) are limited to 6 per date of service individually or in combination when performed in an office setting. Molar root canals (D3330) are limited to 2 per date of service in an office setting. One molar root canal can be performed with 3 anterior or premolar root canal procedures in an office setting.

The following codes are covered only on permanent teeth and require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D3310, D3320, D3330, D3351, D3410, and D3430. Endodontics (D3310 – D3430) are **only** covered when there are documented tests performed (electrical pulp tests, thermal, percussion, palpation) in the record consistent with radiographic findings and symptoms which support a documented pulpal pathology diagnosis of an irreversible nature on a specific restorable tooth and one of the following procedures are indicated: D3310, D3320, or D3330. When reviewing a radiograph, canals must be filled at approximately 1mm from the apex of the root and have no voids in material. There should be a sealing material between the root canal filling material and restorative material.

Intentional endodontics performed for reasons other than documented irreversible pulpal pathology of a specific restorable tooth, such as, but not limited to: prosthetics, bleaching, orthodontics, non-covered periodontal or oral surgery procedures, pain of undetermined origin, preference of the recipient or provider, etc. are not covered.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3310	Anterior, excluding final restoration (age 6 or older)	No
D3320	Bicuspid, excluding final restoration (age 9 or older)	No
D3330	Molar, excluding final restoration (age 6 or older)	No
D3332	Incomplete endodontic therapy; inoperable or fractured tooth (age 6 or older)	No
D3351	Apexification, per treatment visit (nonvital permanent teeth only) This procedure is only covered after apical closure is obtained and demonstrated with a postoperative periapical radiograph maintained in the record. This postoperative film must be taken after apexification is completed but before canal obturation is performed. Usually several treatments are required. Treatment performed in less than 180 days is not covered.	No

Periapical Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3410	Apicoectomy - Anterior, per tooth - Limit 1 per tooth per lifetime	Yes
D3430	Retrograde filling - Limit 1 per tooth per lifetime (covered only in conjunction with D3410 on anterior teeth)	Yes

D3310, D3320, D3330, D3410 and D3430: require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file. In addition, follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Prior Authorization requests for D3410 and D3430 require a postoperative endodontic periapical film with the history and examination findings to include: symptoms, periodontal probings, palpation, percussion, mobility, presence of swelling or sinus tract, etc. and an explanation of why re-treatment is not being considered.

Periodontics

Periodontics requires prior authorization. Prior authorization for periodontal therapy codes, D4341 or D4910 requires the following:

- Complete periodontal charting (including probing depths) and free gingival margins in relation to Cementoenamel Junctions(CEJs)
- Posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs to be submitted with the prior authorization request

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D4341	Periodontal scaling and root planing, per quadrant Prior authorization for scaling and root planing requires documentation of pocket depths as follows:	Yes

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
	• Patients over 12 years old must have a generalized pocket depth greater than 4 mm, with demonstrable radiographic evidence of generalized periodontitis. (This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque from these surfaces.) • For patients under 12 years old, this procedure is ordinarily not indicated unless some unusual circumstance requires a more in-depth review and documentation (for example, familial juvenile periodontitis.) • This procedure will not be authorized for treatment of pseudopockets. • This procedure requires that radiographs (posterior bitewings and anterior periapicals or bitewings) and complete periodontal charting (including probing depths, free gingival margins in relation to CEJs, etc.) be provided with the request. A limit of no more than **two quadrants** of scaling and root planing will be permitted for each date of service, except for patients treated as inpatient/outpatient hospitalization cases. This procedure not allowed for same quadrant, same date of service with: D1110, D1120, D1201, D1205, D4355, or D4910.	
D4355	Full mouth debridement Covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation. This is a preliminary procedure and does not rule out the need for other procedures. This procedure requires that appropriate radiographs (bitewings, periapicals) be sent with the request. Clinical photographs/images may be required upon request. This procedure is not allowed on the same date of service or within 21 days of scaling and root planing. If prior approved, this procedure must be performed before a comprehensive evaluation is done. This procedure is not allowed on same date of service or within 6 months of : D1110, D1120, D4341, or D4910	Yes
D4910	Periodontal maintenance procedures Prior authorization for Periodontal/Special Maintenance following active therapy requires the following information: • A clinical description of the service • Procedure recommendations • X-rays • Complete periodontal charting (probing depths, free gingival margins in relation to CEJs) • CDT-2005 procedure code • The number of units or visits Approval is typically given for a specified time frame of one to three months. This procedure is not allowed on same date of service with: D1110, D1120, D4341 or D4355	Yes

Oral Surgery

Extractions

Extractions include local anesthesia, aveoloplasty, and routine postoperative care. Extractions of exfoliating primary teeth will not be covered unless there is a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the dental record.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No

Surgical Extractions

Effective July 1, 2003, surgical extractions include and require documentation of local anesthesia, alveoloplasty, mucoperiosteal flap elevation, osseous removal, sectioning and removal of tooth structure, sutures, and routine postoperative care. Radiographs are required with PA request for procedure codes D7240 and D7241. D7241 requires a report by tooth number of actual unusual surgical complication(s). The following codes are only covered for permanent teeth: D7210, D7220, D7230, D7240, D7241, and D7250. **Exception: Ankylosed or impacted primary teeth may be submitted by report with radiographs.** To be reimbursed, providers must send a diagnostic x-ray of primary tooth, report and completed claim form directly to: AL Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36130-5624.

Extractions due to crowding to facilitate orthodontics are not covered unless the orthodontics is covered meeting Medicaid criteria.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Requires documentation of cutting of both gingival and bone, removal of tooth structure, and closure. (covered for permanent teeth only)	No
D7220	Removal of impacted tooth – soft tissue occlusal surface must be covered by soft tissue, requires documentation of mucoperiosteal flap elevation, (covered for permanent teeth only)	No
D7230	Removal of impacted tooth – partially bony a portion of the crown must be covered by bone, requires documentation of mucoperiosteal flap elevation and bone removal (covered for permanent teeth only)	No
D7240	Removal of impacted tooth – completely bony most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal, (covered for permanent teeth only)	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal, (covered for **actual** complications only by	Yes

Procedure Code	Description of Procedure	Prior Authorization Required
	report, covered for permanent teeth only)	
D7250	Surgical removal of residual tooth roots must require documentation of cutting of both soft tissue and bone and removal of tooth structure. Not covered if a portion or all of crown is present (covered for permanent teeth only)	No

Procedures: D7210, D7220, D7230, D7240, D7250 requirements listed above (i.e. flap, bone removal, sectioning, etc.) must be documented in the dental record to be covered.

Other Surgical Procedures Applied To Teeth

Procedure Code	Description of Procedure	Prior Authorization Required
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus. This fee includes any composite or bonding attachment to evulsed or displaced tooth and adjacent teeth as well as any brackets, wire or line used.	No
D7280	Surgical exposure of impacted or unerupted tooth to aid eruption	No
D7285	Biopsy of oral tissue, hard (bone, tooth)	No
D7286	Biopsy of oral tissue, soft (all others)	No

Removal of Tumors, Cysts, and Neoplasms

Procedure Code	Description of Procedure	Prior Authorization Required
D7410	Excision of benign lesion up to 1.25 cm	No
D7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7451	Removal of odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No
D7460	Removal of non-odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7461	Removal of non-odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No

Excision of Bone Tissue

Procedure Code	Description of Procedure	Prior Authorization Required
D7471	Removal of exostosis – per site	No
D7510	Incision and drainage of abscess, intraoral soft tissue Requires documentation of incision through mucosa, area of incision, presence of any purulence from the abscess, use of any drain or sutures. Not allowed in same site as a surgical tooth extraction. Incisions through the gingival sulcus are not covered.	No
D7520	Incision and drainage of abscess, extraoral soft tissue Requires documentation of incision through skin and area of incision, type of drain (if any) and sutures (if	No

Procedure Code	Description of Procedure	Prior Authorization Required
	closed)	

Treatment of Fractures - Simple

Procedure Code	Description of Procedure	Prior Authorization Required
D7610	Maxilla - open reduction (teeth immobilized if present)	No
D7620	Maxilla - closed reduction (teeth immobilized if present)	No
D7630	Mandible - open reduction (teeth immobilized if present)	No
D7640	Mandible - closed reduction (teeth immobilized if present)	No

Reduction of Dislocation - Management of Other Temporomandibular Joint Dysfunctions

Procedure Code	Description of Procedure	Prior Authorization Required
D7820	Closed reduction of dislocation	No

Other Repair Procedures

Excision of hyperplastic tissue (D7970) requires:

- Complete periodontal charting (including probing depths and free gingival margins in relation to CEJs)
- Medical documentation, that the hyperplasia is drug-induced
- Possible oral images/photographs (if required by Medicaid)

Procedure Code	Description of Procedure	Prior Authorization Required
D7911	Complicated suture, up to 5 cm.	No
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	No
D7970	Excision of hyperplastic tissue; per arch (covered for drug-induced cases only)	Yes
D7971	Excision of pericoronal gingiva (covered for partially erupted or impacted teeth only) Use for operculectomy Not allowed for crown lengthening or gingivectomy	No

Orthodontics

Orthodontic services require prior authorization. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. See Section 13.3.3 of this chapter entitled *Orthodontic Services* for more details.

Adjunctive General Services

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9110	Palliative (emergency) treatment of minor dental pain. This procedure requires documentation in the record of: symptoms, findings, tests (if performed), radiographs if taken, diagnosis, and description of emergency treatment. Cannot be billed with the following definitive or emergency procedures: D0210, D0350, D0470, D1110 through D7970, D7971, D9220 and D9610. This is a specific code and must not be used to bill for any procedure that has its own unique code, even if the most appropriate code is not covered. Always bill the most appropriate CDT-2005 code. (Limit one per visit)	No

Procedures

The following procedures are limited to one per visit when not covered by separately listed procedures.

Anesthesia

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9220	General anesthesia (requires current state board GA permit)	No
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide or similar analgesia is authorized for payment in special cases such as mentally retarded or extremely uncooperative patients. Effective April 1, 2004, documentation of medical necessity, written informed consent, and nitrous oxide dosage (% nitrous oxide and/or flow rate, duration), must be in the medical record. The provider or recipient's desire to use this procedure, by itself, does not qualify it as medically necessary.	No
D9241	Intravenous sedation/analgesia (requires current state board IV or GA permit)	No

Drugs

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9610	Therapeutic parental drug, single administration, by report billable only when no definitive treatment rendered in same visit	Yes
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	Yes

Tooth Numbers and Letters

- Enter the tooth number or letter for the appropriate tooth. Use the letters and/or numbers shown on the dental chart. Additional tooth designations are listed below. Insert these in the "Tooth # or Letter" block on the claim when indicated.

- Tooth Numbers should include for Permanent dentition: 01 through 32
- Tooth Numbers should include for Primary dentition: A through T
- Supernumerary are as follows:

A supernumerary tooth for Permanent Dentition (Tooth numbers 01-32) would have 50 added to its tooth number. Therefore if a patient had an extra tooth number 30 it would be coded as tooth number '80' (30 + 50 = 80). Valid numbers would be 51 through 82. Primary dentition (Tooth numbers “A” through “T”) would place an 'S' after the tooth code. If a patient had an extra 'A' tooth, it would be coded 'AS'. Valid letters would be ‘AS’ through ‘TS’.

The following codes may be used in conjunction with those listed on the claim form:

Code	***Designation***	***Code***	***Designation***
00	Full mouth	30	Lower Left Quadrant
01	Upper Arch	40	Lower Right Quadrant
02	Lower Arch		
10	Upper Right Quadrant	L	Left
20	Upper Left Quadrant	R	Right

Surface

Please bill the single most appropriate surface involved using the following abbreviations:

Code	***Designation***	***Code***	***Designation***
B	Buccal; Labial	L	Lingual
D	Distal	M	Mesial
I	Incisal	O	Occlusal
F	Facial; Labial		

When more than one surface on the same tooth is affected, use the following combinations:

2 Surfaces			***3 Surfaces***				***4 Surfaces***		***5 Surfaces***	
MO	IF	ML	MOD	IFL	BOL	MID	MODB	MIFL	*MODBL*	*MODFL*
DB	IL	OB	MOB	MIL	DOB	MIF	MODL	DIFL	*MIDBL*	*MIDFL*
MB	DI	DO	MOL	DIL	DOL	DIF	MOBL	MIDL		
DL	MI	OL	MBD	MLD			MIDF			

13.6.4 Place of Service Codes

The following place of service codes apply when filing claims for dental services:

Place of Service Codes	***Place of Service***
11	Dental office
21	Inpatient hospital
22	Outpatient hospital
31	Skilled nursing facility or nursing facility

NOTE:

Place of service codes other than 11 require prior authorization before delivery of the service, unless recipient is under 5 years old.

13.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

13.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
ADA Dental Claim Form Instructions	Section 5.4
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Dental Prior Authorization Form	Section 5.4

14

14 Durable Medical Equipment (DME)

Medicaid authorizes supplies, appliances, and durable medical equipment (DME) to Medicaid recipients of any age living at home. A provider of these benefits must ensure the following:

- The supplies, appliances, and DME are for medical therapeutic purposes.
- The items will minimize the necessity for hospitalization, nursing facility, or other institutional care.

The attending physician is responsible for ordering the items in connection with his or her plan of treatment. The attending physician must be a licensed, active, Alabama Medicaid provider. The DME provider is responsible for delivering and setting up the equipment as well as educating the recipient in the use of the equipment.

Request for coverage of durable medical equipment must be received by EDS within thirty days after the equipment is dispensed. When the request is not received within the thirty day time frame for **ongoing rental equipment (such as apnea monitors, pulse oximeters, oxygen, cpap machines, ventilators, bipap machines, compressors)** the thirty days will be calculated from the date the prior authorization request is received by EDS. (See section 14.3.1 Authorization for Durable Medical Equipment)

NOTE:

A recipient does not have to be a Home Health Care recipient in order to receive services of this program.

The policy provisions for DME providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 13.

14.1 Enrollment

EDS enrolls supply, appliance, and durable medical equipment providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*. A copy of your approved Medicare enrollment application is required.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a DME provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for DME-related claims.

NOTE:

All nine digits are required when filing a claim.

DME providers are assigned a provider type of 91 (DME) and a provider specialty (V4) for DME providers of Durable Medical Equipment/Oxygen.

Enrollment Policy for DME Providers

To participate in the Alabama Medicaid Program, DME providers must meet the following requirements:

- The provider's business must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. This requirement does not apply to Medicare crossover providers.
- There must be at least one person present to conduct business at the physical location. Answering machines and/or answering services are not acceptable as personal coverage during normal business hours (8:00 a.m. – 5:00 p.m.). Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, however the satellite could enroll with a separate provider number.
- Medicaid will enroll manufacturers of augmentative/alternative communication devices (ACDs) regardless of location.
- Medicaid will enroll manufacturers of high frequency chest wall oscillation air pulse generator systems regardless of location

Added: Medicaid will enroll…regardless of location.

- The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.

14.2 Benefits and Limitations

This section defines durable medical equipment, discusses Medicaid policy for supplying medical supplies and appliances as a DME provider, discusses prior authorization for DME, provides a listing of non-covered services, and describes reimbursement policy. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

14.2.1 Supplies, Appliances, and DME

A written order or a signed prescription from the attending physician to a participating supplier determines medical necessity for covered items of supplies and appliances. A prescription is considered to be outdated by Medicaid when it is presented to EDS past ninety days from the date it was written. Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the attending physician to determine medical necessity for continued dispensing of medical supplies. Prior authorization by Medicaid is not required for supplies and

appliances except for when more than the Medicaid allowed units are required (i.e. blood glucose test strips and lancets).

The recipient or their authorized representative is responsible for obtaining the prescription from the attending physician for Medicaid-covered items and taking it to a participating Alabama Medicaid DME provider.

Upon receipt of the prescription, the DME provider must:

- Verify Medicaid eligibility by checking the RID number and verifying that number using AVRS, AEVCS or the Provider Assistance Center at EDS
- Obtain necessary managed care referrals and prior authorization
- Collect the appropriate copayment amount
- Furnish the covered item(s) as prescribed
- Retain the prescription on file
- Submit the proper claim form to EDS

Upon furnishing durable medical equipment/supplies, the supplier should obtain a signature on any form he/she desires indicating that the equipment/supplies have been received by the recipient. If the recipient is unable to sign for the equipment/supply items the supplier should verify the identity of the person signing for the items, i.e. relative, homehealth worker, neighbor.

14.2.2 Durable Medical Equipment

Medicaid covers new durable medical equipment items for long-term use, long term use is defined as the use of durable medical equipment that exceeds six months. Standard durable medical equipment items (e.g. wheelchairs/beds) for EPSDT related services may be rented for six months or less.

Durable medical equipment is necessary when it is expected to make a significant contribution to the treatment of the recipient's injury or illness or for the improvement of physical condition.

As defined by Medicaid, durable medical equipment is equipment that meets the following conditions:

- Can stand repeated use
- Serves a purpose for medical reasons
- Is appropriate and suitable for use in the home

The cost of the item must not be disproportionate to the therapeutic benefits or more costly than a reasonable alternative. The item must not serve the same purpose as equipment already available to the recipient.

Providers should be aware of Medicaid policy regulating medical necessity for durable medical equipment. The policy is described below for DME covered by Medicaid.

Warranty, Maintenance, Replacement, and Delivery

All standard durable medical equipment must have a manufacturer's warranty of a minimum of one year. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, replacements and maintenance for the first year. The warranty begins on the date of delivery (date of service) to the recipient. The original warranty must be given to the recipient and the provider must

keep a copy of the original warranty for audit review by Medicaid. Medicaid may request a copy of the warranty.

Medicaid covers repair of standard durable medical equipment. These services must be prior approved by Medicaid. Medical documentation submitted must support the need for servicing of the equipment. Providers should submit their usual and customary charges for the service.

Requests for items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the Long Term Care Division for review and consideration. Request for repair/replacement due to extenuating circumstances should be mailed to, Alabama Medicaid Agency, 501 Dexter Ave., LTC Division, Montgomery AL, 36103.

Added:
The request for…need for replacement.

The Alabama Medicaid DME Program covers replacement equipment as needed due to wear, theft, irreparable damage, or loss by disasters. Documentation must accompany prior authorization requests for replacement in these instances. The request for replacement of equipment must be submitted to the Alabama Medicaid Agency with a police/fire report or other appropriate documentation justifying the need for replacement. However, cases suggesting malicious damage, neglect, or wrongful misuse of the equipment will be investigated. Requests for equipment will be denied if such circumstances are confirmed.

Payment for repair/replacement of equipment which has been denied by Medicaid would be the responsibility of the recipient/caregiver.

NOTE:

This section describes medical policy for DME. For valid procedure codes and modifiers, refer to Appendix P, Procedure Codes and Modifiers.

Suction Pump, Home Model, Portable (E0600)

A physician must prescribe a suction pump as medically necessary for the equipment to qualify for Medicaid reimbursement. EDS must receive a request for coverage within **thirty calendar days** after the date the pump is dispensed. The recipient must be unable to clear the airway of secretions by coughing secondary to one of the following conditions:

- Cancer or surgery of the throat
- Paralysis of the swallowing muscles
- Tracheostomy
- Comatose or semi-comatose condition

The suction device must be appropriate for home use without technical or professional supervision. Individuals using the suction apparatus must be sufficiently trained to adequately, appropriately, and safely use the device.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any recipient under the age of 21 who is referred through the EPSDT program. The information submitted must include documentation that the recipient meets the above medical criteria.

NOTE:

Purchase of the suction pump will be limited to one per recipient every five years provided the above criteria is met.

Home Blood Glucose Monitor (E0607)

Home blood glucose monitors, monitor replacement batteries, calibrator solution/chips, and spring powered lancet devices must be prescribed as medically necessary by the primary physician. To be considered for coverage Medicaid beneficiaries must be diagnosed as having either Type 1 Type 2 or gestational diabetes and **at least two** of the following medical criteria must be met:

- Home blood glucose monitoring is required two or more times a day.
- Documentation of at least two episodes of (hyperglycemia (blood sugar < 60 mg/dl), hypoglycemia blood sugar > 240 mg/dl) is provided.
- Recipient has had at least one emergency room visit or one hospital admission related to diabetes complications within the 12 months prior to the date of the request; or
- Medical documentation with two or more fasting blood sugars greater than 126 mg/dl, hemoglobin HbAlc greater than 7.0%, random blood sugar greater than = 200 mg/dl, with the presence of increased urination, thirst or unexplained weight loss, or 2-h plasma glucose 200 mg/dl or greater during an oral glucose tolerance test; or
- Recipient experiences complications resulting from poor diabetes control including neuropathy, nephropathy, retinopathy, recurrent hyperglycemia/hypoglycemia, repeated infections or non-healing wounds, stroke, and cardiovascular disease; or
- Recipient has experienced two or more HbAlc levels greater than 7.0%, at least three months apart.

NOTE:

Recipients with gestational diabetes due to pregnancy who were diagnosed with diabetes prior to the pregnancy are eligible to receive diabetic equipment/supplies.

Recipients receiving Total Parental Nutrition (TPN) Therapy are eligible to receive diabetic equipment/supplies if the criteria listed below are met:

1. Home blood glucose monitoring is required two or more times a day; and
2. Documentation of at least two episodes of hypoglycemia or hyperglycemia is provided; and
3. Plan of Care is submitted defining the length of TPN Therapy.

The medical documentation listed above, which justifies medical necessity, must be in the recipient's file. Documentation in the recipient's file must also include certification that the recipient or their caregiver is receiving, or has received, diabetes education and training on the use of the glucose monitor, strips and lancets in the appropriately prescribed manner in the home.

Requests for Medicaid's authorization of a replacement glucose monitor will be accepted for review **every five years.** A request for replacement of the glucose monitor submitted within less than five years which is due to a natural disaster, or an occurrence beyond the recipient's control, and not the result of misuse, neglect or malicious acts by the user may be considered for approval and payment. The request for a replacement glucose monitor must be submitted to the Long Term Care Provider/Recipient Services Unit at 501 Dexter Avenue, Montgomery, AL 36130. The request must be submitted with a police/fire report or other appropriate documentation justifying the need for replacement.

For Recipients with Diabetes

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

If more than 3 boxes of strips or 2 boxes of lancets are needed for an insulin dependent diabetic, a prior authorization request must be submitted to EDS for review. The request must contain medical justification for the additional strips or lancets from the primary physician.

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

If more than 2 boxes of strips or 1 box of lancets are needed for a non insulin dependent diabetic, a prior authorization request must be submitted to EDS for review. The request must contain medical justification for the additional strips or lancets from the primary physician.

For a recipient receiving TPN Therapy, blood glucose test or reagent strips are limited to 2 boxes (50 per box) per month. Lancets are limited to 1 box (100 per box) per month

If more than 2 boxes of strips or 1 box of lancets are needed for a recipient receiving TPN Therapy, a prior authorization request must be submitted to EDS for review. The request must contain medical justification for the additional strips or lancets from the primary physician.

When billing Medicaid for diabetic supplies for a recipient who requires additional strips or lancets above the Medicaid established limit, please bill for three boxes of strips (A4253) and two boxes of lancets (A4259) before you bill for the additional amounts approved on the prior authorization. When you bill for the additional strips and lancets, that were prior approved, use the appropriate prior authorization number when submitting the claim.

Providers dispensing diabetic supplies must have the recipient's prescription on file from the primary care physician. A valid prescription will contain the frequency for daily blood sugar testing. Providers must ensure that diabetic supplies are dispensed based on the daily frequency of blood sugar testing indicated on the recipient's prescription. For example if blood sugar testing is prescribed twice a day, (2 X 30 days) = 60 strips) two boxes of strips must be dispensed for the first month. For subsequent months the provider should only dispense one box (50ct) or additional boxes as needed. The recipient should have forty strips remaining from the previous month. Lancets (100ct) should also be dispensed based on the daily frequency of blood sugar testing.

It is the provider's responsibility to ensure that the recipient does not have an excessive supply of strips/lancets. If it is determined through Provider Audits that Medicaid has reimbursed the provider for excessive amounts of strips/lancets, the amount paid for the excessive supply will be recouped.

The following diabetic supplies are also available for recipients who are eligible for the home blood glucose monitor:

Diabetic supplies	Limits
A4233 Replacement battery, Alkaline, other than J cell	2 units/year
A4234 Replacement battery, Alkaline, J cell	2 units/year
A4235 Replacement battery, Lithium	2 units/year
A4236 Replacement battery, Silver Oxide	2 units/year
A4256 Normal, low and high calibrator solution/chips	4 units /year (1/qtr)
A4258 Spring-powered device for lancet, each	1 per year

External Ambulatory Infusion Pump (E0784), and Supplies (A4232, A4221)

An external ambulatory infusion pump is a small portable battery device worn on a belt around the waist and attached to a needle or catheter designed to deliver measured amounts of insulin through injection over a period of time. The ambulatory infusion pump will be limited to one every five years.

The external ambulatory infusion is approved by the Alabama Medicaid Agency for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment, and must be prior authorized.

E0784 - External Ambulatory Infusion Pump will be limited to one every five years based on submitted documentation. This procedure code will be a capped rental item with rental payment of $360.00 per month for twelve months. At the end of the twelve month period the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance/repair cost would be subject to an EPSDT screening and referral and a prior authorization as addressed under current Medicaid policy.

A4232 - Syringe with needle for External Insulin Pump, sterile 3cc (each) will be supplied in quantities prescribed as medically necessary by the physician.

A4221 - Supplies for maintenance of drug infusion catheter per week will be limited to three supply kits per week; no more than twelve supply kits per month. These supply kits must be prescribed as medically necessary by the recipient's physician. If additional supply kits are needed an EPSDT screening and referral and a prior authorization must be submitted to Medicaid for review and approval.

The following criteria must be met in determining medical necessity for the insulin pump (All seven must be met):

1. Patient must be under 21 years of age and EPSDT eligible.
2. A board certified or eligible endocrinologist must have evaluated the patient and ordered insulin pump.
3. Patient must have been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the CSII pump.
4. Patient has documented frequency of glucose self-testing an average of at least four times per day during the three months prior to initiation of the insulin pump.
5. Patient or caregiver must be capable, physically and intellectually, of operating the pump.

6. Type 1 diabetes must be documented by a C-peptide level < 0.5.
7. Records must have documentation of active and past recipient compliance with medications and diet, appointments and other treatment recommendations.

Two or more of the following criteria must also be met:

1. Copies of lab reports documenting two elevated glycosylated hemoglobin levels (HbA1c>7.0%) within a 120-day span, while on multiple daily injections of insulin.
2. History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements). A history of not less than 3 documented episodes of severe hypoglycemia (<60 mg/dl) or hyperglycemia (>300 mg/dl) in a given year.
3. Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dl).
4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl.

Approved Diagnoses:

Approval will be given for only the following type 1 diabetes mellitus diagnosis codes, if above criteria is met: 250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.41, 250.43, 250.51, 250.53, 250.61, 250.63, 250.71, 250.73, 250.81, 250.83, 250.91, 250.93.

Hospital Bed (E0250, E0255, E0260) (E0303) (E0304)

A physician must prescribe a hospital bed as medically necessary in order for a recipient to qualify for Medicaid reimbursement. EDS must receive the request for coverage within **thirty calendar days** after the date that the equipment was dispensed. The recipient must meet one of the following conditions:

1. Recipient positioning of the body not feasible on an ordinary bed.
2. Recipient has medical conditions that require head of bed elevation.
3. Recipient requires medical equipment which can only be attached to the hospital bed.

At least one of the criteria listed above must be met as well as any of the following for coverage of variable height hospital bed:

1. Recipient has medical condition or injuries to lower extremities and the variable height feature allows recipient to ambulate by placing feet on the floor while sitting on edge of bed.
2. Recipient's medical condition is such that they are unable to transfer from bed to wheelchair without assistance**.**
3. Severely debilitating diseases and conditions require the need of the variable height bed to allow recipient to ambulate or transfer.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria.

Medicaid covers hospital beds (E0304) extra heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 600 pounds.

Medicaid covers hospital beds (E0303) heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 350 pounds, but less than 600 pounds. Replacement mattresses for the heavy duty, extra wide bed or the extra heavy duty bed can be obtained using procedure code E1399.

Medicaid will use the established prior authorization criteria for these hospital beds, but will add the weight, width and length requirements. Individuals approved for these beds must be fitted and measured by the Durable Medical Equipment Company providing these services. Medicaid will reimburse providers at invoice cost plus 20% for these Bariactric beds.

Hospital Bed Accessories

(E0271, E0275, E0276, E0280, E0310 E0621, E0630, E0910, E0911, E1399)

Hospital bed accessories must be prescribed as medically necessary, require prior authorization and medical documentation must be submitted justifying the need.

If hospital bed is medically necessary and is needed for six months or less the equipment will be rented. This policy is applicable for all Medicaid recipients. If the equipment continues to be medically necessary and is needed longer than six months another PA request and prescription must be submitted documenting the need. If approval is granted a capped rental will be established and previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price.

NOTE:

For benefit limits refer to the DME Fee Schedule.

Powered Pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty (E0181)

Gel or gel-like pressure pad for mattress, standard mattress length and width (E0185)

Powered pressure reducing mattress overlay/pad, alternating with pump, includes heavy duty or a gel/gel-like pressure pad for mattress will be considered for Medicaid payment when prescribed as medically necessary by a physician.. Requests for the equipment must be received by EDS within thirty calendar days after the date that the equipment was dispensed. The patient is bed confined for at least 75 to 100% of the time and the following criteria are met:

1. Patient is unable to physically turn or reposition self; and
2. Patient is medically at risk for skin breakdown (define as to why)
3. Patient's care plan must document the following:
   a. Caregiver/recipient has had education on prevention/management of pressure ulcers
   b. Regular health care assessment at least every 30 days

c. Caregiver/recipient understands and can perform turning and positioning

d. Caregiver/recipient understands management of moisture/incontinence

e. Recipient has nutritional assessment documenting nutritional status

Initial Approval of the equipment requires prior authorization and will consist of up to 6 months only. If physician documents that recipient will need equipment longer than six months the equipment will become a capped rental to purchase item. Previous rental payments will be applied toward the total purchase price of the equipment. The monthly rental payment includes delivery, in service for caregiver, maintenance, repair and supplies if applicable.

The gel/gel like pressure pad for mattress (E0185) will be purchased as this item is not considered reusable.

NOTE:

For benefit limits refer to the DME Fee Schedule.

Mattress Replacement (E0271)

To qualify for Medicaid reimbursement of a mattress replacement, a physician must prescribe the equipment as medically necessary. Request for coverage must be received by EDS within **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria:

- The patient has a safe and adequate hospital bed in his home
- Documentation must be submitted showing the mattress in use is damaged and inadequate to meet the patient's medical needs.

NOTE:

For benefit limits refer to the DME Fee Schedule.

Bed Side Rails (E0310)

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. EDS must receive the request for coverage within **thirty calendar days** after the date that the equipment was dispensed. The recipient must be bed confined and have one or more of the following conditions:

- Disorientation
- Positioning problem
- Vertigo
- Seizure disorder

NOTE:

For benefit limits refer to the DME Fee Schedule.

Recipient Hydraulic Lift With Seat or Sling (E0630)

Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. Request for coverage must be received by EDS within **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria:

- Documentation must indicate the recipient has, or is highly susceptible to decubitus ulcers, and/or:
- The recipient must be essentially bed confined and would require the assistance of more than one person to transfer from bed to chair or wheelchair or commode without a lift.

NOTE:

For benefit limits refer to the DME Fee Schedule.

Trapeze Bar, AKA Recipient Helper, Attached to Bed with Grab Bar (E0910) (E0911)

To qualify for Medicaid reimbursement of a trapeze bar, the physician must prescribe the equipment as medically necessary for the recipient. Request for coverage must be received by EDS within **thirty calendar days** after the date that the equipment was dispensed. The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must have positioning problems. Documentation must show that the recipient has physical/mental capability of using the equipment for repositioning.
- The recipient must have difficulty getting in and out of bed independently.

Medicaid covers Trapeze Bar (E0911), heavy duty for patient weight capacity greater than 250 pounds, Attached to Bed with Grab Bar

Medicaid will use the established prior authorization criteria for these trapeze bars, but will add the weight requirements. Individuals approved for these trapeze bars must weigh over 250 pounds. Medicaid will reimburse providers at invoice cost plus 20% for these trapeze bars.

NOTE:

For benefit limits refer to the DME Fee Schedule.

Short Term Rental Policy

Certain Durable Medical Equipment items prescribed as medically necessary will be rented if needed on a short term basis. Short term is described as (6) months or less. These procedure codes will be indicated on the fee schedule with an RR for rental.

Medicaid payment for short term rental will be made under the following conditions:

1. Written order documenting estimated period of time (number of months) medical equipment will be needed
2. Documentation that establishes medical necessity for short term rental

Initial approval will consist of up to 90 days only. If recipient needs the equipment after the initial 90 day period, written documentation must be submitted that demonstrates continued medical necessity.

If equipment continues to be medically necessary longer than six months a capped rental is established, previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price of the equipment.

Nebulizer (E0570)

The nebulizer is a covered service in the DME program for all recipients. The nebulizer can be provided only if it can be used properly and safely in the home. A physician must prescribe it as medically necessary.

This equipment may be purchased for any qualified Medicaid recipient based on the criteria listed below. This equipment may also be rented for any recipient under the age of 21 who is referred through the EPSDT Program.

The policy limiting purchase of a nebulizer (E0570) to one every two years was revised. One nebulizer may be purchased every four years for recipients if medcially necessary. Medicaid system changes were made to ensure that nebulizer purchases subject to the limitation of one every two years has an end date of December 31, 2002 and purchases subject to the limitation of one every four years has a begin date of January 1, 2003. The system looks at claims from previous years as well as current history to ensure that claims paid in 2002 will not be paid again until the four years are up.

The prior authorization requirement for neulizers was dropped in June 1999, therefore, nebulizers do not require prior authorization and should not be submitted to EDS for prior authorization.

Request for consideration of payment for replacement of nebulizers due to theft or loss by disasters must be submitted with a police or fire report and a clean claim to the Alabama Medicaid Agency, 501 Dexter Avenue, Long Term Care Division, Montgomery, AL, 36103.

Age Group	***Purchase or Rental Requirements***
Children 6 years of age or under	**Purchases** require documentation of previous episodes of severe respiratory distress associated with one of the following diagnoses: • Asthma • Reactive Airway Disease • Cystic Fibrosis • Bronchiectasis • Bronchospasm Short-term **Rentals** (6 months or less) are allowed for first time episodes associated with one of the above diagnoses. Supporting documentation must accompany the request.

Age Group	*Purchase or Rental Requirements*
Children 7 through 18 years of age	**Purchases** require documentation of one of the diagnoses listed above. Documentation must also be submitted of one of the following: • The recipient has had a failed trial of a least four weeks of anti-inflammatory drugs (for example, Cromolyn, Nedocromil, and steroids) and bronchodilators (for example, B2 adrenergics, Ipratropium) delivered by metered dose inhaler (MDI) and spacer or dry powder inhalers (DPI). • The recipient's medical condition prevents the coordination necessary to effectively use an MDI and spacer or DPI (i.e. cerebral palsy, mental retardation, neuromuscular weakness, or muscle paralysis).
Recipients 18 years of age and above	**Purchases** require documentation of one of the following diagnoses: • Asthma • Bronchiectasis • Cystic Fibrosis Recipients with a diagnosis of asthma must have documentation of one of the following: • The recipient has had a failed trial of at least four weeks of inhaled or oral anti-inflammatory drugs and inhaled bronchodilators. • The recipient is a moderate or severe asthmatic whose rescue treatment with MDIs is insufficient to prevent hospitalizations or emergency room visits (2 or more ER visits for asthma or 1 or more hospitalizations in the past 12 months). **Rentals** are approved only on a short-term basis (6 months or less) for acute complications of pneumonia.
Children and Adults	**Purchases** may be approved to deliver medications that can be administered only by aerosol (i.e. Pulmozyme for cystic fibrosis). Must be accompanied by supporting documentation. **Rentals** may be approved on a short-term basis (6 months or less) to administer medications as an alternative to intravenous administration of those drugs (for example, nebulized tobramycin, colistin, or gentamicin). Must be accompanied by supporting documentation.

NOTE:

Purchase of the nebulizer is limited to one every four years for recipients who meet the above criteria.

Iron Chelation Therapy Equipment (E0779, A4222, A4632, E1399 & E1340)

Iron Chelation Therapy equipment will be considered for Medicaid payment when prescribed as medically necessary by a physician for an eligible recipient who meets the following criteria:

- Documentation must be submitted indicating the recipient has been diagnosed as having Sickle Cell Disease.
- A Sickle Cell Foundation office must submit the request for the equipment.
- EDS must receive a prior authorization request after obtaining the above information within **thirty calendar days** after the date that the equipment was dispensed. This includes the Auto-Syringe Infusion Pump for Iron Chelation Therapy (E0779) and the Auto-Infusion Pump Repair for Iron Chelation Therapy (E1399 & E1340).

Iron Chelation Therapy equipment will be purchased for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above criteria.

Augmentative Communication Devices (E2500), (E2502), (E2504), (E2506), (E2508), (E2510), (E2511), (E2512), (E2599)

Augmentative Communication Devices (ACDs) are defined as portable electronic or non-electronic aids, devices, or systems for the purpose of assisting a Medicaid eligible recipient to overcome or improve severe expressive speech-language impairments/limitations due to medical conditions in which speech is not expected to be restored. These devices also enable the recipient to communicate effectively.

These impairments include but are not limited to apraxia of speech, dysarthria, and cognitive communication disabilities. ACDs are reusable equipment items that must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or his family. Medicaid will not provide reimbursement for ACDs prescribed or intended primarily for vocational, social, or academic development/enhancement.

E2500 Speech generating device digitized speech using pre-recorded messages, less than or equal to eight minutes recording time.

E2502 Speech generating device, digitized speech using pre-recorded messages greater than 8 minutes, but less than or equal to 20 minutes recording time.

E2504 Speech generating device, digitized speech using pre-recorded messages greater than 20 minutes, but less than or equal to 40 minutes recording time.

E2506 Speech generating device, digitized speech using pre-recorded messages greater than 40 minutes recording time.

E2508 Speech generating device, synthesized speech requiring message formulation by spelling and access by physical contact with the device.

E2510 Speech generating device, synthesized speech permitting multiple methods of message formulation and access by physical contact with the device.

E2511 Speech generating software program, for personal computer or personal digital assistant.

E2512 Accessory for speech generating device**,** mounting system.

E2599 Accessory for speech generating device not otherwise classified.

V5336 Repair modification of augmentative communication system or device (excludes adaptive hearing aid).

Scope of services includes the following elements:

- Screening and evaluation
- ACD, subject to limitations
- Training on use of equipment

These are inclusive in the allowable charge and may not be billed separately.

NOTE:

This section describes candidacy criteria, evaluation criteria, and prior authorization and limits for ACDs.

Candidacy Criteria

Candidates must meet the following criteria:

Age	*Candidacy Criteria*
Under age 21	• EPSDT referral by Medicaid enrolled EPSDT provider. • Referral must be within one year of application for ACD. The EPSDT provider must obtain a referral from the Patient 1st Primary Medical Provider where applicable • Medical condition which impairs ability to communicate as described above • Evaluation required by qualified, experienced professional • Physician prescription to be obtained after the evaluation and based on documentation contained in evaluation.
Adults, age 21+	• Referral from a primary care physician (Patient 1st PMP where applicable). • Referral must be within one year of application for ACD • Medical condition which impairs ability to communicate as described above • Evaluation by required qualified experienced professionals • Physician prescription to be obtained after the evaluation and based on documentation provided in the evaluation.

Evaluation Criteria

Qualified interdisciplinary professionals must evaluate the candidate. Evaluation by interdisciplinary professionals must include a speech-language pathologist and a physician. Qualifications for a speech-language pathologist include:

- Master's degree from accredited institution
- Certificate of Clinical Competence in speech/language pathology from the American Speech, Language, and Hearing Association
- Alabama license in speech/language pathology
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs
- Current continuing education in the area of Augmentative Communication

Evaluations by interdisciplinary professionals should also include, but may not be limited to, a physical therapist, social worker, and/or occupational therapist.

A physical therapist must possess the following qualifications:

- Bachelor's degree in Physical Therapy from accredited institution
- Alabama license in Physical Therapy
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

A social worker must possess the following qualifications:

- Bachelor's degree from accredited institution
- Alabama license in Social Work
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

An occupational therapist must possess the following qualifications:

- Bachelor's degree in Occupational Therapy from accredited institution
- Alabama license in Occupational Therapy
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

Prior Authorization Process

ACDs and services are available only through the Alabama Medicaid prior approval process. Requests for authorization must be submitted to Medicaid for review. Documentation must support that the client is mentally, physically and emotionally capable of operating/using an ACD. The request must include documentation regarding the medical evaluation by the physician and recipient information.

Medical examination by a physician is required to assess the need for an ACD to replace or support the recipient's capacity to communicate. The examination should cover:

- Status of respiration
- Hearing
- Vision
- Head control
- Trunk stability
- Arm movement
- Ambulation
- Seating/positioning
- Ability to access the device

The evaluation must be conducted within 90 days of the request for an ACD.

Medicaid requires the following recipient information with the prior authorization request:

Topic	***Information required for the PA***
Identifying information	• Name • Medicaid RID number • Date(s) of Assessment • Medical diagnosis (primary, secondary, tertiary) • Relevant medical history
Sensory status (As observed by physician)	• Vision • Hearing • Description of how vision, hearing, tactile and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination)
Postural, Mobility & Motor Status	• Motor status • Optimal positioning • Integration of mobility with ACD • Recipient's access methods (and options) for ACD
Development Status	• Information on the recipient's intellectual/cognitive/development status • Determination of learning style (e.g., behavior, activity level)
Family/Caregiver and Community Support Systems	A detailed description identifying caregivers and support, the extent of their participation in assisting the recipient with use of the ACD, and their understanding of the use and their expectations

Topic	*Information required for the PA*
Current Speech, Language and Expressive Communication Status	• Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis • Speech skills and prognosis • Communication behaviors and interaction skills (i.e. styles and patterns) • Description of current communication strategies, including use of an ACD, if any • Previous treatment of communication problems
Communication Needs Inventory	• Description of recipient's current and projected (for example, within 5 years) speech-language needs • Communication partners and tasks, including partner's communication abilities and limitations, if any • Communication environments and constraints which affect ACD selection and/or features
Summary of Recipient Limitations	Description of the communication limitations
ACD Assessment Components	Justification for and use to be made of each component and accessory requested
Identification of the ACDs Considered for Recipient-Must Include at Least Two (2)	• Identification of the significant characteristics and features of the ACDs considered for the recipient • Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate) • Identification of manufacturer • Justification stating why a device is the least costly, equally effective alternative form of treatment for recipient • Medical justification of device preference, if any
Treatment Plan & Follow Up	• Description of short term and long term therapy goals • Assessment criteria to measure the recipient's progress toward achieving short and long term communication goals • Expected outcomes and description of how device will contribute to these outcomes • Training plan to maximize use of ACD
Additional Documentation	• Documentation of recipient's trial use of equipment including amount of time, location, analysis of ability to use • Documentation of qualifications of speech language pathologists and other professionals submitting portions of evaluation. Physicians are exempt from this requirement. • Signed statement that submitting professionals have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs. One statement signed by all professionals will suffice.

NOTE:

Medicaid reserves the right to request additional information and/or evaluations by appropriate professionals.

Limits

ACDs including components and accessories will be modified or replaced only under the following circumstances:

- Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition that significantly alters the effectiveness of the device.
- Age of Equipment: ACDs outside the manufacturer's or other applicable warranty that do not operate to capacity will be repaired. At such time as repair is no longer cost effective, replacement of identical or comparable component or components will be made upon the request of the recipient. Full documentation of the history of the service, maintenance, and repair of the device must accompany such request.
- Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by present device.

All requests for replacement, modification as outlined above require a new evaluation and complete documentation. If new equipment is approved, old equipment must be returned.

Other Information

Topic	***Required for the PA***
Invoice	The prior authorization request and the manufacturer's invoice must be forwarded to EDS Prior Authorization department.
Trial Period	No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. Prior authorization for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request. Prior authorizations for rental of ACD device E2510 may be approved for a four (4) week trial period of usage by the recipient. The manufacturer must agree to this trial period. Medicaid will reimburse the manufacturer for the dollar amount authorized by the Agency for the four (4) week trial period. This amount will be deducted from the total purchase price of the ACD device.
Repair	Repairs are covered only to the extent not covered by manufacturers' warranty. Repairs must be prior approved and billed using procedure code V5336. Battery replacement is not considered repair but does require prior authorization using procedure code E2599.
Loss/Damage	Replacement of identical components due to loss or damage must be prior approved. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.
Component / Accessory Limits	No components or accessories will be approved that are not medically required. Examples of non-covered items include but are not limited to the following: • Printers • Modems • Service contracts • Office/business software • Software intended for academic purposes • Workstations • Any accessory that is not medically required.

The ACD device must be tailored to meet each individual recipient's needs. Therefore, a recipient may need to try more than one device until one is suitable To meet their needs is identified. The Medicaid Agency will allow rental of the device, on a week to week basis for $135.00 per week, for a maximum one month with a maximum rental cap of $540.00. The amount paid for this rental will be deducted from the total purchase price of the ACD device. The procedure code for one month rental of this device is E2510 (R).

Wheelchairs

To qualify for Medicaid reimbursement of a wheelchair, the physician must prescribe the equipment as medically necessary for the recipient. Request for coverage must be received by EDS within **thirty calendar days** after the date that the equipment was dispensed. The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must be essentially chair confined or bed/chair confined.
- The wheelchair is expected to increase mobility and independence.

A standard wheelchair (procedure code E1130) should be requested unless documentation supports the need for any variation from the standard wheelchair. An example of this variation is an obese recipient who requires the wide heavy-duty wheelchair (E1093). For a list of valid wheelchair procedure codes, refer Appendix P, Procedure Codes and Modifiers.

Medicaid reimburses Durable Medical Equipment providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. Medicaid covers these wheelchairs as a purchase by using HCPC code K0007.

Medicaid covers the other manual wheelchair base to accommodate weight capacity of 600 pounds or greater. The other manual wheelchair base will be covered using HCPC code K0009. The wheelchair component or accessory not otherwise specified for the wheelchair will be covered using procedure code K0108 (an already existing code). We will use the established prior authorization criteria for the other manual wheelchair base, and the wheelchair component or accessory not otherwise specified. Medicaid will require provider to submit available MSRPS from three manufacturers for the items. Medicaid will require weight, width and depth specification for these items.

NOTE:

The provider must ensure that the wheelchair is adequate to meet the recipient's need. For instance, providers should obtain measurements of obese recipients to ascertain body width for issuance of a properly fitted wheelchair.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any recipient under the age of 21 who is referred under the EPSDT program. The information submitted must include documentation that the recipient meets the above medical criteria.

Motorized/Power Wheelchairs

The Alabama Medicaid Agency covers motorized/power wheelchairs and to qualify for the motorized/power wheelchairs an individual must meet full Medicaid financial eligibility and established medical criteria. All requests for motorized/power wheelchairs are subject to Medicaid Prior Approval provisions established by the Alabama Medicaid Agency. The patient must meet criteria applicable to manual wheelchairs pursuant to the Alabama Medicaid Agency Administrative Code Rule No. 560-X-13-.17. The attending physician must provide documentation that a manual wheelchair cannot meet the individual's medical needs, and the patient must require the motorized/power wheelchair for six (6) months or longer.

The following are policies related to the coverage of motorized/power wheelchairs:

- Effective November 15, 2006, HCPC K0813 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891,and K0898 will be used as appropriate for related motorized wheelchairs. Procedure codes K0010, K0011, K0012, and K0014 will no longer be use to cover motorized power wheelchairs effective November 15, 2006.

  Reimbursement for the new K codes for power wheelchairs has been established and the effective date of the new reimbursement is May 1, 2007. E1220 is still on the fee schedule. Providers must use an appropriate code for power/custom manual wheelchairs and accessories if one is available. If there is no appropriate code then the provider can use E1220. All prior authorization requests submitted using procedure code E1220 will be reviewed to ensure that there is not another code available.

- Repairs and/or replacement of parts for motorized/power wheelchairs will require prior authorization by the Alabama Medicaid Agency. Prior authorization may be granted for repairs and replacement parts for motorized/power wheelchairs not previously paid for by Medicaid and those prior authorized through the EPSDT program. Wheelchair repairs and replacement parts for motorized/power wheelchairs may be covered using the appropriate HCPC code listed in Section 14.5.3 under Wheelchair Accessories.
- Reimbursement may be made for up to one month for a rental of a wheelchair using procedure code K0462 while patient owned equipment is being repaired. When submitting prior authorization (PA) request for loaner wheelchairs, providers must submit the appropriate HCPC code for the specific loaner wheelchair to be dispensed as it appear on the Medicare fee schedule. Alabama Medicaid will then establish the monthly rental at 80% of Medicare's allowable price for the wheelchair codes with the exception of the new K codes for power wheelchairs. If one of the new K codes for power wheelchairs is submitted, Medicaid will establish the monthly rental price for these wheelchair codes at 86% of the Medicare allowable price. When submitting the claim to EDS for payment, providers must bill using procedure code K0462 with the Medicaid established rate as it appears on the PA approval form.
- Suppliers providing motorized/power wheelchairs to recipients must have at least one employee with certification from Rehabilitation Engineering and assistive Technology Society of North America (RESNA) or registered with the National Registry of Rehab Technology Suppliers (NRRTS). **After October 1, 2004, suppliers must meet these certification requirements to provide motorized/power wheelchairs.**

For information regarding certification through RESNA contact: Ms. Tonya Vaughn at (703) 524-6686, extension 311.

The following is the process for obtaining prior approval of a motorized/power wheelchair and accessories:

- The attending physician must provide the patient with a prescription for the motorized/power wheelchair.
- The attending physician must provide medical documentation that describes the medical reason(s) why a motorized/power wheelchair is medically necessary. The medical documentation should also include diagnoses, assessment of medical needs, and a plan of care.
- The patient must choose a Durable Medical Equipment (DME) provider that will provide the wheelchair.
- The DME provider should arrange to have the Alabama Medicaid Agency Motorized/Power Wheelchair Assessment Form 384 completed by an Alabama licensed physical therapist who is employed by a Medicaid enrolled hospital outpatient department. **The physical therapist's evaluation is paid separately and is not the responsibility of the DME provider.** Reimbursement is only available for physical therapists employed by a Medicaid enrolled hospital through the hospital outpatient department. An occupational therapist (OT) or a physical therapist (PT) not employed by a Medicaid enrolled hospital may perform the wheelchair assessment without any reimbursement from the Alabama Medicaid Agency. The OP/PT performing the wheelchair assessment may not be affiliated in any way with the DME company requesting the physical therapy evaluation. If it is determined that the OT/PT is affiliated with the DME company the DME company and the OT/PT will be penalized and referred to the Medicaid Fraud and Investigation Unit.
- The DME provider must ensure that the prior authorization request for the motorized/power wheelchair includes the product's model number and name, the name of the manufacturer, and a list of all wheelchair accessories with applicable procedure codes.

The DME provider must complete the Alabama Medicaid Agency Prior Authorization Form 342. This form may be submitted electronically or hard copy. If form 342 is submitted electronically all attachments which include medical documentation from the physician and form 384 completed by an Alabama licensed physical therapist employed by an enrolled Medicaid hospital (unless otherwise approved by Alabama Medicaid) must be sent to EDS along with a copy of the prior authorization response which providers receive after their initial electronic PA submission. This information may be mail to EDS, Prior Authorization Unit, P.O. Box 244032, Montgomery, Alabama 36124-4032 or faxed to EDS at (334) 215-4298.

NOTE:

Purchase of the wheelchair is limited to one every five years for recipients who meet the above criteria.

Low Pressure and Positioning Equalization Pad for Wheelchair E2603, E2604

(K0108) To be used for wheelchair cushions for obese individuals unable to use codes listed above

To qualify for Medicaid reimbursement of a low pressure equalization pad, the equipment must be prescribed as medically necessary for the recipient by the physician. Requests for coverage must be received by EDS within **thirty calendar days** after the date that the equipment was dispensed. To qualify for Medicaid reimbursement or a Low Pressure and Positioning Equalization Pad for a wheelchair, the recipient must meet the following **documented** conditions:

- A licensed physician must prescribe the equipment as medically necessary.
- Recipient must have decubitus ulcer or skin breakdown.
- Recipient must be essentially wheelchair confined.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any recipient under the age of 21 who is referred through the EPSDT Program. The information submitted must include documentation that the recipient meets the above medical criteria.

Deleted: ~~code E0192~~
Added: codes E2603 and E2604

Medicaid also reimburses Durable Medical Equipment providers for the Roho Cushions for the Extra Heavy Duty Wheelchair. This wheelchair cushion is covered as a purchase through Medicaid using Medicare's procedure code K0108. This HCPC code may be used to cover wheelchair cushions for obese individuals who could not use HCPC codes E2603 and E2604.

NOTE:

Medicaid will use the established prior authorization criteria for the Extra Heavy Duty Wheelchair and Roho Cushion, but we will add weight, width and depth specifications. Individuals approved for these items must be fitted and measured for wheelchair and cushion by the Durable Medical Equipment company providing these services.

NOTE:

Purchase of a Low Pressure and Positioning Equalization Pad will be limited to one every two years for recipients who meet the above criteria.

Oxygen

Oxygen is necessary for life. When we breathe in, oxygen enters the lung and goes into the blood. When the lungs cannot transfer enough oxygen into the blood to sustain life, an oxygen program may be necessary.

Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Requests for coverage must be received by EDS within **thirty calendar days** after the oxygen equipment is dispensed. The 30 days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than 30 days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit.

(See section 14.3.1 Authorization for Durable Medical Equipment) The DME provider will be notified in writing of the assigned effective date and additional justification requirements if applicable.

In order to receive a prior authorization number, forms 360 and 342 must be completed and submitted to EDS. Oxygen therapy is based on the degree of desaturation and/or hypoxemia. To assess patient's need for oxygen therapy, the following criteria must be met:

a. The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at secretions, bronchospasm and infection) were tried without success, and that continuous oxygen therapy is required. **Oxygen will not be approved for PRN use only.**

b. Recipients must meet the following criteria:

i. Adults with a current **ABG** with a **PO2 at or below 59 mm Hg** or an **oxygen saturation at or below 89 percent**, taken at rest, breathing room air. If the attending physician certifies that an ABG procedure is unsafe for a patient, an oximetry for SaO2 may be performed instead. Pulse oximetry readings on adults will be considered only in unusual circumstances. Should pulse oximetry be performed, the prescribing physician must document why oximetry reading is necessary instead of arterial blood gas.

ii. Recipients 20 years old or less with **a SaO2 level:**

- **For ages birth through three years, equal to or less than 94%**
- **For ages four and above equal to or less than 89%**

c. The physician must have seen the recipient and obtained the ABG or SaO2 **within 6 months** of prescribing oxygen therapy. Submission of a copy of a report from inpatient or outpatient hospital or emergency room setting will also meet this requirement. Prescriptions for oxygen therapy must include **all of the following**:

i. type of oxygen equipment

ii. oxygen flow rate or concentration level

iii. frequency and duration of use

iv. estimate of the period of need

v. circumstances under which oxygen is to be used

d. Medical necessity initial approval is an approval for no more than three months. To renew approval, ABG or oximetry is required within the third month of the initial approval period. Approval for up to 12 months will be granted at this time if resulting pO2 values or SaO2 levels continue to meet criteria. If ABG or oximetry is not obtained within the third month of the initial approval period or in the case of a subsequent recertification requests within 6 months prior to the end of the current certification period, approval will be granted beginning with the date of the qualifying ABG or oximetry reading.

e. Criteria for equipment reimbursement

i. Oxygen concentrators will be considered for users requiring one or more tanks per month of compressed gas (stationary unit). Prior approval requests will automatically be subjected to a review to determine if a concentrator will be most cost effective.

ii. Reimbursement will be made for portable O2 only in gaseous form. Medicaid will cover portable oxygen for limited uses such as physician visits or trips to the hospital. This **must** be stated as such on the medical necessity or prior approval request. Portable systems that are used on a standby basis only will not be approved. **Only one portable system (E0431) consisting of one tank and up to four refills (E0443) per month will be approved based on a review of submitted medical justification.** An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

Medicaid will reimburse for only one stationary system.

iii. **For initial certification for oxygen the DME supplier, and its employees, may not perform the ABG study or oximetry analysis used to determine medical necessity**.

iv. Effective January 1, 2005 for recertification for oxygen only following qualifying sleep study which allows for approval of nocturnal oxygen, the DME supplier may perform the oximetry analysis to determine continued medical necessity for recipients receiving nocturnal oxygen only. A printed download of the oximetry results must be submitted with a prior authorization request. Handwritten results will not be accepted.

NOTE:

There are no restrictions related to oxygen flow rate and eligibility for oxygen coverage. The restriction is related only to the procedure codes covered.

Include a copy of the EPSDT Screening and Referral form with oxygen requests for children under age 21. This form is used to allow additional medical necessity equipment and/or supplies to be covered beyond current limitations. Only one portable system consisting of one tank and up to four refills per month will be approved based on a review of submitted medical justification.

At initial certification for continuous oxygen an ABG or O2Sat is acceptable. For initial certification of nocturnal oxygen a sleep study is required. At recertification for continuous oxygen an ABG or O2Sat is acceptable. For recertification of nocturnal oxygen an overnight oximetry, an ABG or an O2Sat is acceptable.

Pulse Oximeter - (E0445)

Pulse oximetry is a non-invasive method of determining blood oxygen saturation levels to assist with determining the amount of supplemental oxygen needed by the patient.

Request for coverage of pulse oximeters must be received by EDS within thirty days after the equipment is dispensed. When the request is not received within the thirty-day time frame for **pulse oximeters,** the thirty days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than thirty days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

Pulse oximeters are a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and whose blood saturation levels fluctuate, thus requiring continuous or intermittent monitoring to adjust oxygen delivery.
To receive prior authorization, submit a written request to include, but not limited to, all the following requirements:

- A completed Form 342 with required supportive documentation
- Copy of EPSDT form/referral
- Copy of prior approval form for home oxygen (Form 360)

The use of home pulse oximetry, for pediatric patients, is considered medically appropriate if one of the following criteria in documentation requirements A is met in addition to the documentation requirements in B:

Documentation Requirements A:

1. Patient is ventilatory dependent with supplemental oxygen required; or
2. Patient has a tracheostomy and is dependent on supplemental oxygen; or
3. Patient requires supplemental oxygen per Alabama Medicaid criteria (see below) and has unstable saturations[1]; or
4. Patient is on supplemental oxygen and weaning is in process; or
5. Patient is diagnosed with a serious respiratory diagnosis and requires short term[2] oximetry to rule out hypoxemia and/or to determine the need for supplemental oxygen.

[1]Unstable saturations are documented desaturations which require adjustments in the supplemental oxygen flow rates to maintain saturation values. This should be documented to have occurred at least once in a 60 day period immediately preceding the request for certification/recertification.

[2]Short-term is defined as monitoring/evaluation for up to 30 days. “Spot oximetry” is not covered under this policy.

Documentation Requirements B:

The following documentation is required:

1. **Pulse oximetry evaluations**. To qualify, from birth through three years must have a SaO2 equal to or less than 94%. Recipients age four and above must have a SaO2 equal to or less than 89%. Conditions under which lab results were obtained must be specified. When multiple pulse oximetry readings are obtained the qualifying desaturations must occur for five or more minutes (cumulative desatutration time) to qualify. Pulse oximetry evaluations are acceptable when ordered by the attending physician, and performed under his/her supervision, or when performed by a qualified provider or supplier of laboratory services. **A DME supplier is not a qualified provider of lab services.**
2. **Plan of Care.** A plan of care updated within 30 days of request must be submitted to include, at a minimum, plans for training the family or caregiver: The training plan shall provide specific instructions on appropriate responses for different scenarios, i.e., what to do when O2 sats are below 89%.

Initial approval will consist of up to 90 days only. For requests secondary to the need to determine the appropriateness of home oxygen liter flow rates, to rule out hypoxemia and/or to determine the need for supplemental oxygen, approval will be granted for up to 30 days only. Renewal may be requested for patients already approved for oxygen coverage by the Alabama Medicaid Agency. Documentation may also include written or printed results of pulse oximetry readings obtained within the last month with documentation of condition(s) present when readings were obtained. Renewal may be granted for up to a six-month period for patients receiving oxygen coverage through Alabama Medicaid.

Qualifying Diagnoses:

Lung disease, including but not limited to interstitial lung disease, cancer of the lung, cystic fibrosis bronchiectasis.

- Hypoxia related symptoms/conditions, such as pulmonary hypertension
- Recurrent CHF secondary to cor pulmonale
- Erythrocytosis
- Sickle cell disease
- Severe Asthma
- Hypoplastic heart disease
- Suspected sleep apnea or nocturnal hypoxia
- Other diagnoses with medical justification

Medicaid Coverage for Pulse Oximeter

The Pulse Oximeter must be an electric desk top model with battery backup, alarm systems, memory and have the capacity to print downloaded oximeter readings. Downloads for each month of the most current certification period are required for all recertification requests. Recertification is required until the recipient no longer meets criteria or the device is removed from the home. The monthly payment will include delivery, in-service for the caregiver, maintenance, repair, supplies and 24-hour service calls. If the pulse oximeter is no longer medically necessary (criteria no longer met), the oximeter will be returned to the supplier and may be rented to another client who meets criteria for pulse oximeter. Medicaid will pay for repair of the pulse oximeter after the initial 10 months only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized and the necessary documentation to substantiate the need for repairs must be submitted to EDS who will forward this information to Medicaid's Prior Authorization Unit. Replacement of the pulse oximeter -requires prior authorization and is considered after three (3) years based upon the review of submitted documentation. If the replacement is due to disaster or damage which is not the result of misuse, neglect or malicious acts by users, then requests for consideration of payment for replacement equipment must be submitted to the Alabama Medicaid Agency, Long Term Care Division with a police report, fire report or other appropriate documentation. In addition, one reusable probe per recipient per year will be allowed after the initial 10 months capped rental period.

Limitations

Diagnoses not covered:

- Shortness of breath without evidence of hypoxemia
- Peripheral Vascular Disease
- Terminal illnesses not affecting the lungs, such as cancer not affecting the lungs or heart disease with no evidence of heart failure or pulmonary involvement.

Pulse oximeter requests for renewal will not be approved after the initial monitoring/evaluation period for those recipients not meeting criteria for oxygen coverage. Spot oximetry readings are non-covered service under the DME program.

14.2.3 Coverage of supplies for the Pulse Oximeter

Supplies for the Pulse Oximeter will only be paid for by Medicaid after completion of the ten month rental period.

A4606 - non disposable probe is limited to one per year per recipient.

A4606 – disposable probe is limited to two per month per recipient.

NOTE:

When requesting disposable probes medical documentation must be submitted justifying the need for disposable probes. The documentation must show why a non-disposable probe is medically necessary.

Volume Ventilator – Stationary or Portable (E0450, E0461-R) and Pressure Ventilator – E0463 (R)

Volume Ventilators are stationary or portable, with backup rate feature, and used with non-invasive interface or invasive interface (e.g., tracheostomy tube). Non-invasive volume ventilators are laptop sized, designed for homecare and allows maximum mobility. Pressure ventilators weigh about 12.4 pounds which enables the user to be mobile and contain pressure control, pressure support and flow triggering features. These devices decrease the work of breathing while increasing patient comfort.

Request for coverage of ventilators must be received by EDS within **thirty calendar days** after the equipment is dispensed. When the request is not received within the thirty day time frame for **ventilators** the thirty days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than thirty days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

Volume ventilator and pressure ventilators are covered for children with an EPSDT screening when prescribed by a physician as medically necessary:

The recipient must meet the following conditions:

- Medically dependent on a ventilator for life support at least 6 hours a day
- Dependent for at least 30 consecutive days (or the maximum number of days authorized under the State Plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;
- Except for the availability of respiratory care services (ventilator equipment) would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the state plan.
- Adequate social support services to be cared for at home are available.
- Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual without continuous technical or professional supervision. (Reference 42 CFR Section 440.185 Respiratory care for ventilator-dependent individuals.)

and

Patient has at least one or more of the following conditions:

a. Chronic respiratory failure

b. Spinal cord injury

c. Chronic pulmonary disorders

d. Neuromuscular disorders, or

e. Other neurological disorders and thoracic restrictive diseases.

Initial approval will be allowed for up to 12 months based on the EPSDT screening.

Subsequent approvals will require documentation from the physician which substantiates that the recipient continues to meet the medical criteria and indicate the recipient's overall condition has not improved sufficiently.

The ventilator will be reimbursed as a monthly rental item. The monthly rental includes delivery, in-service for caregiver, maintenance, a backup ventilator, back up battery, all medically necessary supplies, and repairs and on call service as necessary. Recertification is required until the recipient no longer meets the criteria or the device is removed from the home. If the ventilator is no longer medically necessary (i.e., the criteria is no longer met) it will be returned to the supplier.

Continuous Positive Airway Pressure Device (E0601)

Supplies for CPAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044 and A7046

CPAP therapy is covered through the EPSDT Program for children up to the age of 21. Diagnosis must be documented by a sleep study performed by a registered or approved sleep laboratory. CPAP therapy is considered medically appropriate if the conditions listed below are met and the documentation requirements listed below are submitted:

A physician either specializing in pulmonary, neurology or a board certified sleep specialist must document that the recipient meets the following conditions:

1. Patient is diagnosed with obstructive sleep apnea, upper airway resistance syndrome, or mixed sleep apnea; and

2. The diagnosis is supported by associated signs and syndromes of craniofacial malformations, neuromuscular disorders, cardiopulmonary or metabolic disorders, morbid obesity or adenotonsillar hypertrophy, tracheomalacia, tracheostomy complications or other anomalies of the larynx, trachea and bronchus that can be documented to improve and maintain airway patency and oxygenation through the use of CPAP.

The following documentation must be submitted:

1. The results of a sleep study recorded for at least 360 minutes or 6 hours must be submitted. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or 4 hours.

The sleep study must document the following:

a. A respiratory disturbance index (RDI) or apnea/hypopnea index (AHI) greater than or equal to 5 per hour of recorded sleep, and

b. At least 30 apneas and/or hypopneas within the sleep study period, and

Medicaid will approve the CPAP based on the EPSDT Screening. To renew approval physician must submit documentation indicating that the recipient's overall condition has not changed and that CPAP is still medically necessary. At a minimum a physician's evaluation must be obtained at least once every six (6) months. Documentation of patient compliance with treatment is required and can be substantiated with smart card downloads. The patient must use the device at least four (4) hours per night, 50% of all nights. In addition, for continued coverage a repeat sleep study is required if the last study was conducted more than 2 years ago.

The CPAP will be a continuous rental item. The monthly rental payment will include delivery, in-service for the caregiver, maintenance, repair and all supplies. Recertification is required until the recipient no longer meets criteria, or the device is removed from the home. If CPAP is determined not to be medically necessary the device will be returned to the supplier.

NOTE:

Upon initial approval of the CPAP device, recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

Bilateral Positive Airway Pressure (BI-PAP) Device (E0470)

Supplies for BI-PAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044 and A7046

The Bilateral Positive Airway Pressure (BI-PAP) devices are designed to deliver slightly pressured air to keep the throat open during the night. A mask containing tubing connects to the device and fits over the nose. The machine supplies two levels of pressure through the tube, one for inhaling and one for exhaling. Also, the machine applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person exhales.

The use of the BI-PAP device, for children under the age of 21 with an EPSDT screening, is considered medically appropriate if the following criteria are met in addition to the documentation requirements. Also failure on B-IPAP therapy is required unless the patient is 5 years of age or younger. The diagnosis is documented by a sleep study performed by a registered or approved sleep laboratory if the patient has not attempted use of BI-PAP therapy. The prescribing physician, either specializing in pulmonary, neurology or board certified sleep specialist, must document that the recipient has one of the following diagnosis:

1. Patient is diagnosed with obstructive sleep apnea, or
2. Patient is diagnosed with upper airway resistance syndrome,
3. Patient is diagnosed with mixed sleep apnea, and

The prescribing physician documents that the recipient meets one of the following conditions:

1. Patient has had an unsuccessful trial on the CPAP device,
2. Patient is 5 years of age or younger, and

The following documentation is required:

The results of a sleep study recorded for at least 360 minutes or 6 hours must be submitted. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or 4 hours.

The sleep study must document the following:

a. A respiratory disturbance index (RDI) or apnea/hypopnea index (AHI) is greater than or equal to 5 per hour of recorded sleep, and
b. At least 30 apneas and/or hypopneas within the sleep study period, and
c. A reduction on BI-PAP in the patient's sleeps events of at least 50%.

Initial approval will consist of 90 days of therapy. To renew approval, a statement is needed from the physician indicating that the recipients overall condition has not changed and that BIPAP is still medically indicated. Documentation of patient compliance with treatment is required. Patient must use the device at least 50% of sleep time. For continued coverage, a sleep study is required if the last study was conducted more than 2 years ago.

The BI-PAP will be a capped rental item. The equipment will be rented for up to 10 months with the total rental payments equal to purchase price. At the end of the 10 month rental period the item is considered to be a purchased item for the recipient paid in full by Medicaid. The monthly rental payment will include delivery, in-service for the caregiver, maintenance, repair and all supplies. Recertification is required until the recipient no longer meets criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If BI-PAP is determined not to be medically necessary and if the total rental amount paid is less than the established purchased price the device will be returned to the supplier. Supplies and repairs for BI-PAP are only covered after the 10 month rent to purchase period. Supplies and repairs for the BI-PAP are covered through prior authorization. Supplies will be covered up to the maximum allowed units for the specified timeframe. BI-PAP devices will be limited to one per recipient every eight years.

NOTE:

Upon initial approval of the BI-PAP device recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

Home Phototherapy (E0202)

Home phototherapy is a covered service in the DME Program for neonatal jaundice, is frequently used for management of physiologic hyperbilirubinemia. The infant is exposed to continuous ultraviolet light via a lamp used in the home for a prescribed period of time. The ultra violet light helps to reduce elevated bilirubin levels which can cause brain damage.

Prior authorization for Home Phototherapy for the first four (4) consecutive days of therapy is no longer a requirement. Prior authorization is required if therapy continues to be medically necessary after four (4) consecutive days.

If prior approval is granted the prior authorization number assigned will only be used a tracking mechanism by the Prior Authorization Unit, When submitting claims for payment it is not necessary to put the prior authorization number in item 23 of the CMS 1500 claim form.

The use of Home phototherapy for children under age 21 is considered medically appropriate if all of the following criteria are met:

1. The infant is term (37 weeks of gestation or greater), older than forty-eight hours and otherwise healthy; and
2. The serum bilirubin levels> 12; and
3. The serum bilirubin level is not due to a primary liver disorder; and
4. The diagnostic evaluation (described below) is negative; and
5. The infants' billirubin concentrations as listed below indicate consideration of phototherapy

AGE, HOURS	Consider phototherapy when total serum bilirubin is:
25-48	Greater than 12 (170)
49-72	Greater than 15 (260)
Greater than 72	Greater than 17 (290)

NOTE: These are recommendations for phototherapy for inpatient and outpatient use

NOTE:

An EPSDT screening is not required.

Diagnostic evaluation

Prior to therapy, a diagnostic evaluation should include:

- History and physical examination;
- Hemogobin concentration or hematocrit;
- WBC count and differential count;
- Blood smear for red cell morphology and platelets;
- Reticulocyte count
- Total and direct-reacting bilirubin concentration
- Maternal and infant blood typing and Coombs test; and
- Urinalysis includes a test for reducing substances.

Documentation from the attending physician should indicate the duration of treatment, frequency of use per day and the maximum number of days for home phototherapy. A registered nurse with active license must perform home visits for professional services associated with phototherapy. Providers must submit written verification to the Medicaid agency which includes the nurse's name and license number with an effective date and expiration date for the nurse's license. The provider must assure that the parent or caregiver receives education for the safe and effective use of the home phototherapy equipment. The procedure code (E0202) used for phototherapy includes a global fee per day for equipment, nurse visits, and collection of lab work.

NOTE:

A skilled nursing visit may not be billed in the Home Health program for this service.

High Frequency Chest Wall Oscillation Air Pulse Generator System (E0483) (Includes Hoses and Vest)

A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. Request for the HFCWO must be received by EDS within thirty calendar days after the equipment is dispensed. When the request is not received within thirty calendar day time frame the thirty days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than thirty days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

The recipient must meet the following conditions:

The HFCWO is covered for EPSDT referred recipients when prescribed as medically necessary by a physician and all of the following criteria are met:

1. The patient has had two or more hospitalizations or episodes of home intravenous antibiotic therapy for acute pulmonary exacerabations during the previous twelve months; and

2. The FEV1 (forced expiratory flow in one second) is less than 80% of predicted value or FVC (forced vital capacity) is less than 50% of the predicted value; and

3. There is a prescribed need for chest physiotherapy at least twice daily; and

4. There is a well documented failure of other forms of chest physiotherapy which have been demonstrated in the literature to be efficacious, including hand percussion, mechanical percussion, and Positive Expiratory Pressure (PEP) device. The evidence must show that these have been tried in good faith and been shown to have failed prior to approval of the vest; and

5. The patient does not have a caretaker available or capable of assisting with hand percussion, then a trial of hand percussion would not be a necessary prerequisite, but such patients would still need to in good faith complete a trial of mechanical percussion and the use of the PEP device.

NOTE:

The qualifying diagnosis for the HFCWO system is Cystic Fibrosis (277.00, 277.02).

Medicaid Coverage for the HFCWO (Capped Rental)

The initial rental approval will consist of up to 90 days. At the end of the 90 days, documentation is required that demonstrates recipients usage and compliance levels. Renewal will be granted up to the capped rental period of 10 months if compliance with prescribed use is documented and documentation is found that respiratory status is stable or improving. The rental period will allow the patient to demonstrate compliance with the device. The rental will include all accessories necessary to use the equipment, education on the proper use and care of the equipment as well as routine servicing, necessary repairs and replacements for optimum performance of the equipment. The monthly payment will include delivery, in-service for the caregiver, maintenance and repair. After the device is purchased no additional cost will be incurred by the Medicaid Agency because the device (the inflatable vest, generator and hoses) is covered under lifetime warranty and the responsibility of the manufacturer or supplier to provide maintenance or replace the device. Recertification is required until the
recipient no longer meets the criteria, the device is removed from the home, or the device is purchased. If the HFCWO is determined not to be medically necessary (i.e., the criteria is no longer met) the HFCWO will be returned to the supplier if the total rental amount paid is less than the established purchase price.

Percussor Electric or Pneumatic

Chest percussors, electric or pneumatic, are used to mobilize secretions in the lungs. Chest percussions may be performed by striking the chest with cupped hands or with a mechanical hand held unit. An electric percussor is a vibrator that produces relatively course movements to the chest wall to mobilize respiratory tract secretions and stimulate the cough mechanism.

Requests for coverage of the percussor must be received by EDS within thirty days after the equipment is dispensed. When the request is not received within the thirty-day time frame for the percussor**,** the thirty days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than thirty days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

The percussor is considered medically necessary for patients with excessive mucus production and difficulty clearing secretions if the following criteria are met:

- Must be an EPSDT Medicaid eligible individual; and
- Patient has a chronic lung condition of cystic fibrosis or bronchiectasis; and
- Other means of chest physiotherapy such as hand percussion and postural drainage have been used and failed; and
- No caregiver available or caregiver is not capable of performing manual therapy; and
- Clinical documentation indicates that manual therapy has been used and does not mobilize respiratory tract or the patient can not tolerate postural drainage

Deleted: ~~T4522~~
Added: T4521

Incontinence Products (Disposable Diapers) T4521, T4522, T4523, T4524, T4529, and T4530

The procedure codes listed above will be honored for prior authorizations approved for dates of services extending into year 2004. Prior authorizations (for diapers) requested on or after January 1, 2005 will be considered using procedure codes T4521, T4522, T4523, T4524, T4529, and T4530.

These incontinence products (disposable diapers) require prior authorization.

Medicaid will consider payment of disposable diapers when referred as medically necessary from an EPSDT screen and the criteria below are met:

1. Recipient must be at least 3 years old;
2. Patient must be non-ambulatory or minimally ambulatory;
3. Patient must be medically at risk for skin breakdown, which is defined as meeting at least two of the following:
   a) Unable to control bowel or bladder functions,
   b) Unable to utilize regular toilet facilities due to medical condition
   c) Unable to physically turn self or reposition self,
   d) Unable to transfer self from bed to chair or wheelchair without assistance.

T4521 Adult-sized incontinence product, diaper, small

T4522 Adult-sized incontinence product, diaper, medium

T4523 Adult-sized incontinence product, diaper, large

T4524 Adult-sized incontinence product, diaper extra large

T4529 Child-sized incontinence product, diaper small/medium

T4530 Child-sized incontinence product, Large

Apnea Monitor (E0619)

The apnea monitor is a covered service with prior authorization in the DME program for EPSDT referred recipients. The apnea monitor can be provided only if it can be used properly and safely in the home and if it has been prescribed as medically necessary by a physician. Request for coverage of **apnea monitors** must be received by EDS within **thirty calendar days** after the equipment is dispensed. When the request is not received within the thirty day time frame for apnea monitors the thirty days will be calculated from the date the prior authorization request is received by EDS. All prior authorization requests received with a date greater than thirty days from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

To qualify for the placement of an apnea monitor and Medicaid reimbursement for the monitor, the recipient must meet/have documentation of **at least one** of the following (Infants are defined as less than or equal 12 months of age):

- Apnea that lasts 20 or more seconds that is associated with baby's color changing to pale, purplish or blue, bradycardia (heart rate below 80 beats per minute), baby choking or gagging that requires mouth-to-mouth resuscitation or vigorous stimulation documented by medical personnel (documented pathologic apnea).
- Pre-term infants with periods of pathologic apnea
- Sibling of SIDS victim
- Infants with neurological conditions that cause central hypoventilation
- Infants or children less than two years of age with new tracheostomies (tracheostomy within the last 60 days)

The following must also be included:

- Documentation from the physician with a patient specific plan of care, proposed evaluation and intervention to include length of time of use each day, anticipated reevaluation visits/intervals, additional therapeutic interventions appropriate for diagnosis/cause of apnea
- Documentation of counseling to parents must include the understanding that monitoring cannot guarantee survival
- Documentation of parental training and demonstration of proficiency in CPR and resuscitation methods

Approval is for three (3) months only.

Renewal criteria **must** include the following:

- A copy of nightly monitor strips or monthly download is required as documentation of pathologic apnea or bradycardia for the past three months.
- A letter from the physician with patient-specific plan of care to justify the medical necessity for continued use of monitor at **each** recertification period.

Discontinuation Criteria include:

- Apparent Life-Threatening Event (ALTE) infants that have had two to three months free of significant alarms or apnea.
- The provider must check for recipient compliance (i.e. documentation via download monthly or through nightly strips). The monitor will be discontinued with documentation of non-compliance. Non-compliance is defined as failure to use the monitor at least 80% of each certification period.
- Sibling of SIDS victim who is greater than six months of age
- Tracheostomy recipients greater than two years of age

Effective September 2001, before an Apnea Monitor is provided to a Medicaid recipient, it is a Medicaid requirement that the parent/caregiver has documentation showing that they have had CPR training and demonstrated proficiency in CPR and resuscitation methods. The staff providing CPR training must have a license/certification to provide such training. Provider Notice 99-13, reflecting the amended Apnea Monitor policy was mailed to providers in August of 1999. The effective date of this provider notice was September 1, 1999.

The statement listed below is information used to support the revision to the Apnea Monitor coverage policy related to parents/caregivers having CPR training. This information was taken from an article entitled “Infantile Apnea and Home Monitoring.” This article was published in the National Institute of Health Consensus Development Conference Statement.

"All families who have babies with Apnea are encouraged to be trained in infant cardiopulmonary resuscitation (CPR) before the baby is discharged from the hospital. Although it is unlikely that you will ever have to use CPR, it is best that you be prepared." It is the DME provider’s responsibility to ensure that parents provide them with documentation of CPR training. This documentation must show proficiency in CPR and resuscitation methods. It is not the provider’s responsibility to provide CPR training to the parents. However, the provider may direct the parents to agencies such as the Red Cross, Fire Departments, etc., where CPR training is provided.

If a prior authorization request for an Apnea Monitor is submitted to Medicaid without this requested documentation, the request will be denied. The Prior Authorization Unit will request the provider to resubmit the prior authorization request with the needed documentation. No prior authorizations will be approved without this documentation.

Enteral Nutrition equipment and supplies

B9002, B4034, B4035, B4036, B9998, E1399 (EPSDT only)

B4081, B4082, B4086, A4213 (entire Medicaid population)

Enteral nutrition equipment and supplies are covered for children under the age of 21 with an EPSDT Screening and Referral. Recipients age 21 and above (with noted limitations) qualify based on medical necessity and prior authorization when the following criteria are met:

1. The recipient meets the following criteria for enteral nutrition:
   a. Recipient is < age 21 and record supports that > than 50 % of need is met by specialized nutrition; or
   b. Recipient is > age 21 and record supports 100 % of need is met by specialized nutrition and provided by tube feedings.

3. Prior authorization requests are required for Enteral Nutrition Equipment and Supplies (B9002, B4034, B4035 B4036, and B9998). Prior authorization requests must be submitted with verification that all medical criteria have been met.

4. Enteral nutrition for adults 21 years of age and above is provided through bolus feeds using procedure code A4213

Total Parenteral Nutrition (TPN) and Supplies (B9004, B9006, B4081, B4082, B4086)

TPN supplies (B9004, B9006) are provided for all Medicaid recipients based on medical necessity and require prior authorization when the following criteria are met:

1. The recipient meets the criteria for total parenteral nutrition (TPN)
   a. Recipient < age 21 and record supports that > than 50 % of need is met by specialized nutrition, or
   b. Recipient > age 21 and record supports 100 % of need is met by specialized nutrition.
2. The patient cannot be sustained through oral feedings and must rely on enteral nutrition therapy which is administered by some form of intravenous therapy.
3. Verification that the criteria have been met must accompany the PA request.

NOTE:

A caregiver trained and capable of performing Cardiopulmonary Resuscitation (CPR) must be available in the home. Documentation must be provided.

When submitting a prior approval request for Medicaid's authorization of an apnea monitor for a sibling of a SIDS victim, use the diagnosis code V201. DME providers should use V201 only for a recipient who is a sibling of a SIDS victim. Do not use diagnosis code 7980. The clinical statement on PA Form 342 must include documentation from the physician supporting the recipient's diagnosis of 'Sibling of SIDS victim.'

14.2.4 Non-covered Items and Services

Medicaid does not cover the following types of items:

- Items of a deluxe nature
- Replacement of usable equipment
- Items for use in hospitals, nursing facilities, or other institutions
- Items for recipient's comfort or the caring person's convenience
- Items not listed as covered by Medicaid
- Rental of equipment, with exceptions noted below
  - EPSDT referred services
  - Medicare crossovers
  - Certain intravenous therapy equipment
  - Short term use due to institutionalization
  - Short term use due to death of a recipient

14.3 Prior Authorization and Referral Requirements

Certain DME requires prior authorization. Please refer to Appendix P, Procedure Codes and Modifiers, for items that require prior authorization from Medicaid. Payment will not be made for these procedures unless the prior authorization request is received within **thirty calendar days** after the service is provided.

NOTE:

Prior authorization is not a guarantee of payment. The authorization number does not guarantee recipient eligibility at the time the equipment is dispensed. The provider is responsible for verifying recipient's eligibility.

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

All requests for prior approval should be initiated and signed by the attending physician and must document medical necessity. Requests may be sent electronically using the EDS Provider Electronic Solution software or mailed in hardcopy to the Prior Authorization Unit, P.O. Box 244032, Montgomery, Alabama 36124-4032. The PA Unit at Medicaid will approve, deny, or return the request. EDS will return any requests containing missing or invalid information. Please see Chapter 4, Obtaining Prior Authorization, for additional information.

Procedures for changing rendering providers

1. Obtain a written statement from the initial rendering provider indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled.

2. Confirm this decision with the recipient by having the new provider submit a written statement that they will now be submitting a PA request on the patient's behalf and have the patient sign that they agree and understand.

3. Cancel the approved PA request in the system.

4. Review the new providers request and approve or deny.

14.3.1 Authorization for Durable Medical Equipment

Provider must have a prescription on file from the attending physician that a specific covered item of durable medical equipment is medically necessary for use in the recipient's home prior to completing the Alabama Prior Review and Authorization Request form.

Prior authorization requests for purchase, rental, or re-certification of DME must be received by Medicaid's fiscal agent within **thirty calendar days** of the signature date the equipment was dispensed. Time limits for submitting requests for services and resubmitting additional information are as follows:

- All prior authorization requests received with a **date greater than thirty days** from dispensed date will be assigned an effective date based on actual date received by EDS if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. If additional information is needed to process a prior authorization request is **not received within thirty days** the prior authorization request will be denied.
- All prior authorization requests for the **purchase** of DME received beyond **thirty calendar days** after equipment is provided will be denied.
- All prior authorization requests for certification of **rental** services received beyond **thirty calendar days** of beginning services will be authorized for reimbursement effective the date of receipt at EDS.
- All prior authorization requests for re-certifications of DME rental services must be submitted to EDS within **thirty calendar days** of the re-certification date. Completed re-certifications received beyond the established time limit will be authorized for reimbursement effective the date of receipt at EDS.

Medicaid will review the request and assign a status of approved, denied, or suspended. Providers are sent approval letters indicating the ten-digit PA number that should be referenced on the claim form for billing. Providers and recipients will also be notified on denied requests.

DME Review Criteria

Medicaid reviews all DME prior authorization requests for the following:

- Medicaid eligibility
- Medicare eligibility
- Medical necessity
- Therapeutic purpose for use of equipment in the recipient’s home
- Referral through the Sickle Cell Foundation, when appropriate

Although equipment prescribed by the physician may be on the list of covered items, Medicaid will determine to what extent it would be reasonable for Medicaid reimbursement. Equipment may be authorized when it is expected to make a significant contribution to the treatment of the recipient’s injury or illness or to improve his physical condition. Equipment will be denied if it is disproportionate to the therapeutic benefits or more costly than a reasonable alternative.

In the event Medicaid receives an authorization form from more than one provider prescribing the same item for a recipient, Medicaid will consider the authorization form received first.

NOTE:

For information on submitting Electronic PA Requests Requiring Attachments refer to Chapter 4, section 4.2.1 (Submitting PAs Using Provider Electronic Solutions) of the Alabama Medicaid Provider Manual.

Disposition of Equipment

The recipient or caregiver should contact the Alabama Medicaid Agency, DME Program, when the need for the equipment no longer exists. The DME provider should not take back equipment from recipients or caregivers that was purchased by Medicaid. The provider should have the recipient or caregiver call the DME Program at 1 (800) 362-1504 when the equipment is no longer being used or needed.

14.3.2 EPSDT Program Referrals

The Omnibus Budget Reconciliation Act of 1989 expanded the scope of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for Medicaid recipients under age 21. Effective October 1, 1990, Medicaid began prior authorizing certain approved medical supplies, appliances, and durable medical equipment prescribed as a result of an EPSDT screening to treat or improve a defect, an illness, or a condition.

The Alabama Medicaid Agency EPSDT Referral for Services form (Form 167) or Patient 1st EPSDT Referral for Services form (Form 345) as applicable, and any supporting documentation must be sent to EDS, Prior Authorization Unit, for review. Complete documentation describing how prescribed items will treat or improve a condition must be included on Form 167 or 345. Indicate prescribed items and appropriate procedure codes, and units billed in blank areas on the form.

Requests for EPSDT-referred specialized wheelchair systems

The Alabama Medicaid Agency's Prior Authorization Form 342 must be completed to receive EPSDT-referred specialized wheelchair systems. This form may be submitted electronically or hard copy. If form 342 is submitted electronically all attachments which include medical documentation from the physician and form 384 completed by an Alabama licensed physical therapist employed by an enrolled Medicaid hospital (unless otherwise approved by Alabama Medicaid) must be sent to EDS along with a copy of the prior authorization response which providers receive after their initial electronic PA submission. This information may be mailed to EDS, Prior Authorization Unit, P. O. Box 244032, Montgomery, Alabama 36124-4032 or faxed to EDS at (334) 215-4298.

Medicaid uses Medicare-based allowables for EPSDT-referred wheelchair systems. If no Medicare price is available, reimbursement rates established by Medicaid for EPSDT-referred wheelchair systems are based on a discount from Manufacturers Suggested Retail Price (MSRP) instead of a "cost-plus" basis.

Providers are required to submit available MSRPs from three manufacturers for wheelchair systems (excluding seating system and add-on products) appropriate for the individual's medical needs.

Requests submitted with fewer than three prices from different manufacturers must contain documentation supporting the appropriateness and reasonableness of requested equipment for a follow-up review by Medicaid professional staff. Provider must document non-availability of required MSRPs to justify not sending in three prices.

The established rate will be based on the MSRP minus the following discounts:

- Manual Wheelchair Systems - 20% discount from MSRP
- Power Wheelchair Systems - 15% discount from MSRP
- Ancillary (add-on) products - 20% discount from MSRP

Suppliers requesting approvals for medical items must provide Medicaid with an expected date of delivery.

For medical items approved based on medical necessity, Medicaid will indicate the time frame allowed for providers to dispense equipment on the approval letter.

When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied in a timely manner. All requests for extensions must be submitted to Medicaid prior to the expiration date indicated on the approval letter. Medicaid will cancel approvals for medical items that are not dispensed in a timely manner when there is no justifiable reason for delay.

The Medicaid screening provider and recipient will be notified when an approved request for equipment is canceled due to provider noncompliance and the recipient will be referred to other Medicaid providers to obtain medical items.

A supplier providing EPSDT referred specialized wheelchair systems to recipients must be registered with the National Registry of Rehab Technology Suppliers (NRRTS) or have certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

14.4 Patient 1st Referrals

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

14.5 Cost-Sharing (Copayment)

Medicaid recipients are required to pay and suppliers are required to collect the designated copay amount for the rental/purchase of services, supplies, appliances, and equipment, including crossovers. The copayment does not apply to services provided for pregnant women, recipients less than 18 years of age, emergencies, surgical fees, and family planning.

The Medicaid DME Program requires copayment at the following rates:

Item	***Copay Amount***
Durable Medical Equipment, including crossovers	$3.00 for each item
Supplies and Appliances, including crossovers	$3.00 for items costing $50.01 or more $2.00 for items costing $25.01-$50.00 $1.00 for items costing $10.01-$25.00 $.50 for items costing $10.00 or less
Iron Infusion Pump Repair	$3.00 for each Prior Authorization (PA) Number

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing amount imposed.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online

14.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

DME providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed on the Medical Medicaid/Medicare-related Claim Form.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

14.6.1 Time Limit for Filing Claims

Medicaid requires all claims for DME to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

14.6.2 Diagnosis Codes

DME providers may bill diagnosis code V729 on hard copy and electronically submitted claims.

14.6.3 Procedure Codes and Modifiers

The medical supplies and appliances listed in Appendix P are available to eligible Medicaid recipients for use in their homes as prescribed by the attending physician and dispensed by a Medicaid contract provider.

For a complete listing of procedure codes and modifiers refer to Appendix P: Durable Medical Equipment (DME) Procedure Codes and Modifiers.

14.6.4 Place of Service Codes

The following place of service code applies when filing claims for DME:

POS Code	*Description*
12	Home

14.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

14.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
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15

15 Eye Care Services

Medicaid pays for certain eye care services provided by participating Optometrists, Opticians, and Ophthalmologists.

Ophthalmologists may refer to Chapter 28, Physician, for additional information.

Medicaid also contracts with a Central Source contractor who is responsible for providing lenses and frames for Medicaid recipients. At the option of the provider taking the frame measurements, eyeglasses may be obtained from the Central Source or from any other source. Medicaid will pay no more than the contract price charged by the Central Source. Sample kits are available (frames and display containers) which can be purchased by eye care practitioners at the contractor's cost of frames plus mailing. Currently, the Central Source contractor is Classic Optical. Classic Optical's phone number is 1 (888) 522-2020 and the website address is www.classicoptical.com.

The policy provisions for eye care providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 17.

15.1 Enrollment

EDS enrolls eye care providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Eye Care provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for eye care related claims.

NOTE:
All nine digits are required when filing a claim.

Opticians and Optometrists are assigned a provider type of 22 (Optician/Optometrist). Valid specialties for Eye Care providers include the following:

Optician (X3)

Optometrist (X4)

Ophthalmologists are enrolled with a provider type of 01 (Physician). The valid specialty is Ophthalmologist (18).

Enrollment Policy for Eye Care Providers

To participate in Medicaid, eye care providers must have current certification and be licensed to practice in the state of Alabama, allowed by their licensing board and the laws of State of Alabama.

To prescribe therapeutic agents for the eye, the optometrist must be appropriately licensed by the Alabama Board of Optometry.

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

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

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

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

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

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

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

    (i) Eyeglasses,

    (ii) Comprehensive Audiological services,

    (iii) Comprehensive Opthalamological services,

    (iv) Patient 1st and EPSDT Referrals,

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

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

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

15.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

This section also discusses the types of eye examinations covered by Medicaid and describes the standards and procedures used to provide eyeglasses.

NOTE:

The Agency establishes annual benefit limits on certain covered services. Benefit limits related to eye care services are established every two calendar years for recipients 21 years of age or older. Therefore, it is imperative Eye Care Providers/Contractors furnishing services to recipients 21 years of age and older, verify benefit limits for the current year and the past year to determine if the eye care benefit limits have been exhausted. Providers/Contractors who do not verify benefit limits for two calendar years (last year and current year) for recipient's 21 years of age and older risk a denial of reimbursement for those services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

NOTE:

Prior authorized (PA) frames, lenses, exams, and fittings are now posting to the benefit limits screen. It is imperative to verify eligibility and benefit limits prior to rendering services. Please refer to Chapter 3, Verifying Recipient Eligibility for details.

15.2.1 Examinations

Medicaid eye care providers may administer and submit claims for several kinds of examinations, including the following:

- Examination for refractive error
- Optometrist services other than correction of refractive error
- Physician services

Providers may render services to Medicaid recipients confined to bed in a health care facility if the patient's attending physician documents that the patient is unable to leave the facility and that the examination is medically necessary.

Examination for Refractive Error

Medicaid recipients 21 years of age and older are authorized one complete eye examination and work-up for refractive error every two calendar years. Recipients under 21 years of age are authorized the same service each calendar year or more often if documented medical necessity indicates.

Complete Eye Examinations

The appropriate procedure codes to use when filing claims for a complete eye examination and refractive error work-up are codes 92004 and 92014.

A complete eye examination and refractive error work-up includes the following services:

- Case history review
- Eye health examination
- Visual acuity testing
- Visual fields testing (if indicated)
- Tonometry
- Eyeglasses prescription (if indicated)
- Determination of optical characteristics of the lenses (refraction)

Examiners use the appropriate diagnosis code(s) to indicate the diagnosis.

NOTE:

For children, examine eye tension and visual fields only if indicated.

Please refer to Section 15.5.3 for additional information.

Optometrist Services

Optometrists may provide services other than correction of refractive error as follows:

- During an eye examination, if the optometrist suspects or detects irregularities requiring medical treatment that is not allowed by state law to be provided by an optometrist, the optometrist refers the case to an appropriate doctor of medicine or osteopathy.
- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.

Added:
, require prior authorization

- Orthoptics (eye exercises) require prior authorization.
- Photochromic lenses and UV400 coating require prior authorization.
- Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Refer any subsequent abnormal or unusual conditions diagnosed during follow-up care back to the ophthalmologist.
- Artificial Eyes

Physician Services

Physicians may provide the following eye care services when diseases, injuries, or congenital defects are present:

- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.

Added: , require prior authorization

- Artificial Eyes

15.2.2 Eyeglasses

If a Medicaid recipient requires eyeglasses, services include verification of prescription, dispensing of eyeglasses, frame selection, procurement of eyeglasses, and fitting and adjustment of the eyeglasses to the patient.

Recipients 21 years of age and older are authorized one pair of eyeglasses each two calendar years if indicated by an examination. Prior authorization is required for additional glasses within same benefit period. Recipients under 21 years of age are authorized the same service each calendar year, or more often if documented medical necessity indicates. These limitations also apply to fittings and adjustments.

Any exception to these benefit limits must be based on medical necessity and the reasons documented in the medical record. Examples of medical necessity could be for treatment of eye injury, disease, significant prescription change, or unrepairable damage to glasses. Additional eyeglasses can not be authorized for convenience but only for clearly documented medically necessary reasons. An example for convenience may be more than one (1) pair of eyeglasses.

At the option of the provider taking the frame measurements, either the Medicaid Central Source or any other source may provide eyeglasses that conform to Medicaid standards. Medicaid will pay no more than the contract price charged by the Central Source.

Frame Standards

See Section 15.5.3, Procedure Codes and Modifiers, for frame procedure codes and contract prices.

The authorized frames, or frames of equal quality, are provided for Medicaid recipients at the contract prices shown on the list. Under normal circumstances, the date of service for eyeglasses is the same as the date of examination. All frames must meet American National Standards Index (ANSI) standards. This information and color photos of the frames are also available to view and to download at the website of the Central Source (www.classicoptical.com).

Lens Standards

Lens specifications are authorized at the specified contract price. See Section 15.5.3, Procedure Codes and Modifiers, for lens procedure codes and contract prices.

Lenses are composed of clear glass or clear plastic unless prior authorized by Medicaid because of unusual conditions. All lenses must meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements.

Spherical lenses must have at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (no other error) is 0.50 diopter.

New Lenses Only

Patients who have old frames that meet the above standards may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lenses only.

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

New Frame Only

Patients who have old lenses that meet the above standards may have them installed in a new frame instead of receiving new eyeglasses. Medicaid will pay for the frame only.

Include the following statement on the patient’s record: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."

Patient Requests Other Eyeglasses

If a patient chooses eyeglasses other than those provided by Medicaid, the patient must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for the patient's record: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

Additional Eyeglasses and Eye Exams

If medically necessary, Medicaid may prior authorize additional eye exams and eyeglasses for treatment of eye injury, disease, significant prescription change, or other circumstances resulting in unusable glasses/lenses. The provider should forward an electronic PA request or an Alabama Prior Review and Authorization Request (Form 342) with a letter justifying necessity to EDS prior to ordering the eyeglasses.

Replacement of Glasses

When a patient presents to your office requesting replacement of glasses for medically necessary reasons or unrepairable damage to glasses within the benefit limit period, the following instructions should be followed. For patients 21 years of age or older, prior authorization is required for additional glasses above the benefit limit of 1 pair of glasses each two (2) calendar years. Patients less than 21 years of age are authorized additional services when

medically necessary and documentation in the medical record supports medical necessity, without a prior authorization.

When it is determined that a second pair of glasses is medically necessary or unrepairable, the block on Classic Optical's job order form entitled "Date of Exam/Order" must have the date the patient returned to your office as opposed to the original date of the eye examination. This date will represent the "order" date. If the date of the original examination is transcribed, Classic's claim will deny.

If this is a recent replacement and does not necessitate another eye exam, you are not required to perform another eye exam.

If the replacement reason is necessary due to warranty or workmanship reasons and within 90 days of the original issue of eyeglasses, contact Classic Optical at 1(888) 522-2020 for replacement at no cost.

Ordering Frames, Lenses and Eyeglasses

As provided in Section 15.2.2 above, providers may order eyeglasses from the Central Medicaid source, Classic Optical, or any other source that conforms to Medicaid standards.
From the Central Source, providers can place orders electronically via the Internet at www.classicoptical.com, fax 1(888) 522-2022 or mail. To enhance the effectiveness and efficiency of eyeglass ordering, the Central Source recommends for providers to order eyeglasses electronically via the Internet at www.classicoptical.com. There is no additional charge for placing eyeglass orders electronically. The benefits of ordering via the internet include:

- Quicker order processing and turnaround
- Immediate order correction via online **SMART Order Form®** which prevents ordering non-contract items and impossible ophthalmic combinations
- Immediate e-mail response order confirmation
- Ability to print copy of Rx order
- Improved access to information including date of next eligible vision benefit
- Access to Recipient Vision Profile Screen
- Ability to track orders including confirm expected ship date
- Ability to view backorder frames
- Online frame catalogue (view and print frame photos)
- Stock frame **SMART Order Form®** online ordering
- Answers to Alabama Medicaid Vision Program Frequently Asked Questions

Visit www.classicoptical.com to view these benefits or call a Classic Optical Tech Rep at 1(888) 522-2020 to get a username and password to access these functions. For complete instructions for ordering via the internet visit www.classicoptical.com.

NOTE:

When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

Completing the Paper Eyeglass Prescription Form

Paper Eyeglass prescription forms are available from the Central Source, upon request. When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

Field on Form	***Information To Enter***
Provider Number	Enter ordering provider number.
Date	Enter only the date of service or date of prior authorization letter. Do not enter any other dates.
Eyeglasses Prescription Information	Enter the prescription in the appropriate fields provided.
P.D. Far-Near	Indicate as appropriate.
Eye	Enter appropriate measurement.
Bridge	Enter appropriate measurement.
Seg Height	Enter appropriate measurement.
Type Lenses	Indicate plastic or glass.
Temple Length	Enter appropriate measurement.
SV	Check appropriate block.
Frame	Enter appropriate frame name and color.
Special Instructions	Indicate as applicable.
Insurer's ID Number or RID number	Enter the 13-digit RID number from the recipient's plastic Medicaid card. Please verify this information. The Eyeglass Central Source is dependent upon the examiner for this vital information. Failure to furnish accurate information may delay or deny payment to the Medicaid Central Source.
Patient name	Enter the patient's last name, first name, and middle initial as it appears on the plastic Medicaid card.
Date of Birth	Enter patient's date of birth.
Patient's Address	Enter address
Patient or Authorized Person's Signature/Doctor's Signature	Have patient or patient's authorized representative sign and indicate the doctor's signature.
Prior Authorization	If services performed require prior authorization, indicate the ten-digit number supplied by Medicaid.
Provider	Enter the provider name and address to which the Central Source will deliver the completed eyeglasses.

The provider keeps the pink copy and forwards the other copies to the Central Source. The remainder of the form will be completed by the Central Source. Providers may submit paper order forms by faxing to Classic Optical at 1(888) 522-2022, or by mail, to Classic Optical at P.O. Box 1341, Youngstown, Ohio 44501. For inquiries on your order or to order by phone, you may contact Customer Service at Classic Optical at 1(888) 522-2020.

15.3 Prior Authorization and Referral Requirements

The Medicaid program requires that Medicaid give authorization prior to the delivery or payment of certain eye care services. Refer to Chapter 4, Obtaining Prior Authorization, for information about requesting prior authorization.

Prior authorization from Medicaid is required for the following eye care services:

Lens and frame change in same benefit period

Orthoptic training (eye exercises)

Additional comprehensive exams in same benefit period

Photochromic lenses

UV 400 lens coating

Low vision aids

Contact lenses (for anisometropia, keratoconus, aphakia, and high magnification difference between lenses)

Progressive Lenses

All requests for prior authorization should include the following information:

1. Recipient's name
2. Recipient's Medicaid Number (thirteen-digits)
3. If the PA is requested due to a prescription change, past and current prescription data (complete for both eyes), including diagnosis code(s), is required
4. Exception requested (what is being requested)
5. Reason for exception (explain, e.g., cataract surgery date, etc…), with current justification
6. Signature of practitioner
7. Address of practitioner

Refer to Section 15.5.3, Procedure Codes and Modifiers, for the appropriate procedure codes for services requiring prior authorization.

Other Situations

Providers may render special services for unusual situations upon prior authorization. Medicaid must receive full, written information justifying medical necessity prior to the service being rendered. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

Patient 1st Referral Requirements

The following ranges of procedure codes (including routine vision exams, eyeglasses, fittings, and lenses) **do not require a referral** for Patient 1st recipients:

Procedure Code	***Description***
V0100-V2799	CMS Assignment of Vision Services
V2020	Eyeglasses, Frames
V2025	Eyeglasses, Special Order Frames
92002-92015	Ophthalmological services for new or established patients
92313	Corneoscleral lens
92315-92317	Corneal lens/Corneoscleral lens
92326	Replacement of lens

Refer to Chapter 39, Patient 1st, for more information on Patient 1st requirements.

Eyeglass Contractors

If the Central Source provides eyeglasses, send them a copy of the approval letter from Medicaid bearing the ten-digit prior authorization number.

15.4 Cost Sharing (Copayment)

The copayment amount for optometric office visits is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.
The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

15.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit

Eye care providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

This section explains how to file claims for the following situations:

- Eye examination only
- Eye examination and fitting by one provider, eyeglasses from the Central Source
- Fitting only, eyeglasses from the Central Source
- Post-operative care
- Ophthalmoscopy extended (92225) and subsequent (92226)
- Other situations

NOTE:

Providers who furnish services should only bill for those services provided. Please be aware when filing claims that the claim reflects services actually rendered/provided. Billing for services not provided could be considered fraudulent. Please ensure your billing staff is aware of appropriate billing practices.

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, claims should be sent to the Medical Support unit at the Alabama Medicaid Agency within 120 days of the Medicare EOMB date. The claim must have Medicare denial attached. These claims require manual review for appropriateness and will be overridden when indicated.

Eye Examination Only

When the Medicaid recipient undergoes an eye examination only, the examiner completes a claim that specifies "Complete Eye Examinations and Refraction."

If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code or office visit code. Refer to 15.5.3, Procedure Codes and Modifiers, for a list of possible procedure codes. Send this claim directly to EDS.

Eye Examination and Fitting by One Provider, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs an eye examination (including refraction) and fitting (including frame service, verification, and subsequent service) and the central Medicaid source contractor provides the eyeglasses.

1. The examiner completes the CMS-1500 claim form, separately identifying the examination, refraction, and fitting. The examiner does not bill lenses and frames.
2. The examiner forwards the Medicaid job order form reflecting all necessary prescription data, including frame required, to the Central Source.

3. The contractor fills the prescription and returns the eyeglasses to the examiner for delivery to the patient. The Patient or Authorized Signature box must be complete with the appropriate signature or the statement "Signature on file."
4. The Central Source contractor submits claims for payment to EDS.

When eyeglasses are NOT procured from the Central Source contractor, the claim should separately specify charges for the examination performed, refraction, fitting, lenses, and frame.

When Opticians provide eyeglasses, the claim should identify only the fitting service, lenses, and frame. The claim is sent directly to EDS. Lenses and frames are reimbursed at the Central Source contract prices.

Fitting Only, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs a fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

The provider completes a claim that specifies the fitting services only. Send claims for payment directly to EDS.

Post-Operative Care

Medicaid will not process post-operative management claims until the referring ophthalmologist has received payment for surgery. The surgeon must first submit a modifier 54 with the appropriate surgical code. The optometrist should then submit a modifier 55 with the appropriate surgical code after the ophthalmologist has been paid in order to be paid for post-operative care.

Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

Ophthalmoscopy extended (92225) and subsequent (92226)

Ophthalmoscopy extended (92225) and subsequent (92226) are considered reasonable and necessary services for example, evaluation of tumors, retinal tears, detachments, hemorrhages, exudative detachments, retinal defects without detachment, and other ocular defects for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem when photography is not adequate or appropriate. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy which requires further detailed study. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. Accordingly, medical record documentation should be recorded in the patient's medical record.

15.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

15.5.2 Diagnosis Codes

The International Classification of Diseases Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

15.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed by Medicare

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

This section lists procedure codes for optometric services and equipment arranged by type of service or equipment:

- Common Optometric services
- Special Optometric services
- Contact lenses
- Eyeglasses codes

Services requiring prior authorization are identified in the Prior Authorization column (PA Required).

To report intermediate, comprehensive, and special services, use the specific ophthalmological description.

Common Optometric Services

The Optometric Services listed below are those commonly used by Optometrists and Ophthalmologists. Procedure codes 92004 and 92014 should include a complete eye exam and work-up as outlined in Section 15.2.1.

Procedure Code	*Description*
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Comprehensive, established patient, one or more visits

Procedure Code	***Description***
92015	Determination of refractive state (Bill as an add-on charge with complete eye exam when refraction is accomplished)
99201	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A problem-focused history • A problem-focused examination; and • Straightforward medical decision making
99202	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components • An expanded problem-focused history • An expanded problem-focused examination; and • Straightforward medical decision making
99203	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A detailed history • A detailed examination; and • Medical decision making of low complexity
99204	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of moderate complexity
99205	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of high complexity
99211	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A problem-focused history • A problem-focused examination • Straightforward medical decision making
99213	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • An expanded problem-focused history • An expanded problem-focused examination • Medical decision making of low complexity
99214	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A detailed history • A detailed examination • Medical decision making of moderate complexity
99215	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity

Miscellaneous Procedures

Procedure Code	*Description*
99241	Office consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99242	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99251	Initial inpatient consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99252	Initial inpatient consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99261	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity
99262	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity
99311	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity
99312	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity
99313	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A detailed interval history • A detailed examination • Medical decision making of moderate to high complexity

Special Optometric Services

Procedure Code	***Description***	***PA Required***
92018	Opthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic evaluation	No
92019	Limited	No
92020	Gonioscopy (separate procedure)	No
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	No
92065	Orthoptic training and/or pleoptic training, with continuing medical direction and evaluation (requires prior authorization from Medicaid)	Yes
92070	Fitting of contact lens for treatment of disease, including supply of lens	No
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	No
92082	Intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	No
92083	Extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 300	No
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	No
92136	Opthalmic biometry by partial coherence interferometry with intraocular lens power calculation	No
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	No
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	No
92226	Subsequent	No
92230	Florescein angioscopy with interpretation and report	No
92250	Fundus photography with interpretation and report	No
92260	Opthalmolodynamometry	No
92270	Electro-oculography with interpretation and report	No
92275	Electroretinography with interpretation and report	No
92283	Color vision examination extended, e.g., anomaloscope or equivalent	No
92284	Dark adaptation examination with interpretation and report	No
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	No
92330	Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation	No

Procedure Code	Description	PA Required
92335	Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation	No
92340	Fitting of spectacles, except aphakia; monofocal	No
92341	Bifocal	No
92342	Multifocal, other than bifocal	No
92352	Fitting of spectacle prosthesis for aphakia; Monofocal	No
92353	Multifocal	No
92354	Fitting of spectacle mounted low vision aid; single element system	No
92355	Telescopic or other compound lens system	No
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	No
92370	Repair and refitting spectacles; except for aphakia	No
92371	Spectacle prosthesis for aphakia	No
92390	Supply of spectacles, except prosthesis foe aphakia and low vision aids	No
92391	Supply of contact lenses, except prosthesis for aphakia	Yes
92392	Supply of low vision aids (A low vision aid is any lens or device used to aid or improve visual function in a person whose vision cannot be normalized by conventional spectacle correction. Includes reading additions up to 4D)	Yes
92393	Supply of ocular prosthesis (artificial eye)	No
92395	Supply of permanent prosthesis for aphakia; spectacles	No
92396	Contact lenses	Yes

Surgical Procedures

Procedure Code	Description
65205*	Removal of foreign body, external eye; conjunctival superficial
65210*	Conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220*	Corneal, without slit lamp
65222*	Corneal, with slit lamp
68801*	Dilation of lacrimal punctum, with or without irrigation
68810*	Probing of nasolacrimal duct, with or without irrigation

* Service Includes Surgical Procedure Only

Post Operative Care Modifiers

Use the appropriate modifier identifying post-operative management when submitting claims.

1st Modifier	Description
55	Postoperative Management (Optometrist)
54	Surgical Care (Opthamologist)
2nd Modifier	**Description**
RT	Right Eye
LT	Left Eye

Contact Lenses

Contact lenses may be provided for post-cataract surgery, anisometropia, keratoconus treatment, and high magnification difference between lenses. Fitting services are billed as a separate billed item. Lenses are billed per lens. Prior authorization is required for lenses and fitting services.

Procedure Code	***Modifier, If Applicable***	***Description***	***PA Required***
V2510		Contact lens, gas permeable, spherical	Yes
V2511		Contact lens, gas permeable, toric	Yes
V2513		Contact lens, gas permeable, extended wear	Yes
V2520		Contact lens, hydrophilic, spherical	Yes
V2521		Contact lens, hydrophilic, toric	Yes
V2523		Contact lens, hydrophilic, extended wear	Yes
92310	52	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	Yes
92311		Corneal lens for aphakia, one eye	Yes
92312		Corneal lens for aphakia, both eyes	Yes
92313		Corneoscleral lens	Yes
92314		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	Yes
92315		Corneal lens for aphakia, one eye	Yes
92316		Corneal lens for aphakia, both eyes	Yes
92317		Corneoscleral lens	Yes
92325		Modification of contact lens (separate procedure), with medical supervision of adaptation	No
92326		Replacement of contact lens	Yes

Eyeglasses Codes

At the option of the provider making the frame measurements, eyeglasses that conform to Medicaid standards may be procured from either the Central Source or from any other source. However, Medicaid will pay only the contract price charged by the Central Source.

Use the procedure codes and prices listed below for lenses. Add-on lens treatments requiring prior authorization are listed separately.

The lens specifications below are authorized at the specified contract price. Lenses must meet FDS impact-resistant regulations and must be made of glass or clear plastic except when other materials are prior authorized by Medicaid for unusual conditions. Spherical lenses must be at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (with no other error) is 0.50 diopter.

Procedure codes are listed in the following order:
Lens Codes

- Single vision
- Bifocal sphere
- Bifocal spherocylinder cylinder
- Other lenses

- Lenses requiring prior authorization from Medicaid before ordering.

The frame specifications below are authorized at the specified contract price. Effective July 1, 2002, the locally assigned procedure codes for frames are converted to one of two codes (PC), V2020 and V2025. A special order frame is designated as V2025 and should be billed as $25.00. Procedure code V2020 is designated for all the other frame codes and **the amount billed should be according to the frame provided**. In other words, **providers should bill the price of the frame in this manual and not their usual and customary price for the frame.**

Frame Codes

- Women's frames
- Girls' frames
- Men's frames
- Boys' frames
- Unisex frames for men, women, boys, or girls
- Special frame (size, type) other than above

Single Vision Spherocylinder (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2100 – Plano – 4.00	$ 5.23
V2101 – 4.25 – 7.00	5.23
V2102 – 7.25 – 12.00	7.00
V2103 – Plano – 4.00/0.25 – 2.00 cylinder	5.43
V2104 – Plano – 4.00/2.25 – 4.00 cylinder	5.43
V2105 – Plano – 4.00/4.25 – 6.00 cylinder	7.26
V2106 – Plano – 4.00/over 6.00 cylinder	7.35
V2107 – 4.25 – 7.00/0.25 – 2.00 cylinder	5.69
V2108 – 4.25 – 7.00/2.25 – 4.00 cylinder	7.14
V2109 – 4.25 – 7.00/4.25 – 6.00 cylinder	7.52
V2110 – 4.75 – 7.00/over 6.00 cylinder	7.85
V2111 – 7.25 – 12.00/0.25 – 2.25 cylinder	7.74
V2112 – 7.25 – 12.00/2.25 – 4.00 cylinder	7.78
V2113 – 7.25 – 12.00/4.25 – 6.00 cylinder	8.70
V2114*– 7.25 – 12.00/over 6.00 cylinder	15.57

Bifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	*Price Per Lens*
V2200 – Plano – 4.00	$ 7.31
V2201 – 4.25 – 7.00	8.20
V2202 – 7.25 – 12.00	9.12

Bifocal Spherocylinder (Plus or Minus)

Bifocal Spherocylinder (Plus or Minus) Cylinder	*Price Per Lens*
V2203 – Plano – 4.00/0.25 – 2.00 cylinder	$ 7.31
V2204 – Plano – 4.00/2.25 – 4.00 cylinder	7.64
V2205 – Plano – 4.00/4.25 – 6.00 cylinder	8.05
V2206 – Plano – 4.00/over 6.00 cylinder	8.84
V2207 – 4.25 – 7.00/0.25 – 2.00 cylinder	8.25

Bifocal Spherocylinder (Plus or Minus) Cylinder	*Price Per Lens*
V2208 – 4.25 – 7.00/2.25 – 4.00 cylinder	8.32
V2209 – 4.25 – 7.00/4.25 – 6.00 cylinder	8.69
V2210 – 4.75– 7.00/over 6.00 cylinder	8.80
V2211 – 7.25 – 12.00/0.25 – 2.25 cylinder	9.18
V2212 – 7.25 – 12.00/2.25 – 4.00 cylinder	9.85
V2213 – 7.25 – 12.00/4.25 – 6.00 cylinder	10.42
V2214* – 7.25 – 12.00/over 6.00 cylinder	10.42
V2199 – Over plus or minus 12.00 diopters	18.80
V2700 – Balance lens	5.15

Other

Other	*Price Per Lens*
V2115 – Lenticular (Myodisc) * (stand alone)	$ 31.56
V2121 – Lenticular lens, per lens, single * (stand alone)	5.00
V2299 – Executive Bifocals * (stand alone)	9.85
V2399 – Trifocals * (stand alone)	10.28
V2499 – Aspheric * (stand alone cost)	11.69
V2710 – Slab-off Prism * (stand alone)	30.90
V2715 – Prism Add ** (add-on)	1.50
V2718 – Press On Fresnell Prisms ** (add on)	11.18
V2745 – Tinted Lenses ** (add-on)	2.00
V2784 – Polycarbonate Lenses * (stand alone)	11.98

NOTE:

Procedure Code V2784 (Polycarbonate Lens) is a stand alone code and should not be billed in addition to another lens code for the same eye.

Lenses Requiring Prior Authorization from Medicaid Before Ordering

Lens	*Price per Lens*
V2744 – Photocromic ** (add-on cost)	$ 6.38
V2755 – UV 400 Coating ** (add-on cost)	3.00
V2781 - Progressives - CR-39 (effective July 1, 2002)	25.00

* Stand Alone Cost: This item is all-inclusive, billed with no other lens code.

** Add-on Cost: This item to be billed in addition to appropriate lens code.

Frames

NOTE:

Providers shall bill the price of the frame in this manual and not their usual and customary price for the frame.

Women's Frames- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code -Description*	*Price*
V2020	Betty Spring	10.95
V2020	CC 52	8.95
V2020	Regina (Metal) deleted 12-31-2006	9.45
V2020	Oretha Limited Edition	10.95
V2020	Hart - LG - 6021	11.95
V2020	CC 53	8.95
V2020	J5602	9.95
V2020	J5631	9.95
V2020	LG 8403	5.00
V2020	515 Detari/Europa deleted 12-31-2006	8.95
V2020	905 Detari/Europa	8.95
V2020	Ltd. 915 Ltd Edition	8.95
V2020	Debra Ltd. Edition deleted 12-31-2006	8.95
V2020	CC 57 Zimco	8.95
V2020	Zimco S-310	6.95
V2020	Zimco Karen	7.95
V2020	Zimco S-304	7.95
V2020	Zimco S-302	7.95
V2020	Zimco Christy	6.95

Girls' Frames- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code-Description*	*Price*
V2020	Mainstreet 415 (boys frames also)	12.50
V2020	Nino	6.95
V2020	Boulevard 4170	8.95
V2020	Pumpkin	9.95
V2020	Pumpkin S	9.95
V2020	Panda CC	12.50
V2020	Panda CCS	12.50
V2020	Detari/Europa	8.95
V2020	Curly Ltd. Edition	8.95
V2020	Gift Modern	8.95

Men's Frames- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code Description*	*Price*
V2020	Trenton	8.95
V2020	Atlantic	8.95
V2020	Manchester Limited Edition	11.95
V2020	Moscow	8.95
V2020	Eddie	8.95
V2020	Elay	11.95
V2020	Leo #2	8.95
V2020	Star	8.95
V2020	Uptown	6.95
V2020	J5638	7.95
V2020	J5603	6.95
V2020	901 Detari/Europa	8.95

Frame	*Code Description*	*Price*
V2020	908 Detari/Europa	8.95
V2020	Zimco Brunswick	6.95

Boys' Frames- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code-Description*	*Price*
V2020	Chuckles	$12.95
V2020	IG 27	8.95
V2020	Nick deleted 12-31-2006	5.95
V2020	Pacific	8.95
V2020	Rae	5.95
V2020	CC 42	8.95
V2020	CC 37	8.95
V2020	Chris deleted 12-31-2006	8.95

Unisex Frames for Men, Women, Boys, Girls- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code Description*	*Price*
V2020	Cambridge	8.95
V2020	S-502	7.95
V2020	Boulevard 1104 Hart deleted 12-31-2006	8.95
V2020	Robby Limited Edition	11.95
V2020	Overlook Hart	4.95
V2020	Ontario Zimco	9.95
V2020	Gusto	8.95
V2020	Boulevard 4502 Hart	9.95
V2020	Boulevard 4508 Hart (may substitute Ellen - Phil Optiks)	9.95
V2020	S 301	8.95
V2020	Boulevard 4509 Hart	10.95
V2020	Boulevard 4511 Hart	10.95
V2020	Boulevard 4517 Hart deleted 12-31-2006	10.95
V2020	Kidco 6	9.95
V2020	J5616	8.95
V2020	J5606	8.95
V2020	J5612	8.95
V2020	Bella 223	11.95
V2020	Kidco 5	9.95
V2020	LG 8023 deleted 12-31-2006	10.95
V2020	LTD 182	10.95
V2020	LTD 183	10.95
V2020	905 Detari/Europa	8.95
V2020	911 Detari/Europa	8.95
V2020	Zimco Chelsea	6.95
V2020	Zimco Monaco	6.95
V2020	Zimco S-510	6.95
V2020	Zimco Overvue	6.95

Special Frame (Size, Type) Other Than Above- **Providers should bill the price of the frame in this manual and not their usual and customary price for the frame**

Frame	*Code Description*	*Price*
V2025	Special Order Frames (***PA REQUIRED***)	$39.95 -

15.5.4 Place of Service Codes

The following place of service codes apply when filing claims for eye care services:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility

15.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances.

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

15.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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16

16 Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a health care center that meets one of the following requirements:

- Receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act
- Meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service
- Qualifies through waivers of the requirements described above as determined by the secretary for good cause
- Functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act

The policy provisions for FQHC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 48.

16.1 Enrollment

EDS enrolls FQHC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a FQHC provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for FQHC-related claims.

NOTE:
All nine digits are required when filing a claim.

FQHC facilities are assigned a provider type of 49 (FQHC) and the valid specialty is F2 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the rendering provider number (Block 24K) on the CMS-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual Medicaid provider numbers that are linked to the FQHC number. Each of these providers is assigned a provider type of 49 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to specialty table below)
- N2 (Nurse Midwife)
- N3 (Certified Registered Nurse Practitioner)
- N6 (Physician Assistant)

Specialty (Applicable for physicians only)	***Code***
Allergy/Immunology	03
Anesthesiology	05
Cardiac surgery and cardiovascular disease	S1
Cardiovascular Disease	S1
Cochlear implant team	C9
Colon and rectal surgery	S2
Dermatology	07
EENT	XA
Emergency medicine	E1
Endocrinology	E2
EPSDT	E3
Family practice	08
Gastroenterology	10
General Dentistry	V2
General practice	01
General surgery	02
Geriatrics	38
Hand surgery	21
Hematology	H2
Infectious diseases	55
Internal medicine	11
Mammography	M7
Neonatology	NI
Nephrology	39
Neurological surgery	14
Neurology	13
Nuclear medicine	36
Nutrition	40
Obstetrician/Gynecology	16
Oncology	XI
Ophthalmology	18
Oral and maxillofacial surgery	SE
Orthopedic	X6
Orthopedic surgery	20
Otorhinolaryngology	X9
Pathology	22
Pediatrics	37
Plastic, reconstructive, cosmetic surgery	24
Primary care provider (not a screening provider but can refer patients)	AE
Proctology	28
Psychiatry	26
Pulmonary disease	29
Radiology	30

Specialty (Applicable for physicians only)	*Code*
Rheumatology	R4
Thoracic surgery	33
Urology	34
Vascular surgery	S4

Enrollment Policy for FQHC Providers

To participate in the Alabama Medicaid Program, FQHC providers must meet the following requirements:

- Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter
- Submit a budgeted cost report for its initial cost reporting period
- Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification
- Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites

Provider contracts are valid for the time of the grant award period, and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to Medicaid as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the *Alabama Medicaid Agency Administrative Code* Rule No. 560-X-48-01 have been met.

FQHCs approved for enrollment will be issued a provider agreement for the services for which they agree to provide. This agreement must be signed and returned to Medicaid within 30 days of the date mailed to the provider. Names of satellite center(s) are indicated in the provider agreement.

NOTE:

Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants associated with the clinic must also complete enrollment applications.

FQHCs are required to notify EDS in writing within five state working days of any of the following changes:

- Losing FQHC status
- Any changes in dates in the FQHC grant budget period
- Opening(s) and/or closing(s) of any satellite center(s)
- Additions or terminations of providers

Patient 1st Requirements for Federally Qualified Health Centers (FQHC)

- The clinic must be a licensed, federally recognized FQHC clinic, enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, patient management, 24 hour coverage, and other program requirements.
- The FQHC clinic (and/or site) must be opened a minimum of 40 hours per week and the physician must practice at that location a minimum of 40 hours per week to be considered a full time equivalent (FTE).
- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of total patient caseload will be allowed, based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension.
- The FQHC clinic must specify what arrangements have been made for hospital admissions. If the physicians within the FQHC clinic do not have admitting privileges, then a designee must be specified. If the FQHC clinic/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees, including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.

Change of Ownership

Medicaid must be notified within 30 calendar days of the date of a FQHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency.

16.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

NOTE:

FQHC physicians should refer to Chapter 28, Physician, for additional information.

16.2.1 Benefits

Services provided by an FQHC include medically necessary diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurses, or clinical social worker; and services and supplies incidental to such services as would otherwise be covered if furnished by a physician. Any other ambulatory services offered by the center that are included in the State Plan are covered except for home health.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP can not make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

16.2.2 Limitations

Home health services are excluded as an FQHC service because home health services are available on a statewide basis.

Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21, family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. These services do not count against the routine benefit limits for medical encounters.

FQHC clinic visits, outpatient, and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

16.2.3 Reimbursement

FQHC services and other ambulatory services provided at the FQHC including satellite center(s) will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state

FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

Costs Reimbursed by Other Than FQHC Encounter Rate

Costs reimbursed by other Medicaid programs are not reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

- Maternity care, primary contractor
- Prescription drugs by enrolled pharmacy providers

NOTE:

For Non-Plan First patients, the dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring and are seeing providers at a Federally Qualified Health Center (FQHC) will obtain these supplies from the FQHC. **Prescriptions for these supplies will not be honored at a pharmacy for Plan First patients.**

FQHC's will provide and bill for oral contraceptives, the contraceptive patch and the vaginal ring using their specific Plan First provider number (example 227701000). Covered services using this provider number are limited to the following procedure codes with modifier:

- S4993 FP Oral Contraceptives
- J7304 FP Contraceptive Patch
- J7303 FP Contraceptive Ring

These services are limited to 13 units annually and **should be billed for Plan First recipients only.**

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

NOTE:

Costs for Maternity Care sub-contractors are not an allowable cost and are shown only in the non-reimbursable section of the cost report.

16.2.4 Encounters

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

This does not apply to dental service, however. Dental services are limited to one dental encounter per date of service. A patient can have one dental encounter and one other encounter on the same day.

Encounters are classified as billable or non-billable.

Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to EDS for payment through the proper filing of claims forms. Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, weight check only or blood pressure check only. Non-billable encounters cannot be forwarded to EDS for payment.

16.3 Prior Authorization and Referral Requirements

FQHC procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

16.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

16.5 Medicare Co-insurance

For Federally Qualified Health Centers, Medicaid pays the Medicare co-insurance up to the encounter rate established by Medicaid.

16.6 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

FQHC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

NOTE:

Physicians, Certified Registered Nurse Practitioners, and Physician Assistants bill using their own provider number on Block 24K of the CMS-1500 claim form. Enter the clinic's number in Block 33 in the GRP # portion of the field. Please refer to Section 5.2.2, CMS-1500 Claim Filing Instructions, for more information.

16.6.1 Time Limit for Filing Claims

Medicaid requires all claims for FQHC providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

16.6.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

16.6.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Nurse Practitioners/Physician Assistants

Covered services for FQHC-employed nurse practitioners and physician assistants are limited to the following:

- VFC codes, as specified in Appendix A, EPSDT
- Injectable drug codes, as specified in Appendix H, Alabama Medicaid Injectable Drug List
- Laboratory codes for which the clinic is certified to perform
- CPT codes as specified in Appendix O, CRNP and PA Services

Effective January 1, 1998, services provided by Registered Nurses (RNs) employed in a FQHC will be reimbursed only under the FQHC site name and number. Reimbursable services provided by an RN in an FQHC are restricted to the following:

Procedure Codes	***Description***
99205-FP	Family Planning, initial visit
99214-FP	Family Planning, annual visit
99213-FP	Family Planning, periodic revisit
99212-FP	Family Planning, expanded counseling visit
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age
99381-EP	Periodic EPSDT, normal, under 1 year of age
99382-EP	Periodic EPSDT, normal, 1-4 years of age
99383-EP	Periodic EPSDT, normal, 5-11 years of age
99384-EP	Periodic EPSDT, normal, 12-17 years of age
99385-EP	Periodic EPSDT, normal, 18-20 years of age
99381-EP	Periodic EPSDT, abnormal, under 1 year of age
99382-EP	Periodic EPSDT, abnormal, 1-4 years of age
99383-EP	Periodic EPSDT, abnormal, 5-11 years of age
99384-EP	Periodic EPSDT, abnormal, 12-17 years of age
99385-EP	Periodic EPSDT, abnormal, 18-20 years of age
*99391	Interperiodic Screening, Infant age- below 1 year old
*99392	Interperiodic Screening, Early Childhood-age 1 thru 4 years
*99393	Interperiodic Screening, Late Childhood-age 5 thru 11 years
*99394	Interperiodic Screening, Adolescent-age 12 thru 17 years
*99395	Interperiodic Screening-age 18 thru 20 years
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen

* Must be approved by the Alabama Medicaid Agency to provide these services.

Vaccines For Children (VFC)

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

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

NOTE:

VFC codes must be billed under the FQHC's VFC number.

16.6.4 Place of Service Codes

The following place of service codes apply when filing claims for FQHC services:

POS	*Description*
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
54	Intermediate Care/Facility/Mentally Retarded

NOTE:

Outpatient surgery, outpatient hospital visits, and nursing facility visits should be billed using the FQHC number for the physician rendering services. Do not bill these services on the same claim as other FQHC services.

16.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

16.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

17

17 Home Health

Medicaid provides home health care services to all Medicaid-eligible persons of any age, who meet the admission criteria, based on a reasonable expectation that a patient's medical, nursing, and social needs can adequately be met in the patient's home.

To be eligible for home health care, a recipient must meet the following criteria:

- The recipient's illness, injury, or disability prevents the recipient from going to a physician's office, clinic, or other outpatient setting for required treatment; as a result, he or she would, in all probability, have to be admitted to the hospital or nursing home because of complications arising from lack of treatment.
- The recipient is unable to leave home under normal circumstances. Leaving home requires a considerable and taxing effort by the recipient, and absences from the home are infrequent, of relatively short duration, and for medical reasons.
- The recipient is unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker; requires the use of special transportation or the assistance of another person.

The patient's attending physician must certify the need for home health services and provide written documentation to the home health provider regarding the recipient's condition which justify that the patient meets home health criteria. The physician must re-certify care every 60 days if home services continue to be necessary. The attending physician must be a licensed, active Medicaid provider.

The policy provisions for home health providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 12.

17.1 Enrollment

EDS enrolls home health providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

To become a home health provider, a provider must be a public agency, private non-profit organization, or proprietary agency primarily engaged in providing part-time or intermittent skilled nursing and home health aide services to patients in their homes. Only in-state home health agencies are eligible for participation in Medicaid.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a home health provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for home health-related claims.

NOTE:

All eight characters are required when filing a claim.

Home health providers are assigned a provider type of 14 (Home Health). The valid specialty for home health providers is H3 (Home Health).

Enrollment Policy for Home Health Providers

To participate in Medicaid, home health providers must meet the following requirements:

- Be certified to participate as a Medicare provider
- Be certified by the Division of Licensure and Certification of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation
- Submit a copy of the agency's most recent cost report

For continued participation as a Medicaid home health care provider, an annual Medicare cost report for the home health agency's fiscal year must be submitted to Medicaid within 30 calendar days after the report is submitted to Medicare. A copy of any Medicare audit adjustment or settlement must be submitted to Medicaid within 30 calendar days of receipt by the home health agency.

NOTE:

If the cost report is not provided as required, the home health agency's contract may be terminated for noncompliance.

17.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

17.2.1 Covered Services

Registered Nurse Services (RN)

If ordered by the patient's attending physician, a registered nurse employed by a certified home health agency can provide part-time or intermittent nursing services to a patient.

- The RN is responsible for a nursing care plan, which is made in accordance with the physician's written plan of care.

- Restorative, preventive, custodial and maintenance, and supportive services are covered.

Licensed Practical Nurse Services (LPN)

If ordered by a patient's attending physician, a licensed practical nurse, supervised by an RN employed by a participating home health agency, can provide intermittent or part-time nursing services to the patient when assigned by the RN.

LPN services are provided in accordance with existing laws governing the State Board of Nursing.

Home Health Aide or Orderly Services

A home health aide or orderly can provide personal care and services as specified in the attending physician's plan of treatment.

Supervisory visits by the registered nurse must be performed at least every 60 days when services are provided by the LPN, home health aide, or orderly. These services may be provided on a part-time basis only and must be ordered by the attending physician. The RN who is responsible for the care of the patient must supervise the service.

17.2.2 Noncovered Services

There is no coverage under the Medicaid Home Health Care plan for visits by paramedical personnel, physical therapists, speech therapists, occupational therapists, and inhalation therapists for recipients 21 years of age or older.

Medicaid also does not cover sitter service, private duty nursing service, medical social workers, or dietitians except for recipients under 21 years of age.

Supervisory visits made by an RN to evaluate appropriateness of services being rendered to a patient by an LPN, aide, or orderly are considered administrative costs and may not be billed as skilled nursing services. The registered nurse will provide and document in the case record on-site supervision of the LPN, home health aide, or orderly at least every 60 days. The registered nurse will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the worker.

17.2.3 Visits

A visit is a personal contact in the place of residence of a patient by a health worker employed by a certified Medicaid home health agency for the purpose of providing a covered service.

Home health care visits to Medicaid recipients must be medically necessary and provided in accordance with a Medicaid Home Health Certification form signed by a licensed physician. Home Health records are subject to on-site audits and desk reviews by the professional staff of Medicaid.

If a Medicaid recipient receiving home health visits is institutionalized and is referred to home health upon discharge from the institution, a new Medicaid Home Health Certification form must be completed and retained by the home health agency.

NOTE:

Home health care visits, including nurse aide visits, are limited to 104 per calendar year. Nurse aide visits are restricted to two visits per week.

17.2.4 Medicare/Medicaid Eligible Recipients

Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. If Medicare terminates coverage, Medicaid may provide visits.

17.3 Prior Authorization and Referral Requests

Therapy services are limited to EPSDT recipients and must be prior authorized. Additional skilled nursing visits and home health aide visits are limited to EPSDT and must be prior authorized once the recipient has exceeded 104 home health visits in a calendar year. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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

17.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by home health providers.-

17.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Home health providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

17.5.1 Time Limit for Filing Claims

Medicaid requires all claims for home health to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

17.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

17.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes apply when filing claims for home health services. Include these procedure codes on bill type 33X (Outpatient):

Physical Therapy - Supervised

Revenue Code	*Procedure Code*	*Description*
420	97001	Physical Therapy evaluation
420	97002	Physical Therapy re-evaluation
420	97010	Application of a modality to one or more areas; hot or cold packs
420	97012	traction, mechanical
420	97014	electrical stimulation (unattended)
420	97016	vasopneumatic devices
420	97018	paraffin bath
420	97022	whirlpool
420	97024	diathermy

Deleted: ~~420, 97020, microwave~~

Revenue Code	Procedure Code	Description
420	97026	infrared
420	97028	ultraviolet

Physical Therapy - Constant Attendance

Revenue Code	Procedure Code	Description
420	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
420	97033	iontophoresis, each 15 minutes
420	97034	contrast baths, each 15 minutes
420	97035	ultrasound, each 15 minutes
420	97036	Hubbard tank, each 15 minutes

Physical Therapy Therapeutic Procedures

Deleted: ~~420, 97139, unlisted therapeutic procedure (specify)~~

Deleted: ~~420, 97545, Work hardening/conditioning, initial 2 hours~~

Deleted: ~~420, 97546, each additional hour (List separately in addition to code for primary procedure.~~

Added: 420, 97750, Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Revenue Code	Procedure Code	Description
420	97110	Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
420	97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
420	97113	aquatic therapy with therapeutic exercises
420	97116	gait training (includes stair climbing)
420	97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
420	97140	Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
420	97150	Therapeutic procedure(s), group (2 or more individuals)
420	97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
420	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
420	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
420	97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes (requires Prior Authorization)
420	97542	Wheelchair management, propulsion training, each 15 minutes
420	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Occupational Therapy - Supervised

Revenue Code	Procedure Code	Description
430	97010	Application of a modality to one or more areas; hot or cold packs
430	97018	paraffin bath
430	97022	whirlpool

Occupational Therapy - Constant Attendance

Revenue Code	Procedure Code	Description
430	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

Occupational Therapy Therapeutic Procedures

Revenue Code	Procedure Code	Description
430	97110	Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
430	97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
430	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
430	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
430	97537	Community/work reintegration training (eg, shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-to-one contact by provider, each 15 minutes

Added: 430, 97537, Community/work reintegration training…each 15 minutes.

Orthotics

Revenue Code	Procedure Code	Description
420 or 430	L3650 – L3995	Orthotics
420 or 430	L4205 – L4210	Orthotics repair
420 or 430	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or truck, each 15 minutes
420 or 430	97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
420 or 430	97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Added: 420 or 430, 97760, Orthotic(s) management and training…each 15 minutes

Added: 420 or 430, 97761, Prosthetic training, upper…each 15 minutes

Added: 420 or 430, 97762, Checkout for orthotic/prosthetic…each 15 minutes

Speech Therapy

Revenue Code	Procedure Code	Description
440	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
440	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
440	92620	Evaluation of central auditory function, with report; initial 60 minutes
440	92621	Evaluation of central auditory function, with report; each additional 15 minutes
440	92626	Evaluation of auditory rehabilitation status; first hour
440	92627	Evaluation of auditory rehabilitation status; each additional 15 minutes (list separately in addition to code for primary procedure)
440	92630	Auditory rehabilitation; pre-lingual hearing loss
440	92633	Auditory rehabilitation; post-lingual hearing loss

Added: 440, 92620, Evaluation of central…initial 60 minutes
Added: 440, 92621, Evaluation of central…additional 15 minutes
Added: 440, 92626, Evaluation of auditory…first hour
Added: 440, 92627, Evaluation of auditory…for primary procedure)
Added: 440, 92630, Auditory rehabilitation; pre-lingual hearing loss
Added: 440, 92633, Auditory rehabilitation; post-lingual hearing loss

Other Home Health Services

Revenue Code	*Procedure Code*	*Description*
551	S9124	Nursing care in the home by LPN; per hour
551	S9123	Nursing care in the home by RN; per hour
571	S9122	Home Health aide or CNA providing care in the home; per hour

NOTE:

Claims for Therapy Services (PT, OT, ST) may be span billed. However, providers must indicate on each detail line the date the procedure was performed instead of noting the total number of units.

Billing for Supplies

Home health providers must enroll as a DME provider to bill for supplies. Supplies may not be billed on a UB-92 claim form.

17.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

17.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims With Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

17.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

18

18 Hospice

Hospice is an interdisciplinary program of palliative care and supportive services that address the physical, spiritual, social and economic needs of terminally ill patients and their families. This care may be provided in the patient's home or in a nursing facility, if that is the recipient's place of residence.

The Alabama Medicaid Hospice Care Services Program began October 1, 1990, in order to help people who meet the criteria for hospice services remain in their homes.

Medicaid offers hospice care services to Medicaid-eligible recipients who are terminally ill as certified by the medical director of the hospice, or by the physician member of the hospice inter-disciplinary group and the individual's attending physician, if present. An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Hospice care consists of services necessary to relieve or reduce symptoms of the terminal illness and related conditions.

Medicaid hospice care services are subject to Medicare special election periods applicable to hospice care. Medicaid uses the most recent benefit periods established by the Medicare Program.

Effective June 16, 2005, all Hospice Providers are required to use criteria specific to the Medicaid program to determine medical necessity for recipients electing the hospice benefit when Medicaid is the primary payor. Providers should no longer use the Palmetto GBA Medicare Local Medical Review Policy (LMRP) to determine medical necessity for the hospice program when Medicaid is the primary payor for the hospice services. Providers should continue to use the Palmetto GBA LMRP for dually eligible recipients with Medicare Part A who reside in the community or a nursing facility because Medicare is considered the primary payor for these individuals. The Medicaid hospice criteria should be used to establish eligibility for the following categories of hospice recipients:

- All recipients with full Medicaid benefits
- All recipients with Medicaid and Medicare Part B
- All recipients who are Qualified Medicare Beneficiaries (QMBs) with full Medicaid coverage.

The policy provisions for Hospice providers can be found in Chapter 51 of the *Alabama Medicaid Agency Administrative Code,* and on the agency website at www.medicaid.alabama.gov. For diagnoses not found in the Alabama Medicaid Agency administrative code or for pediatric cases medical necessity review will be conducted on a case-by-case basis.

18.1 Enrollment

EDS enrolls hospice providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hospice provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hospice-related claims.

NOTE:

All eight characters are required when filing a claim.

Hospice providers are assigned a provider type of 47 (Hospice). Valid specialties for hospice providers include Hospice (H6).

Enrollment Policy for Hospice Providers

To participate in Medicaid, hospice providers must meet the following requirements:

Receive certification from the Centers for Medicare and Medicaid Services that the hospice meets the conditions to participate in the Medicare program.

- Possess a letter from the state licensing unit showing the permit number and effective date of the permit
- Possess a document from the licensing unit showing that the hospice meets requirements for the Medicare program
- Possess a copy of the notification to the hospice showing the approved Medicare reimbursement rate, the fiscal year end, and the Medicare provider number

Only hospice programs physically located within Alabama or within 30 miles of the state line may participate.

18.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Hospice providers must establish and maintain a written plan of care for each individual admitted to a hospice program. All services provided by the hospice must adhere to the plan.

The hospice must submit required hospice election and physician certification documentation to Medicaid for coverage of hospice care.

18.2.1 Physician Certification

The hospice must obtain physician certification that the individual recipient is terminally ill.

For the first period, the hospice must obtain written certification statements signed by the medical director of the hospice or the physician member of the interdisciplinary team and the recipient's attending physician, if present. The hospice must obtain physician certification no later than two calendar days after hospice care begins.

If the hospice does not obtain written certification as described, the hospice may obtain verbal certification within the two-day period, but must obtain written certification no later than eight calendar days after care begins. If every effort is made to secure written certification within eight calendar days and the hospice provider has not obtained the written certification, then a physician signature obtained by fax will meet the certification requirement. Written certification must be secured and retained in the client record within 30 days of the hospice election.

For each subsequent period, the hospice must obtain a written certification prepared by the medical director of the hospice or the physician member of the interdisciplinary team. The hospice must obtain physician certification no later than two calendar days after the period begins.

Each written certification must indicate that the recipient's medical prognosis is such that his or her life expectancy is six months or less. The hospice must retain these certification statements.

18.2.2 Election Procedures

In order to receive hospice care benefits, an individual must qualify for Medicaid and be certified as terminally ill by a doctor of medicine or osteopathy.

An election period is a predetermined timeframe for which an individual may elect to receive medical coverage of hospice care. Individuals may receive hospice care for two 90-day election periods, followed by an unlimited number of subsequent periods of 60 days each.

An individual eligible for hospice care must file an election certification statement with a particular hospice. Beginning April 1, 2005, all Hospice providers must complete the Medicaid Hospice Election and Physician's Certification Form 165 to certify Medicaid recipients for the hospice program. The Medicaid Agency will recognize the Medicare election form as election for both Medicare and Medicaid for dually eligible recipients receiving hospice services in the community. When a dually eligible recipient enters the nursing facility the Hospice Recipient Status Change Form 165B must be completed and returned to the Long Term Care Admissions/Records Unit. Hospice providers must also use this form to report subsequent changes for all hospice recipients during the hospice certification period. Due to the terminally ill individual's mental or physical incapacity, a representative may be authorized to file an election.

An election to receive hospice care is considered to continue from the initial election period through the subsequent election periods without a break in care as long as the following criteria are met:

- Recipient remains in the care of a hospice
- Recipient does not revoke the election provisions
- Election is re-certified when there is a break in care

An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day periods. An individual or representative may not designate an effective date earlier than the date that hospice care begins.

A Medicaid beneficiary who resides in a nursing facility may elect to receive hospice services. The hospice must have a contract with the nursing facility that clearly states which services each has responsibility to provide and details how the nursing facility and hospice will work together.

18.2.3 Medical Records

The hospice has the responsibility to establish and maintain a permanent medical record for each patient that includes the following:

Physician certifications

Services provided

Recipient election statement(s)

Interdisciplinary treatment plan of care and updates

Advance directive documentation

The documentation contained in the medical record must be a chronological, complete record of the care provided to the hospice recipient. The medical record must contain the Medicaid Hospice Election and Physician's Certification, Form 165 that is signed and dated by the physician. A Form 165 must be present for each election period. The documentation must contain the physicians' orders that include medication(s) taken by the recipient, an assessment and a plan of care developed prior to providing care by the attending physician, the medical director or physician designee, and the interdisciplinary team. Identification of a specific terminal illness must be documented and substantiated by labs, x-rays and other medical documentation supporting the terminal illness as set forth by the Medicare/Medicaid guidelines.

The hospice retains medical records for at least three years after the current year.

18.2.4 Advance Directives

The hospice must document in the patient medical records that each adult recipient has received written information regarding rights to make decisions about his or her medical care, under state law.

The hospice must comply with requirements in the Medicaid contract concerning advance directives.

18.2.5 Waiver of Other Benefits

An individual receiving hospice care waives all rights to Medicaid services covered under Medicaid for the duration of hospice care. Waived services include the following:

- Hospice care provided by any hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition
- Any Medicaid services that are equivalent to hospice care

Individuals receiving hospice care **do not waive** the following benefits:

- Services provided by the designated hospice
- Services provided by another hospice under arrangements made by the designated hospice
- Services provided by the individual's attending physician if that physician is not an employee of and does not receive compensation from the designated hospice for those services
- Medicaid-covered services that are not related to the hospice recipient's terminal illness

18.2.6 Election Revocation

An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the election to receive hospice care, any days remaining in that election period are forfeited.

The hospice sends the Alabama Medicaid Hospice Care Program the **Hospice Recipient Status Change Form 165B** to revoke the individual's election for Medicaid coverage of hospice care.

Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

NOTE:
An individual should not revoke the hospice benefit when admitted to the hospital for a condition related to the terminal illness.

18.2.7 Change of Hospice

An individual or representative may change the designation of the particular hospice that provides hospice care one time per election period. The change of the designated hospice is not a revocation of the election for the period in which it is made.

To change the designated hospice provider, the individual or representative must file a signed statement that includes the following information:

- The name of the hospice from which care has been received
- The name of the hospice from which the individual plans to receive care
- The effective date of the hospice change
- The hospice provider transferring the recipient should submit a Hospice Recipient Status Change Form 165B indicating transfer of the recipient
- The accepting hospice provider should submit documentation to the LTC Admissions Records Unit for review and processing to the LTC file

The individual or representative must provide a copy of this statement to the hospice provider and to Medicaid.

The waiver of other benefits remains in effect.

18.2.8 Covered Services

Nursing care, physician services, medical social services, and counseling are core hospice services routinely provided directly by hospice employees.

Appropriately qualified personnel as determined by the nature of the service must perform all covered services.

The following are covered hospice services:

Covered Services	***Description***
Nursing facility care	Provided by or under the supervision of a registered nurse
Medical social services	Provided by a social worker who has at least a bachelor's degree from an approved or accredited school and who works under the direction of a physician
Physician services	Performed by a licensed physician. The medical director and physician member of the interdisciplinary group must be a doctor of medicine or osteopathy.
Counseling services	Provided to the terminally ill individual and the family or other person(s) caring for the patient at home. Counseling includes dietary advice, caregiver training, and counseling for adjustment to approaching death for patients and caregivers.
Short-term inpatient care	Provided in a participating hospice inpatient unit or a hospital or nursing facility that provides services through a contract with the hospice. General inpatient procedures necessary for pain control or acute or chronic symptom management that cannot be provided in another setting; respite inpatient care lasting up to five consecutive days may provide relief for the individual's caregiver at home. Medicaid will not cover respite care when the recipient is a nursing facility resident. These inpatient services must be part of the written plan of care.
Medical appliances and supplies	Includes drugs and biologicals provided to the patient. Drugs must be used primarily for relief of pain and symptom control related to the individual's terminal illness and related conditions. Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care.

Covered Services	Description
Home health aide services	Furnished by qualified aides and homemaker services provided under the general supervision of a registered nurse. These services include personal care and maintenance of a safe and healthy environment as outlined in the plan of care.
Physical Therapy, Occupational Therapy, and Speech Language Therapy	Provided for symptom control or to allow the recipient to maintain basic functional skills and/or activities of daily living

Hospices may contract for supplemental services during periods of peak patient loads and to obtain physician specialty services.

18.2.9 Reimbursement for Levels of Care

With the exception of payment for direct patient care services by physicians, Medicaid pays the hospice for all covered services related to the treatment of the recipient's terminal illness for each day the recipient is Medicaid-eligible and under the care of the hospice, regardless of the services furnished on any given day.

Payment for hospice care must conform to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid bases hospice payment rates on the same methodology used to set Medicare rates and adjusts rates to disregard offsets due to Medicare co-insurance amounts. Each rate comes from a CMS estimate of the costs generally incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. Medicaid adjusts the rates of reimbursement to reflect local differences in wages.

Medicaid pays reimbursements to the dispensing pharmacy for drugs not related to the recipient's terminal illness through the Medicaid Pharmacy Program.

NOTE:

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at www.medicaid.alabama.gov.

With the exception of payment for physician services, Medicaid reimburses hospice care at one of four rates for each day in which a Medicaid recipient receives hospice care. The payment amounts are determined within each of the following categories:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

Routine Home Care

The hospice receives reimbursement for routine home care for each day that the recipient receives hospice care at home but does not receive continuous home care. Medicaid pays this rate without regard to the volume or intensity of routine home care services provided on any given day.

Continuous Home Care

The hospice receives reimbursement for continuous home care when the recipient receives nonstop nursing care at home. Continuous home care is intended only for periods of crisis when skilled nursing care is needed on a continuous basis to manage the recipient's acute medical symptoms, and only as necessary to maintain the recipient at home. Continuous home care consists of a minimum of eight hours per day.

Inpatient Respite Care

The hospice receives reimbursement for inpatient respite care for each day that the recipient receives respite care. Patients admitted for this type of care do not need general inpatient care. Medicaid provides inpatient respite care only on an intermittent, non-routine, and occasional basis and will not reimburse for more than five consecutive days, including date of admission, but not date of discharge.

General Inpatient Care

The hospice receives reimbursement for general inpatient care for each day that the recipient occupies an approved inpatient facility for the purpose of pain control or acute or chronic symptom management.

NOTE:

Payment for total inpatient care days (general or respite) for Medicaid patients cannot exceed twenty percent of the combined total number of days of hospice care provided to all Medicaid recipients during each 12-month period of November 1 through October 31.

Reimbursement for Physician Services

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians employed by or working under arrangements made with the hospice.

Group activities, which include participation in establishing plans of care, supervising care and services, periodically reviewing and updating plans of care, and establishing governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

- Physicians employed by or working under arrangements made with the hospice may bill for direct patient care services rendered.
- Services provided by the attending physician who is not employed by or receiving compensation from the hospice will be paid to that physician in accordance with the usual billing procedures for physicians. Refer to Chapter 28, Physician, for physician billing procedures.

- Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

Nursing Facility Residents

Medicaid will not restrict hospice services based on a patient's place of residence. A nursing facility resident may elect to receive hospice benefits if he or she meets the requirements for hospice care under the Medicaid program.

If the resident elects to receive hospice benefits, the nursing facility submits discharge information per LTC Admission Notification Software.

A Medicaid hospice recipient residing at home who enters a nursing facility may continue to receive services under the hospice benefit. Any applicable resource liability amount and/or third party liability amount for a nursing facility resident need to be established and applied to the amount paid to the hospice by Medicaid for the nursing facility services. Nursing facility residents are required to use income to offset the cost of nursing facility care. Additionally, if a resident in a nursing facility elects, the hospice income will be applied to offset the cost of hospice care. The Medicaid district office will provide the hospice provider a copy of the Notice of Award or Notice of Change of Liability in order to inform the hospice of the claimant's liability required amount to be paid from claimant's income.

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Long Term Care Admissions/Records Unit for **dually eligible** institutionalized recipients:

- Initial nursing home admission
- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Long Term Care Admissions/Records Unit for **Medicaid only** institutionalized recipients upon:

- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital

NOTE:

Medicaid pays the hospice 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing facility for that individual under the State Plan. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides.

Medicare/Medicaid Eligibility

The Hospice Election and Physicians Certification Form 165 must be completed for all recipients who are Medicaid eligible. However, for dually eligible recipients who have Medicare Part A, Medicare will pay the daily hospice rate for the appropriate level of care – routine, continuous, inpatient respite, or general inpatient.

If the dually eligible hospice recipient with Part A Medicare resides in a nursing facility, Medicare pays the daily hospice rate as usual. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. The number of days of Medicare coverage must equal the number of days requested for nursing facility room and board. Any applicable resource liability amount and/or third party liability amount is deducted from the payment made to the Hospice provider for the facility services.

The Qualified Medicare Beneficiary (QMB) recipient who has **QMB-only** is not eligible for any Medicaid benefits, i.e., home health, hospice, medications, etc. A recipient who has **QMB+** does have full Medicaid benefits and would be eligible for home health, hospice, and medications.

Coinsurance amounts for drugs and biologicals or respite care may be billed to Medicaid as crossover claims for dually eligible recipients for whom Medicare is the primary payer.

Drugs and biologicals furnished by the hospital while the recipient is not an inpatient may be billed at 5 percent of the cost of the drug or biologicals, not to exceed $5.00 per prescription.

Medicaid Waiver Eligibility

A Medicaid-only recipient cannot receive hospice services and waiver services simultaneously; however, a Medicare/Medicaid-eligible recipient may receive the hospice benefit and waiver service if Medicare is the payer for the hospice service. The hospice provider must inform Medicaid recipients receiving Medicaid Waiver Services that they will lose Medicaid Waiver Services when they elect to receive hospice benefits and notify the Waiver Provider of the election of the hospice benefit.

Audits

The provider of hospice care may be asked to furnish the Medicaid Hospice Care Program with information regarding claims submitted to Medicaid. The provider of hospice care must permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

The provider of hospice care must maintain complete and accurate medical and fiscal records that fully disclose the extent of the services and billings. The provider retains these records for the period of time required by state and federal laws.

Inpatient Respite Care

Medicaid pays coinsurance claims for inpatient respite care, drugs, and biologicals for dually eligible recipients. Medicaid pays 5 percent of the Medicare payment for a day of respite care. This payment will not exceed the inpatient hospital deductible applicable for the year in which the hospice co-insurance period began. Medicaid will not pay for more than five consecutive days.

Medicaid pays 5 percent of the cost of each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The cost may not exceed $5.00 for each prescription.

NOTE:

When filing coinsurance claims for inpatient respite care or for drugs and biologicals, the provider must complete the UB-92 claim form. See Section 5.6.2, Institutional Medicaid/Medicare Related Claim Filing Instructions, for instructions on completing the crossover claim form.

18.3 Medicaid Approval for Hospice Care

Providers must adhere to all state and federal specific timeframes and documentation requirements under the Medicaid Hospice Program.

Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission; including hospice stays of six months or more. Hospice providers will no longer have the ability to submit dates of service to the LTC file for hospice admission or recertification.

Policies and Procedures for Hospice Admission and Recertification

- Applicants to Medicaid approved hospice providers must be certified, by their attending physician or hospice medical director, to have a terminal illness with a life expectancy of six months or less. The certification for terminal illness is substantiated by specific findings and other medical documentation including, but not limited to, medical records, labs, x-rays, pathology reports, etc.
- The hospice provider will be required to comply with all state and federal rules related to an individual's election of the hospice benefit.
- The hospice provider must establish a permanent medical record for each patient which documents eligibility for the Medicaid Hospice benefit based upon the medical criteria found in the Alabama Medicaid Agency Administrative Code Rule 560-X-51-.04. Pediatric cases and other diagnoses not found in the Administrative Code will be reviewed on a case by case basis.
- All hospice providers certifying patient initial admission, recertification or hospice stays for six months or more must submit medical documentation to the LTC Admissions Records Unit for review. When approved the LTC Admissions/Records Unit will submit the dates of service to the LTC file.
- When submitting records the Hospice Program cover sheet must accompany the medical record. Mail the information to:

Alabama Medicaid Agency

LTC Admissions/Records

P.O. Box 5624

Montgomery, AL 36103-5624

- The LTC Admissions/Records Nurse Reviewer will review the documentation to ensure the appropriateness of admission based on Medicaid's medical criteria for admission as defined in the Alabama Medicaid Agency Administrative Code Rule No. 560-X-51-.04.
- If there are no established criteria for the admitting hospice diagnosis, the Nurse Reviewer will perform a preliminary review of the documentation for terminality and the normal progression of the terminal disease. The Medicaid Agency's Medical Director will make the final determination of approval or denial of the admission and continued stay in the Hospice Program for those diagnoses which have no established medical criteria.
- When there is both medical and financial approval, the application dates will be added to the LTC file by staff in LTC Admissions/Records. The application should not be forwarded for medical review until financial eligibility has been established.
- If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing, etc.) the provider will receive a letter requesting the additional information. If the additional information is not received within 10 days the application will be denied.
- No hospice segment will be approved by LTC Admissions/Records staff for greater than six months. If a recipient remains on hospice beyond six months, the provider must submit documentation which supports continued appropriateness for hospice including documentation of the continued progression of the disease. This information should be forwarded to the LTC Admissions/Records Unit for review two weeks prior to the end of the six month certification period or the case will automatically close. If the documentation demonstrates progression of the terminal illness, then an additional six month certification period will be established and added to the LTC file by the Admissions/Records staff.
- An acceptance will be faxed to the provider within 48 hours of completion of the review. This acceptance will notify the provider of the dates added to the file and may be used for billing of hospice claims.
- Denial letters will be mailed to the provider within two working days.
- All revocations and or discharges should be faxed to the LTC Admissions/Records Unit using the Hospice Recipient Status Change Form.

18.4 Cost Sharing (Copayment)

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Copayment amount does not apply to services provided by a Hospice provider.

18.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Hospice providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a hard copy UB-92 claim form is required. Medicare-related claims should be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

18.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Hospice providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

18.5.2 Diagnosis Codes

The International *Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

18.5.3 Procedure Codes, Revenue Codes and Modifiers

Hospice providers are required to use HCPCS procedure codes for each service rendered. Failure to identify each service with a procedure code will result in denial of the service. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Payment of hospice services is limited to the following codes:

Revenue Code	*Procedure Code*	*Description*
651	T2042	Routine home care, per day
652	T2042-SC	Continuous home care, per day
655	T2044	Inpatient respite care, per day

Revenue Code	Procedure Code	Description
656	T2045	General inpatient care, per day
659	T2046 T2046-SC T2046-SE	Nursing facility room and board, Routine care, per day Nursing facility room and board, Continuous care, per day Nursing facility room and board, per dually eligible recipient, per day

18.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

18.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

18.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

19

19 Hospital

The Alabama Medicaid Program provides inpatient and outpatient hospital care. The policy provisions for hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* chapter 7.

19.1 Enrollment

EDS enrolls hospitals and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hospital is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hospital-related claims.

NOTE:

All eight characters are required when filing a claim.

Hospitals are assigned a provider type of 05 (Hospital). Valid specialties for hospitals include the following:

- Post-extended care (PEC) hospital (WC)
- General hospital (W6)
- Inpatient psychiatric hospital under 21 (W3)
- Inpatient psychiatric hospital over 65 (W2)
- Lithotripsy (L2)
- Mammography (M7)
- Organ transplants (W8)

Enrollment Policy for Hospital Providers

In order to participate in the Alabama Medicaid Program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

- Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the “Hospital/CAH Medicare Database Worksheet” completed by the State Agency Surveyor.
- Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification* Chapter 420-5-7.
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.
- Submit a written description of an acceptable utilization review plan currently in effect.

The effective date of enrollment cannot be earlier than the Medicare certification dates.

Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. Application by nonparticipating hospitals is made to EDS Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

Enrollment Policy for Lithotripsy

The facility must submit an application to EDS Provider Enrollment along with documentation that the lithotripsy machine is FDA approved.

19.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Appendix A, EPSDT for details on benefit limits for medically necessary services provided as a result of an EPSDT screening referral.

This section includes the following:

Section	***Title***	***Topics Covered***
19.2.1	Inpatient Benefits	• Routine Benefits • Extended Hospital Days for Delivery • Other Extended Benefits • Newborn Inpatient Benefits • Bed and Board and Semi-private Accommodations • Nursing and Other Services • Drugs and Biologicals • Supplies, Appliances, and Equipment • Hemodialysis • Organ Transplants • Blood • Sterilization and Hysterectomy • Abortions • Dental Services • Inpatient Noncovered Services • Payment of Inpatient Hospital Services
19.2.2	Post-hospital Extended Care (PEC) Services	• General Information • PEC Provider Number • Admitting a Recipient to a PEC • Reimbursement for PEC Services
19.2.3	Swing Beds	• General Information • Level of Care for Swing Beds • Benefit Limitations for Swing Beds • Admission and Periodic Review
19.2.4	Billing Medicaid Recipients	Describes conditions under which Medicaid recipients may be billed for services rendered
19.2.5	Outpatient Services	• Outpatient Surgical Services • Injectable Drugs and Administration • Emergency Hospital Services • Outpatient Hemodialysis • Obstetrical Ultrasounds • Inpatient Admission after Outpatient Hospital Services • Outpatient Observation • Outpatient Hyperbaric Oxygen Therapy • Outpatient Lab and Radiology • Outpatient Chemotherapy and Radiation • Outpatient Physical Therapy • Outpatient Sleep Studies • Outpatient Cardiac Rehabilitation • Prior Authorization for Outpatient Service • Payment of Outpatient Hospital Services • Pulse Oximetry Services
19.2.6	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.7	Crossover Reimbursement	Provides crossover reimbursement benefit information for inpatient and outpatient services

19.2.1 Inpatient Benefits

This section describes benefits and policy provisions for the following:

Routine Benefits

An inpatient is a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain overnight and occupy a bed (even if he is later discharged or is transferred to another hospital and does not use a bed overnight.)

Inpatient benefits for Medicaid recipients are limited to 16 days per calendar year. The number of days of care charged to a recipient for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is used to report days of care for Medicaid recipients even if the hospital uses a different definition of day for statistical or other purposes.

Medicaid covers the day of admission but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Extended Hospital Days for Delivery

Medicaid authorizes additional inpatient days for delivery for recipients who have exhausted their initial 16 covered days.

When medically necessary, additional days may be approved for deliveries, from onset of active labor to discharge. The number of extended days must meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria in order to be approved. Inpatient days prior to the onset of active labor will not be approved for extended benefits.

All hospitals should contact Quality Assurance (QA) personnel at (334) 242-5187 for authorization of these deliveries. Requests for authorization should not be made prior to delivery. QA personnel issue a ten-digit authorization number for the approved stays.

Claims for extended benefit days should be filed separately from all other inpatient stays.

Other Extended Benefits

Medically necessary inpatient days are unlimited for recipients under the age of one in all hospitals.

Medically necessary inpatient days are unlimited for children under the age of six if the services are provided by a hospital that has been designated by Medicaid as a disproportionate share hospital.

Newborn Inpatient Benefits

Newborns delivered in the hospital are covered by an eligible mother's claim for up to ten days of well-baby nursery care if the mother is in the hospital and is otherwise entitled to Medicaid coverage.

For recipients living in a maternity care district, no additional newborn nursery care may be billed during the time that has been covered by the global fee (two days for vaginal and four days for C-section deliveries).

For routine hospital delivery of newborns, use revenue codes 170 (Nursery) and 171 (Nursery/Newborn). These revenue codes are reflected on the mother's claims in conjunction with her inpatient stay. The hospital per diem rate includes charges for the mother and newborn. Newborn "well baby" care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or conditions and whose mothers have been discharged or are not otherwise eligible for Medicaid, are not separately billable.

Criteria for Revenue Codes 170/171 - The infant is considered to have received "well baby" care if any of these criteria are met in the absence of more severe conditions:

1. Premature infants greater than 5.5 lbs. (2500) grams and/or greater than 35 weeks who are not sick;
2. Stable infants receiving phototherapy for less than 48 hours duration or while the mother is an inpatient receiving routine postpartum care, such as physiologic jaundice, breast milk jaundice, etc;
3. Infants on intake and output measurements;
4. Stable infants on intermittent alternative feeding methods, such as gavage, or frequent feedings;
5. Stabilized infants with malformation syndromes that do not require acute intervention;
6. Infants with suspected infection on prophylactic IV antibiotics while the mother is an inpatient;
7. Infants receiving close cardiorespiratory monitoring due to family history of SIDS;
8. Infants in stable condition in isolation;
9. Observation and evaluation of newborns for infectious conditions, neurological conditions, respiratory conditions, etc., and identifying those who require special attention;
10. Oliguria;
11. Stable infants with abnormal skin conditions;
12. Routine screenings, such as blood type, Coombs test, serologic test for syphilis, elevated serum phenylalanine, thyroid function tests, galactosemia, sickle cell, etc.;
13. Complete physical exam of the newborn, including vital signs, observation of skin, head, face, eyes, nose, ears, mouth, neck, vocalization, thorax, lungs, heart and vascular system, abdomen, genitalia, extremities, and back.

Infants delivered outside the hospital, those remaining after the mother is discharged, and those admitted to accommodations other than well-baby nursery must be eligible for benefits in their own right, and a claim for services must be filed under the infant's number. Please note the following examples:

- If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's recipient number even if the mother is still a patient.
- A claim for three days filed under the mother's name and recipient number receiving six nursery days, will be returned to the hospital with instructions to bill the last three days under the baby's name and recipient number, who must be eligible in his own right.

NOTE:

When billing for multiple births, list each baby's accommodation separately, noting "Baby A," "Baby B," and so on. Also, use the diagnosis codes that indicate multiple live births. For multiple births, nursery days equals the sum of the number of infants times the number of the mother's days.

Unless the newborn infant needs medically necessary, specialized care as defined below, no additional billings for inpatient services are allowed while the mother is an inpatient.

To bill Medicaid utilizing revenue codes 172 (Nursery/Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery Intensive Care), and 179 (Nursery/Other), the infant must meet the following criteria established by Medicaid.

Criteria for Revenue Codes 172/173 - The infant must be 36 weeks gestation or less, or 5.5 lbs. (2500 grams) or less, AND have at least one of the following conditions which would cause the infant to be unstable as confirmed by abnormal vital signs or lab values:

1. Respiratory distress requiring significant intervention, including asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc;
2. Any nutritional disturbances, intestinal problems or known necrotizing entercolitis;
3. Cardiac disease requiring acute intervention;
4. Neonatal seizures;
5. Conditions which require IV intervention for reasons other than prophylaxis;
6. Apgar scores of less than six at five minutes of age;
7. Subdural and cerebral hemorrhage or other hemorrhage caused by prematurity or low birthweight;
8. Hyperbilirubinemia requiring exchange transfusion, phototherapy or other treatment for acute conditions present with hyperbilirubinemia, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
9. Pulmonary immaturity and/or without a pliable thorax, causing hypoventilation and hypoxia with respiratory and metabolic acidosis.

Criteria for Revenue Code 174 – Services must be provided in a neonatal intensive care unit due to the infant's unstable condition as confirmed by abnormal vital signs or lab values AND at least one of the following conditions:

1. Confirmed sepsis, pneumonia, meningitis;
2. Respiratory problems requiring significant intervention, such as asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.;
3. Seizures;
4. Cardiac disease requiring acute intervention;
5. Infants of diabetic mothers that require IV glucose therapy;
6. Congenital abnormalities that require acute intervention;
7. Total parental nutrition (TPN) requirements;
8. Specified maternal conditions affecting fetus or newborn, such as noxious substances, alcohol, narcotics, etc., causing life threatening or unstable conditions which require treatment;
9. IV infusions which are not prophylactic, such as dopamine, isoproterenol, epinephrine, nitroglycerine, lidocaine, etc.;
10. Dialysis;
11. Umbilical or other arterial line or central venous line insertion;
12. Continuous monitoring due to an identified condition;
13. Cytomegalalovirus, hepatitis, herpes simplex, rubella, toxoplasmosis, syphilis, tuberculosis, or other congenital infections causing life threatening infections of the perinatal period;
14. Fetal or neonatal hemorrhage;
15. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
16. Necrotizing enterocolitis, diaphragmatic hernia, omphalocele.

Criteria for Revenue Code 179 – The infant must be unstable as confirmed by abnormal vital signs or lab values AND have one of the following conditions:

1. Close observation after operative procedures;
2. Total parenteral nutrition (TPN);
3. Umbilical or other arterial line or central venous line insertion;
4. Cardiac disease requiring acute intervention;
5. Neonatal seizures;
6. Neonatal sepsis, erythroblastosis, RH sensitization or other causes, or jaundice, requiring an exchange transfusion;
7. Respiratory distress, oxygen requirements for three or more continuous hours, apnea beds, chest tubes, etc.;
8. IV therapy for unstable conditions or known infection;

9. Any critically ill infant requiring 1:1 monitoring or greater may be maintained on a short term basis pending transfer to a Level III nursery;
10. Apgar scores of less than six at five minutes of age;
11. Congenital anomalies requiring special equipment, testing, or evaluation;
12. Bleeding disorders;
13. Hyperbilirubinemia of a level of 12 or greater requiring treatment.
14. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.

These services should be billed on a separate UB-92 claim form under the infant's name and recipient number. The claim must indicate the ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care. The coding of neonatal intensive care claims will be monitored through post-payment review.

Bed and Board in Semi-Private Accommodations

Medicaid pays for semi-private accommodations (two-, three-, or four-bed accommodations). When accommodations more expensive than semi-private are furnished the patient because less expensive accommodations are not available at the time of admission or because the hospital has only private accommodations, Medicaid pays for the semi-private accommodations. In this case, the patient is not required to pay the difference.

When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must have the patient sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must remain on file for review if questions arise regarding payment of private room charges.

Accommodations other than semi-private are governed by the following rules for private rooms.

Medically Necessary Private Rooms

Payment may be made for a private room or for other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms are considered medically necessary when the patient's condition requires him to be isolated for his own health or for that of others. Isolation may apply when treating a number of physical or mental conditions. Communicable diseases may require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Medicaid pays for the use of intensive care facilities where medically necessary.

For the private room to be covered by Medicaid, the following conditions must be met:

- The physician must certify the specific medical condition requiring the need for a private room within 48 hours of admission.
- The physician's written order must appear in the hospital records.
- When the physician certifies the need for continued hospitalization, the private room must also be re-certified as being medically necessary.

Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician.

- When medical necessity for a private room ceases, the patient should be placed in the semi-private accommodation.

Nursing and Other Services

Medicaid covers nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

Drugs and Biologicals

Medicaid covers drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients.

A patient may, on discharge from the hospital, take home remaining drugs that were supplied by prescription or doctor's order, if continued administration is necessary, since they have already been charged to his account by the hospital.

Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid-approved pharmacy. Take-home drugs and medical supplies are not covered by Medicaid as inpatient hospital services.

Supplies, Appliances, and Equipment

Medicaid covers supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of the Medicaid recipient during his inpatient stay in the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, that is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Medicaid as an inpatient hospital service.

Colostomy bags are provided for inpatients only for use while they are hospital patients. Hospitals cannot supply colostomy bags using Medicaid funds for home or nursing facility use.

Hemodialysis

Medicaid provides hemodialysis for chronic renal cases when the patient is not authorized this care under Medicare.

Organ Transplants

Medicaid-covered organ transplants require prior approval, which will be coordinated by the prime contractor. Medicaid's approved prime contractor is responsible for the coordination and reimbursement of all Medicaid-reimbursed organ transplants with the exception of cornea transplants. The Medicaid Professional Services staff has final approval. Contact the Medicaid Clinic Services Unit at (334) 242-5580 for contractor information.

Letters of approval or denial will be sent to the requesting provider by Medicaid's coordinating entity upon completion of review by both the appropriate Medicaid Transplant Consultant and Medicaid's Medical Director.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). Alabama Medicaid's Transplant Program must receive the request for appeal within 30 calendar days from the date of the denial letter, or the decision will be final and no further review will be available.

Coordination services begin at initial evaluation and continue through a five-year post-operative period. Medicaid covers the following organ transplants for any age:

- Bone marrow transplants
- Kidney transplants
- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Pancreas
- Pancreas/Kidney

For Medicaid-eligible children through the age of 20, EPSDT-referred transplants not listed above will be considered for approval if the transplant is medically necessary, therapeutically proven effective, and considered non-experimental.

Reimbursement for all prior authorized transplants will be an all-inclusive global payment. This global payment includes pre-transplant evaluation; organ procurement; hospital room, board, and all ancillary costs both in and out of the hospital setting; inpatient postoperative care; and all professional fees. All services, room, board, pharmacy, laboratory, and other hospital costs are included under the global payment. All charges for services provided after the discharge, such as patient services, drugs, professional services, and other services will be reimbursed as fee-for-service.

The global payment represents payment in full. Any monies paid outside the global payment will be recouped. The recipient cannot be billed for the difference between the submitted amount and what the contractor pays.

For transplants performed at another in-state facility or at an out-of-state facility, the contractor negotiates the reimbursement rate with the facility and is responsible for global payment of the transplant from evaluation through hospital discharge. Medicaid reimburses the prime contractor for services provided.

The global payment for covered transplants performed out of state will be inclusive of all services provided out of state for the transplant, including all follow-up care, medications, food and lodging for caretaker/guardian of minor (if applicable), and home health. Once the patient has been discharged back to Alabama after transplant, services will be reimbursed fee for service and will count against applicable benefit limits.

Medicaid reimbursement is available only to the extent that other third party payers do not cover these services.

Blood

Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

Sterilization and Hysterectomy

Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in Appendix C, Family Planning.

Any Medicaid service that relates to sterilization or hysterectomy must have documentation on file with Medicaid that shows consent or an acknowledgement of receipt of hysterectomy and sterilization information. This documentation must be submitted by the attending physician and is required to be on file at EDS. This documentation must meet the criteria set forth under the sterilization and hysterectomy regulations. See Chapter 28, Physician and Appendix C, Family Planning, for further details.

NOTE:

Please refer to Section 5.7, Attachments, for information on billing electronic claims with attachments.

Abortions

Payment for abortions under Medicaid is subject to the conditions in the chapter pertaining to Physicians. Refer to Chapter 28, Physician, for further details.

Dental Services

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are covered for those recipients eligible for treatment under the EPSDT Program. See Chapter 13, Dentist, for details.

NOTE:

All inpatient hospital claims for dental services require prior authorization with the exception of children aged five and under.

Payment for Inpatient Hospital Services

Payment for all inpatient hospital services will be from approved per diem rates established by Medicaid or the Partnership Hospital Program (PHP). The PHP is the payer for all in-state hospital acute care days with the exception of recipients with Medicare Part A coverage, Maternity Care, and DYS eligible recipients.

Repeat Inpatient Admission

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-92's (even if the readmission was for the same diagnosis).

Inpatient Services for Non-Citizens

- Sterilization codes are non-covered for non-citizens.
- Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid must be processed manually. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the Sobra worker, who determines eligibility; then forwards information to the Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.
- Delivery Services must be billed through EDS for Non-Citizens.
- The Type of Admission restriction for type of admission “1” has been removed for UB-92 inpatient claims.
- For UB-92 inpatient claims, the following per diem is covered: Up to 2 days per diem for vaginal delivery and up to 4 days per diem for c-section delivery.
- Allowable diagnosis codes for UB-92are: V270-V279, V300-V3921, 65100-65993, and 6571-6573.
- Allowable surgical codes for UB-92 are 740-7499.

Inpatient Non-covered Services

Medicaid does not cover the following items and services:

- Free items and services for which there is no legal obligation to pay are excluded from coverage, (for example, chest x-rays provided without charge by health organizations).
- Items and services that are required as a result of an act of war, occurring after the effective date of the patient's current coverage are not covered.
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or to functioning of a malformed body member are not covered. Charges for special items such as radio, telephone, television, and beauty and barber services are not covered.
- Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.
- Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.
- Custodial care and sitters are not covered.
- Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, that coincidentally also serves some cosmetic purpose.

- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, a plan of the United States, or a state plan may not be paid for by Medicaid.
- Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, in a physician's office, or in an appropriate clinic, are not covered.
- Medicaid does not cover psychological evaluations and testing, or psychiatric evaluations, unless actually performed by a psychiatrist in person.
- Medicaid does not cover speech therapy unless actually performed by a physician in person.
- There is no provision under Medicaid for payment of reserved inpatient hospital beds for patients on a pass for a day or more.
- Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's attending physician. In the event that the recipient is receiving other services that require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be noncovered and subject to recoupment. Additionally, all admissions must meet Alabama Medicaid Adult and Pediatric Inpatient Care criteria as defined in the *Alabama Medicaid Agency Administrative Code,* Chapter 44.

19.2.2 Post Extended Care (PEC) Services

General Information

Inpatient hospital services rendered at a level of care lower than acute are considered post extended care services (PEC). The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting PEC reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Refer to Chapter 26, Nursing Facilities, for details.

Medically necessary services include, but are not limited to the following:

- Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis
- Bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay
- Medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician)
- Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient

- Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline)
- Services ordinarily furnished to an inpatient of a hospital

PEC Provider Number

In order to receive reimbursement for PEC, the hospital must enroll with EDS to receive a provider number. The provider number allows the hospital to designate up to ten beds for these services for hospitals with up to 100 beds, and an additional ten beds per each 100 beds thereafter. **All PEC services must be billed using a 'PEC' provider number (the number uses the 'PECXXXXH' format).**

Determining the Availability of Nursing Facility Beds

Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity and that the recipient requires two of the following medically necessary services on a regular basis:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
- Nasopharyngeal aspiration required for the maintenance of a clear airway
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube
- Care of extensive decubitus ulcers or other widespread skin disorders
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Routine medical treatment for a comatose patient

Admission and Periodic Review for PECs

To establish medical necessity, an application packet must be submitted to Medicaid within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped. All applications with a date over 60 days old will be assigned an effective date that is 60 days prior to the date stamp. No payment will be made for the days prior to the assigned effective date. The facility will be informed in writing of the assigned effective date.

The application packet consists of the following:

- A fully completed Medicaid Status Notification form XIX-LTC-4 including documentation certified by the applicant's attending physician to support the need for nursing home care
- Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria
- Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter

In order to continue PEC eligibility, re-certification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for re-certification.

Reimbursement for PEC Services

Reimbursement for PEC services is made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year. There shall be no separate year-end cost settlement. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, for details on rate computation.

A provider must accept the amount paid by Medicaid plus any patient liability amount to be paid by the recipient as payment in full, and further agrees to make no additional charge or charges for covered services.

Any day a patient receives such PEC services is considered an acute care inpatient hospital day. These beds are not considered nursing facility beds.

These services are not subject to the inpatient hospital benefit limitations. At this level of care, PEC days are unlimited if a nursing facility bed is not located.

All PEC services must be billed using the PEC provider number with the exception of outpatient services, pharmaceutical items to include over-the counter products, and prescription drugs.

- Outpatient services such as lab and x-ray services should be billed under the hospital provider number (HOSXXXXH).
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy provider number (100XXXXXX).
- A Medicaid pharmacy provider outside of the hospital may fill the prescriptions if the hospital pharmacy is not a Medicaid provider.

19.2.3 Swing Beds

General Information

Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services.

Swing bed hospitals must meet all of the following criteria:

- Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census
- Be Medicare certified as a swing bed provider
- Have a certificate of need for swing beds
- Be substantially in compliance with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals.)
- Must not have in effect a 24 hour nursing waiver
- Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation

Level of Care for Swing Beds

To receive swing bed services, recipients must require SNF level of care on a daily basis. The skilled services provided must be ones that, on a practical basis, can only be provided on an inpatient basis.

A condition that does not ordinarily require skilled care may require this care because of a special medical condition. Under such circumstances the service may be considered skilled because it must be performed by or supervised by skilled nursing or rehabilitation personnel.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. A patient may need skilled services to prevent further deterioration or preserve current capabilities.

Swing bed admissions not covered by Medicare because they do not meet medical criteria are also considered noncovered by Medicaid. These services cannot be reimbursed as a straight Medicaid service.

Benefit Limitations for Swing Beds

Swing bed services are unlimited as long as the recipient meets the SNF level of care medically and meets all other eligibility criteria, including financial criteria.

Admission and Periodic Review for Swing Beds

The Medicaid Long Term Care Admissions/Records (LTC ADMS/Records) Unit performs a pre-admission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified the need for swing bed care. Medicaid certifies the level of care required by the patient at the time of admission using the XIX-LTC-4 form. A control number is provided for each patient that is admitted.

The Medicaid staff physician(s) will review applications not initially approved by LTC ADMS/Records.

Recipients must meet SNF medical and financial requirements for swing bed admissions just as they are required for SNF admissions.

For recipients who receive retroactive Medicaid eligibility while using swing bed services, the hospital must furnish a form MED-54 to Medicaid. Attach all doctors' orders, progress and nurses' notes for the time in question.

LTC ADMS/Records issues medical approvals if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-13 for SNF care.

The admission application packet must be sent to LTC ADMS/Records within 30 days from the date Medicaid coverage is sought and most contain a fully completed Medicaid status notification (form XIX-LTC-4), including documentation certified by the applicant’s attending physician to support the need for the nursing home care.

Once the LTC-4 is reviewed and approved, a prior control number is issued and entered into the Long Term Care Record file.

An LTC-2 form notifies the facility that the patient is medically eligible if the financial eligibility of the patient has been established and entered on the file. If financial eligibility has not been established and noted in the file, an XIX-LTC-2A is sent to the facility advising that medical eligibility is established but financial eligibility is not. If an LTC-2A is received, the facility should advise the patient or sponsor of the need to establish financial eligibility by applying at the District Office.

Continued stay reviews are required to assure the necessity and appropriateness of skilled care and effectiveness of discharge planning. Re-certification of SNF patients is required 30, 60, and 90 days after admission and then every 60 days thereafter. Physicians must state "I certify" and specify that the patient requires skilled care for continued stay in the facility. Facilities must have written policies and procedures for re-certification. The Inspection of Care team will monitor these during medical reviews to assure compliance.

19.2.4 Billing Medicaid Recipients

Providers may bill recipients for noncovered services, for example, excessive days beyond benefit limitations, private room accommodation charges incurred due to patient's request, or personal comfort items.

The provider is responsible for informing the recipient of noncovered services. Medicaid recipients in hospitals may be billed for inpatient care occurring **after** they have received written notification of Medicaid non-coverage of hospital services. If the notice is issued prior to the recipient’s admission, the recipient is liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient is responsible for payment for all services provided **after** receipt of the notice.

19.2.5 Outpatient Hospital Services

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist at a licensed hospital. Medical services provided in an outpatient setting must be identified and the specific treatment must be documented in the medical record. Outpatient visits (99281, 99282, 99283, 99284 and 99285) are limited to 3 per calendar year unless certified as an emergency. Providers must meet Medicare "provider based status determination" criteria in order to bill Medicaid for outpatient services provided in an 'off-campus' location. Refer to 42 CFR 413.65 for details on "provider based status determination".

Outpatient Surgical Services

Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries (within the range of 10000-69XXX) listed in Appendix I, ASC Procedures List, are covered on an outpatient basis. Surgeries listed on the outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.alabama.gov. Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

NOTE:

Claims for outpatient surgical procedures that are discontinued prior to completion must be submitted with modifier 73 or 74.

Lab and x-ray not directly related to the surgical procedure are not included in the fee and may be billed in addition to the surgical procedures that are reimbursed. Outpatient visits for surgical procedures do not count against the recipient's outpatient visit limit. Surgery procedure codes are billed with units of one.

Any lab and x-ray procedures considered 'directly related' to the surgical procedure are part of the reimbursement for the surgical fee if performed within 3 days (or 72 hours) prior to the surgery.

Added: Any lab and…scheduled surgical procedure.

Any lab and x-ray procedures done as a pre-op for surgery will be covered by Medicaid in instances where the recipient is a 'no-show' for a scheduled surgical procedure.

Surgical procedures that are routinely performed in a physician's office and are not listed on the surgical procedures list may be considered for prior approval to be performed in the outpatient setting if medically necessary and if Medicaid approves the procedure.

In instances where a surgical procedure code has not been established or is an unlisted code the provider may bill the most descriptive procedure code with modifier 22 (unusual procedural services) until a covered procedure code is established.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:

- All nursing and technician services
- Diagnostic, therapeutic and pathology services
- Pre-op and post-op lab and x-ray services
- Materials for anesthesia
- Drugs and biologicals
- Dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

In order to bill for bilateral procedures (previously identified by modifier 50), the most appropriate procedure code must be billed on two separate lines and appended by the most appropriate anatomical modifier (i.e. RT, LT, etc).

Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Providers may visit the Medicaid website: www.medicaid.alabama.gov and click on the link for "Outpatient Fee Schedule", or continue to use the AVRS line at EDS (1 (800) 727-7848) to verify coverage.

NOTE:

Procedures not listed in Appendix I or the Outpatient Fee Schedule may be covered for special circumstances. Approval must be obtained prior to the surgery. Refer to Chapter 4, Obtaining Prior Authorization. Providers should inform recipients prior to the provision of services as to their responsibilities for payment of services not covered by Medicaid.

Injectable Drugs and Administration

Injectable drugs from the Alabama Medicaid injectable drug list do not count against the yearly outpatient visit limitation. Medicaid has adopted Medicare's Drug Pricing Methodology utilizing the Average Sale Price (ASP) for HCPCS injectable drug codes. Hospitals are required to bill the current CPT codes for chemotherapy and non-chemotherapy administration. The crosswalk between the previous codes and the new codes is outlined in Appendix H, Injectable Drug Listing.

The following CPT drug administration code-ranges will remain as covered services:

- CPT code ranges 90760 through 90775, and CPT code ranges 96401 through 96542.

These guidelines should be followed by hospitals for billing administration codes:

- No administration fee (infusions, injections, or combinations) should be billed in conjunction with an ER visit (99281 – 99285).

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV

sites must be utilized. The initial code is the code that best describes the services the patient is receiving and the additional codes are secondary to the initial one.

- “Subsequent” drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has two IV lines per protocol, these services are considered separately billable with a modifier 76.

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 78 on the UB-92 claim form.

UB-92 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-92 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.

Outpatient Hemodialysis

Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 35, Renal Dialysis Facility, for details.

Obstetrical Ultrasounds

Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient’s documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- EDS-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

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.

Outpatient Observation

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

- Patient must be admitted through the emergency room.
- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours but less than 24 hours.

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 – 99285).

Observation coverage is billable in hourly increments only. A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed. Observation charges are billed as follows:

- For the first three hours of observation the provider should bill a facility fee (99281 - 99285) with units of one.
- Procedure code 99218 should be used to bill the 4th through 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A detailed or comprehensive history
  - A detailed or comprehensive examination
  - Medical decision-making that is straightforward or of low complexity

The problem(s) requiring admission to “observation status” is usually of low severity.

- Procedure code 99219 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history

- A comprehensive examination

- Medical decision-making of moderate complexity

The problem(s) requiring admission to “observation status” is usually of moderate severity.

- Procedure code 99220 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history

  - A comprehensive examination

  - Medical decision-making of high complexity

  The problem(s) requiring admission to “observation status” is of high severity.

Providers should bill the appropriate CPT code based on the severity of the patient’s condition. Providers may bill up to 20 units of each procedure code. Units are equal to the number of hours. These codes must be billed with a facility fee (99281-99285). The facility fee is billed with units of one and covers the first three hours. The applicable CPT code would then be billed for the 4th up to the 23rd hour.

Ancillary charges (lab work, x-ray, etc.) may be billed with the facility fee and observation charge.

If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

Outpatient observation charges cannot be billed in conjunction with outpatient surgery.

Medical records are reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria.

Outpatient Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy (HBO) is covered in an outpatient hospital setting under the guidelines listed below. HBO should not be a replacement for other standard successful therapeutic measures. Medical necessity for the use of HBO for more than two months duration must be prior approved. Prior approval (PA) requests for diagnoses not listed below or for treatment exceeding the limitations may be submitted for consideration to the Office of the Associate Medical Director. No approvals will be granted for conditions listed in the exclusion section. HBO should be billed on the UB-92 by the outpatient facility using revenue code 413 and procedure code 99183. Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Reimbursement for HBO is limited to that which is administered in a chamber for the following diagnoses:

Air or Gas Embolism

9580 9991

Limited to five treatments per year. PA required after five treatments.

Acute Carbon Monoxide Poisoning

986

Limited to five treatments per Incidence.

Treatment should be discontinued when there is no further improvement in cognitive functioning. PA required after five treatments

Decompression Illness

9932 9933

Limited to ten treatments per year. Treatment should continue until Clinical exam reveals no further Improvements in response to therapy.

Gas Gangrene

0400

Limited to ten treatments per year. PA required after ten treatments.

Crush Injury

92700	92701	92702
92703	92709	92710
92711	92720	92721
9278	9279	92800
92801	92810	92811
92820	92821	9283
9288	9290	9299
99690	99691	99692
99693	99694	99695
99696	99699	

Limited to 15 treatments per year. Early application of HBO, preferably within four - six hours of injury, is essential for efficacy. The recommended treatment schedule is three 90 minute treatments per day over the first 48 hours after the injury; followed by two 90 minute treatments per day over the second period of 48 hours; and one 90 minute treatment over the third period of 48 hours.

Chronic Refractory Osteomyelitis

73010 - 73019

Limited to 40 treatments per year. To be utilized for infection that is persistent or recurring after appropriate interventions.

Diabetic wounds of lower extremities

70710 70711
70715 70719
70712 70714

Limited to 30 treatments per year. To be utilized only when wound fails to respond to established medical/surgical management. Requires an aggressive multidisciplinary approach to optimize the treatment of problem wounds. Diabetic wounds of the lower extremities are covered for patients who have type I or II diabetes and if the wound is classified as Wagner grade III or higher.

Radiation tissue damage

52689
990

Limited to 60 treatments per year. To be utilized as part of an overall treatment plan, including debridement or resection of viable tissues, specific antibiotic therapy, soft tissue flap reconstruction and bone grafting as may be indicated.

Skin grafts and flaps
99652
Limited to 40 treatments per year.
Twenty treatments to prepare graft site
and 20 after graft or flap has been replaced.

Progressive necrotizing infection
(necrotizing fasciitis)
72886
Limited to 10 treatments per year.

PA required after 10 treatments.

Acute traumatic peripheral
Cyanide poisoning
Ischemia
90253 90301 9031
9040 90441
Limited to 15 treatments per year.

Acute peripheral arterial
insufficiency
44421 44422 44481
Limited to five treatments
per
year. PA required after five
treatments.

9877 9890
Limited to five treatments
per incident. PA required
after five treatments.

Actinomycosis
0390 - 0394
0398 - 0399
Limited to 10 treatments per year.
PA required after 10 treatments.

Exclusions
No reimbursement will be made for HBO provided in the treatment of the following conditions.

Cutaneous, decubitus, and stasis ulcer
Chronic peripheral vascular insufficiency
Anaerobic septicemia and infection other than clostridial
Skin burns
Senility
Myocardial Infarction
Cardiogenic Shock
Sickle Cell Crisis
Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
Acute or chronic cerebral vascular insufficiency
Hepatic necrosis
Aerobic Septicemia
Nonvascular causes of common brain syndrome (i.e., Pick's disease, Alzheimer's disease, Korsakoff's disease)
Tetanus
Systemic aerobic infection
Organ transplantation
Organ storage
Pulmonary emphysema
Exceptional blood loss anemia
Multiple sclerosis
Arthritic diseases
Acute cerebral edema

Outpatient Lab and Radiology

Outpatient visits made solely for lab and radiology procedures do not count against a recipient's outpatient visit limits.

Claims containing only lab and radiology procedures may be span billed for one calendar month.

Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

Outpatient Chemotherapy and Radiation

Visits for these services do not count against the outpatient visit limitations and may be span billed for a calendar month. See Section 19.5.3, Procedure Codes, and Modifiers, for procedure codes to be used for these services. Diagnostic lab, diagnostic x-ray, and blood administration may be span billed in conjunction with outpatient chemotherapy and radiation.

Outpatient Physical Therapy

Physical therapy is a covered service based on medical necessity. Physical therapy is covered in a hospital outpatient setting for acute conditions. Recipients receiving therapy must be under the care of a physician or non-physician practitioner who certifies the recipient's need for therapy.

If the therapy continues past the 60th day, there must be evidence in the patient's medical record that a physician or non-physician practitioner has seen the patient within 60 days after the therapy began and every 30 days past the 60th day. Therapy services are not considered medically necessary if this requirement is not met. The 60-day period begins with the therapist's initial encounter with the patient (i.e., day the evaluation was performed). In the event an evaluation is not indicated, the 60-day period begins with the first treatment session. The therapist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral.

Documentation in the patient's medical record must confirm that all patients receiving physical therapy services have been seen by the certifying physician as specifically indicated above. Having a physician signature on a certification or re-certification will not meet this requirement.

Physical therapy performed in an outpatient hospital setting does not count against the recipient's three non-emergency outpatient visit limits. Rehabilitative services are not covered. Rehabilitative services are the restoration of people with chronic physical or disabling conditions to useful activity.

Physical therapy services are limited to those CPT codes listed in this chapter. Maximum units for daily and annual limits are noted for each covered service.

Form 384 (Motorized/Power Wheelchair Assessment Form) may be obtained by contacting the Long Term Care Provider Services at 1-800-362-1504, option 1 for providers.

Physical therapy records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet the medical criteria below. If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Medical Criteria for Physical Therapy

Physical therapy is subject to the following criteria:

- Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition.

Plan of Treatment

In addition to the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain at least the following information:

- Recipient's name
- Recipient's current Medicaid number
- Diagnosis
- Date of onset or the date of the acute exacerbation, if applicable
- Type of surgery performed, if applicable
- Date of surgery, if applicable
- Functional status prior to and after physical therapy is completed
- Frequency and duration of treatment
- Modalities
- For ulcers, the location, size, and depth should be documented

The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments.

Outpatient Sleep Studies

Sleep studies are covered services in an outpatient hospital. Medicaid does not enroll sleep study clinics. Indications for coverage are as follows:

Polysomnography includes sleep staging that is refined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). For a study to be reported as polysmnography, sleep must be recorded and staged for 6 hours and an attendant must be present throughout the course of the study.

The following are required measurements:

- Electrocardiogram (ECG)
- Airflow

- Ventilation and respiratory effort
- Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
- Extremity muscle activity, motor activity-movement
- Extended EEG monitoring
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions, etc.

For a study to be reported as a polysomnogram:

- Studies must be performed for 6 hours
- Sleep must be recorded and staged
- An attendant must be present throughout the course of the study

Diagnostic testing is covered when a patient has the symptoms or complaints of one of the following conditions:

- Narcolepsy
- Sleep Apnea
- Parasomnias

(Refer to LMRP for further definition of conditions.)

Limitations

Diagnostic testing that is duplicative of previous sleep testing done by the attending physician to the extent the results are still pertinent is not covered because it is not medically necessary if there have been no significant clinical changes in medical history since the previous study.

Home sleep testing is not covered.

Polysomonography will not be covered in the following situations:

- For the diagnosis of patients with chronic insomnia
- To preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected.
- To diagnose chronic lung disease (nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry.)
- In cases where seizure disorders have not been ruled out
- In cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated.

- For patients with epilepsy who have no specific complaints consistent with a sleep disorder.
- For patients with symptoms suggestive of the periodic limb movement disorder or restless leg syndrome unless symptoms are suspected to be related to a covered indication for the diagnosis of insomnia related to depression
- For the diagnosis of insomnia related to depression
- For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change (jet lag), shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non 24-hour sleep wake disorder)

Revenue Codes associated with OP hospital billing:

074X	EEG-general classification
0920	Other diagnostic services-general classification

Refer to the LMRP for ICD-9 Codes that support medical necessity. These ICD-9 Codes are updated occasionally by Medicare.

Outpatient Cardiac Rehabilitation

The following conditions must be met in order for an outpatient hospital based cardiac rehabilitation clinic to provide services:

- Recipient must be referred by their attending physician
- Services must be medically necessary and include at least one of the following medical conditions:
  1. Have a documented diagnosis of acute myocardial infarction within the preceding 12 months.
  2. Began the program within 12 months of coronary bypass surgery.
  3. Have stable angina pectoris (evaluation of chest pain must be done to determine suitability to participate in the cardiac rehabilitation program).
  4. Had heart valve repair/replacement.
  5. Had a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
  6. Had a heart or heart lung transplant.
- The frequency and duration of the program is usually two to three sessions per week for 12 to 18 weeks. Any services provided past 36 in a year will require prior authorization by Medicaid.
- Coverage may be extended with sufficient documentation that the patient has not reached the exit level, but will not exceed a maximum of 72 visits annually.
- Each exercise session must include at least one of the following: Continuous cardiac monitoring during exercise, and EKG rhythm strip with interpretation and physician's revision of treatment; or examination by the physician to adjust medications or for other treatment changes.

- No more than one EKG stress test with physician monitoring at the beginning of the exercise program with a repeat test in three months is reasonable and necessary. The medical necessity for stress tests in excess of the two allowed must be clearly established in the recipient's medical record.

- A physician must be immediately available in the exercise program area in case of emergency.

- Formal patient education services are not reasonable and necessary when provided as part of a cardiac rehabilitation exercise program; therefore, Medicaid will not pay for these services.

Prior Approval for Outpatient Services

Certain procedures require prior authorization. Please refer to Section 19.5.2, Revenue Codes, Procedure Codes, and Modifiers, and Appendix I, ASC Procedures List. Medicaid will not pay for these procedures unless authorized prior to the service being rendered. All requests for prior approval must document medical necessity and be signed by the physician. It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

Payment of Outpatient Hospital Services

Payment for all outpatient hospital services will be from approved rates as established by Medicaid.

Publicly owned hospitals and hospitals that predominately treat children under the age of 18 years may be paid at an enhanced rate. These payments will not exceed combined payments for providing comparable services under comparable circumstances under Medicare.

Extracorporeal Shock Wave Lithotripsy (ESWL)

Extracoporeal Shock Wave Lithotripsy (ESWL) is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter. ESWL is **not** a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half time the regular reimbursement rate for this procedure. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.

ESWL treatments are not subject to outpatient benefit limitations.

The copayment amount for an ESWL treatment is $3.00 per encounter. This amount does not apply to services for recipients under 18 years of age, emergencies and nursing home recipients.

The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Physician (surgeon) services for the ESWL procedure are not included in the facility's reimbursement rate and can be billed separately. No assistant surgeon services will be covered.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and can be billed separately.

Pulse Oximetry

Non-invasive ear or pulse oximetry services (94760-94762) are considered bundled services and, therefore, are not separately reimbursable. The only instances in which these services may be billed are when no other services are billed on the same day by the same provider. They must also be medically necessary and are subject to post-payment review and adjustment.

19.2.6 Outpatient and Inpatient Tests

Medicaid pays for medically necessary laboratory tests, x-rays, or other types of tests that have been ordered by the attending physician or other staff physician provided in inpatient or outpatient hospital facilities.

Hospital labs may bill 'routine venipuncture' only for collection of laboratory specimens when sending blood specimens to another site for analysis. Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. The referring hospital (facility) must not send out more than 30% of the clinical laboratory tests for which it receives requests for testing during the year. It is the responsibility of the hospital to ensure that the independent lab does not also bill Medicaid for these services.

19.2.7 Crossover Reimbursement

Part A

Medicaid inpatient hospital days run concurrently with Medicare days. Medicaid covers the Part A deductible, coinsurance, or lifetime reserve days, less any applicable copayment. Medicaid will not make such payments if the Medicaid covered days for the calendar year have been exhausted. This benefit limit does not apply for QMB recipients.

Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. Medicaid pays an amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate.

Part B

Medicaid pays the Medicare Part B deductible and coinsurance according to lesser of the following:

- Reimbursement under Medicare rules
- Total reimbursement allowed by Medicaid

Medicare-related claims for QMB recipients are reimbursed in accordance with the coverage determination made by Medicare. Medicare-related claims for recipients not categorized as QMB recipients are paid only if the services are covered under the Medicaid program.

Hospital outpatient claims are subject to Medicaid reimbursement methodology.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/ Medicaid-eligible recipients and QMB-eligible recipients must be sent first to the Medicare carrier.

Providers complete the appropriate Medicare claim forms and ensure that the recipient's 13-digit Recipient Identification (RID) is on the form, then forward the completed claim to a Medicare carrier for payment.

QMB-only recipients are eligible for crossover services and are not eligible for Medicaid-only services.

Refer to Chapter 5, Filing Claims, for complete instructions on how to complete the claim form.

Providers in other states who render Medicare services to Medicare/Medicaid-eligible recipients and QMB-eligible recipients should file claims first with the Medicare carrier in the state in which the service was performed.

19.3 Prior Authorization and Referral Requirements

Some procedure codes for hospitalizations require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

Prior authorization is required for certain outpatient surgical procedures. Refer to Appendix I or the Outpatient Fee Schedule on the website: www.medicaid.alabama.gov . Prior authorization is not required for inpatient admissions.

Medicaid issues a 10-digit prior authorization number for those stays. This number must appear in form locator 91 on the hospital claim form.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

19.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. This includes bill types 111, 112, 121, and 122 only (with the exception of admit types 1-emergency and 5-trauma).

The copayment amount for an outpatient visit (99281– 99285) is $3.00 per visit or $3.00 per total bill for crossover outpatient hospital claims. The provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost - sharing (copayment) amount imposed.

The copayment amount for an ESWL visit is $3.00 per visit.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, family planning, renal dialysis, chemotherapy, radiation therapy, physical therapy, and certified emergencies (excluding crossovers).

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-92.

19.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hospitals that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

All inpatient and outpatient claims must contain a valid physician's license number in field 82 of the UB-92 claim form.

Certified Emergency Outpatient Visits

Non-certified visits to the emergency room are limited to three per year. Section 19.2.5, Outpatient Hospital Services, states the visit must be certified as such in the medical record and signed by the attending physician at the time of the visit. Certified emergency claims are also exempt from requiring the Patient 1st referral. Only one emergency room visit per day per provider will be reimbursed by Medicaid. Refer to Chapter 5 (Filing Claims) for claim filing information.

Nonpatient Visits

Specimen and blood samples sent to the hospital for lab work are classified as "nonpatient" since the patient does not directly receive services. This service does not count against the outpatient visit limitations and should be billed as bill type 14X. Refer to Section 5.3, UB-92 Billing Instructions, for description of Type of Bill values.

Recipients with Medicare Part B (Medical Only)

If a Medicaid recipient is Medicare Part B/Medicaid eligible, lab and x-ray procedures are covered under Medicare Part B for eligible recipients. Charges that are covered by Medicare must be filed with Medicare, and Medicaid will process the claim as a crossover claim. The following revenue codes are normally covered for Part B reimbursement (bill type 121): 274,

300, 310, 320, 331, 340, 350, 400, 420, 430, 440, 460, 480, 540, 610, 636, 700, 730, 740, 770, 920, and 942.

Charges that are covered by Medicaid but not by Medicare should be filed directly to Medicaid for consideration. It is not necessary to indicate Medicare on the claim. Providers are not required to file claims with Medicare if the service is not a Medicare-covered service.

Split Billing for Inpatient Claims

Claims that span more than one calendar year must be split billed.

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

Claims that span a Medicaid per diem rate change must be split billed in order for the hospital to receive the correct reimbursement.

Claims that span a recipient's eligibility change must be split billed.

19.5.1 Time Limit for Filing Claims

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 through September 30 that are filed after the last day of February of the next year will be denied by EDS as exceeding the PHP filing limit. Hospitals must seek payment, if any, from PHPs. 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 through September 30 that are filed after the last day of February of the next year will be denied by EDS. Hospitals 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 through September 30 that are filed after the last day of February 28 of the next year with third party liability action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Hospitals must seek payment, if any, from PHPs. Recipients 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. Hospitals must seek payment, if any, from PHPs. Recipients may not be billed.

Medicaid requires all claims for out-of-state inpatient and outpatient services and psychiatric hospitals to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

19.5.2 Revenue Codes, Procedure Codes, and Modifiers

Revenue codes are used for both inpatient and outpatient services. Procedure codes must be used for outpatient services.

Refer to the Alabama UB-92 Billing Manual published by the Alabama Hospital Association for a complete listing of valid revenue codes.

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

This section covers revenue codes, procedure codes, and modifier information under the following topics:

- Emergency department
- Pharmacy
- Laboratory services
- Radiation therapy
- Respiratory services
- Occupational therapy
- Speech therapy
- Miscellaneous procedures
- Outpatient revenue codes
- Outpatient observation
- Esophagus
- Radiology
- Blood
- Physical therapy
- Orthotics
- ESWL

Outpatient Revenue Codes

Medicaid will accept all valid revenue and procedure codes on outpatient claims for dates of service 10/1/04 and after. Reimbursement methodology has not changed; therefore, detail lines with noncovered revenue and procedure codes will continue to deny.

Emergency Department

Emergency and/or outpatient hospital services performed on the day of admission (at the same hospital) must be included on the inpatient billing.

Hospital providers should use the following procedure codes when billing for emergency department services:

Hospitals are to utilize the definitions from the 'old Z codes' when billing for ER visits as described in the two tables below:

'Old Z Codes'	Description
Z5299	Brief – Emergency Department Includes use of facility, equipment, oral medications and incidental supplies, e.g., linens, tongue blades, and tissue.
Z5300	Limited – Emergency Department Includes use of facility, equipment, oral medications

'Old Z Codes'	Description
	and additional supplies, e.g., IV solutions, splints, dressing, sterile trays, etc.
Z5301	Critical Care – Emergency Department Includes use of facility, equipment, oral medication and additional supplies for the treatment of multiple injured, critically ill and/or comatose patients. This code should not be used unless critical care is rendered.

CPT Code	***Rev Code***	***Description***
99281 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A problem-focused history, • A problem-focused examination, and • Straightforward medical decision making
99282 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of low complexity
99283 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of moderate complexity
99284 (old code Z5300)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A detailed history, • A detailed examination, and • Medical decision making of moderate complexity
99285 (old code Z5301)	450	Emergency department visit for the evaluation and management of a patient that requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: • A comprehensive history, • A comprehensive examination, and • Medical decision making of high complexity

NOTE:

The above procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-92 claim form with revenue code 450. Revenue code 450 should not be billed for surgical procedures provided in the emergency room. In these instances the appropriate ER facility fee (99281-85) must be used. Surgical procedures may be billed only when an operating room has been opened for the surgery. Surgical codes must be billed with revenue code 360.

Outpatient Observation

Outpatient Observation is medically necessary extended outpatient care provided to a patient who presents to the emergency department and whose condition warrants more than the three hours of care already included in the emergency department procedure codes 99281-99285 This service is covered only when certified by the attending physician at the time of the service.

Outpatient observation is limited to 23 hours (the first three hours included in the ER facility fee plus up to 20 hours of the appropriate observation code).Observation (99218-99220) may be billed only in conjunction with procedure codes 99281-99285. It may not be billed in conjunction with outpatient surgery. If observation spans midnight, the date of admission should also be the date of discharge on the claim form even though the patient was actually discharged the following day.

Revenue Code	***Procedure Code***	***Description***
76X	99218	Each hour, 4th hour through 23rd hour (maximum units 20), low severity
76X	99219	Each hour, 4th hour through 23rd hour (maximum units 20), moderate severity
76X	99220	Each hour, 4th hour through 23rd hour (maximum units 20), high severity

Pharmacy

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H, Injectable Drug List, of this manual.

Esophagus

Use revenue code 309 with a valid procedure code for Esophagus - Acid reflux test.

Laboratory Services

Use revenue codes 300-310 with valid CPT codes for Laboratory services.

NOTE:

Services may be span billed if claim contains lab procedure codes. Refer to Section 5.3, UB-92 Billing Instructions, for information on span billing.

Radiology

Use revenue codes 320-331 with valid CPT codes for radiology.

Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

Blood Transfusions

Procedure code 36430 should be billed only once a day regardless of how many units were administered during that episode.

Revenue Code	*Procedure Code*	*Description*
39X	36430	Transfusion, blood or blood components

Respiratory Services

Revenue Code	*Procedure Code*	*Description*
412	94010	Spirometry, including graphic record, vital capacity, expiatory flow rate
412	94060	Bronchospasm evaluation
412	94150	Vital capacity total
412	94200	Maximum breathing capacity
412	94240	Functional residual capacity
412	94350	Pulmonary function test, lung volume
412	94360	Determination of resistance to airflow
412	94370	Determination of airway closing volume, (PFT S/B oxygen)
412	94375	Respiratory flow volume loop
412	94620	Pulmonary stress testing
412	94664	Aerosol or vapor inhalations for diagnosis
412	94665	Aerosol or vapor inhalations for sputums
412	94720	PFT - diffusion
412	94642	Aerosol inhalation of pentamidine for pneumocystis carinii (pneumonia treatment for Prophylaxis)
412	94650	Inhalation Services - Intermittent pressure breathing-treatment, air or oxygen, with or without medication
412	94680	Oxygen uptake
412	94770	Carbon Dioxide, expired gas determination
412	94772	Pediatric Pneumogram

Physical Therapy and Occupational Therapy

PT is covered for children and adults when provided in an outpatient setting. An EPSDT referral is NOT required for PT services provided in a hospital. OT is covered ONLY for EPSDT-referred recipients or for QMB recipients. Procedure codes listed below in **BOLD** print may be billed by PT or OT providers. Procedure codes marked with * must be billed in conjunction with therapeutic codes (97110-97542). Use revenue code 42X for PT claims and revenue code 43X for OT claims.

Procedure Code	*Physical Therapy*	*See Note*	*Max Units*	*Annual Limit*
97010	Application of a modality to one or more areas; hot or cold pack	1, 3	1	12
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
95832	Muscle, testing, manual, hand		1	12
95833	Total evaluation of body, excluding hands		1	12
95834	Total evaluation of body, including hands		1	12

Procedure Code	***Physical Therapy***	***See Note***	***Max Units***	***Annual Limit***
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	10
97001 97001-22	Physical therapy evaluation Physical therapy evaluation-Motorized Wheelchair Assessment		1 1	1 1
97002	Physical therapy re-evaluation		1	
97003 (OT only)	Occupational Therapy evaluation		1	1
97004 (OT only)	Occupational Therapy re-evaluation		1	1
97012*	Traction, mechanical*	1	1	12
97014*	Electrical stimulation, unattended*	1, 2	4	12
97016	Vasopnueumatic device*		1	12
97018*	Paraffin bath*	1, 3	1	24
97020*	Microwave*	3	1	24
97022	Whirlpool	3	1	24
97024*	Diathermy*	1	1	24
97026*	Infrared*	1	1	24
97028	Ultraviolet		1	24
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97033	Lontophoresis, each 15 minutes	3	4	96
97034	Contrast baths, each 15 minutes	3	4	96
97035	Ultrasound, each 15 minutes	3	4	96
97036	Hubbard tank, each 15 minutes	3	4	96
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4	96
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	Aquatic therapy with therapeutic exercises*		1	24
97116	Gait training (includes stair climbing)	4	1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	3	1	8
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	

Procedure Code	***Physical Therapy***	***See Note***	***Max Units***	***Annual Limit***
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97530	Therapeutic activities, direct pt contact by the provider, each 15 minutes	3	4	96
97532	Development of cognitive skills to improve attention, memory, problem solving, (included compensatory training), direct (one on one) patient contact by the provider, each 15 minutes	~~3-4~~	4	36
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	~~3-4~~	4	36
97535	Self-care/home management, each 15 minutes		4	36
97542	Wheelchair management/propulsion training, each 15 minutes	3	4	24
97597	Removal of devitalized tissue from wounds		1	104
97598	Removal of devitalized tissue from wounds		1	104
97750	Physical performance test or measurement, (for example, muscoloskeletal, functional capacity) with written report, each 15 minutes	3	4	12
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3-4	4	16
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	16
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	3	4	12

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient on the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for the procedure, not the maximum units allowed for both providers.
4. 97760 should not be reported with 97116 for the same extremity.

Orthotics

NOTE:

Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes.

Orthotics provided by hospitals is limited to the L codes listed on the Outpatient Fee Schedule found on the Medicaid website: www.medicaid.alabama.gov.

Speech Therapy

NOTE:

Speech Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 44X when billing speech therapy codes.

Hospitals may bill the following CPT codes for EPSDT referred speech therapy services.

92506-92508	92597

ESWL

Revenue Code	*Procedure Code*	*Description*
790	50590	Lithotripsy, Extracorporeal shock wave

19.5.3 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

19.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

19.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

19.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Outpatient Fee Schedule	www.medicaid.alabama.gov
Lab & Xray Fee Schedule	www.medicaid.alabama.gov

20

20 Independent Laboratory

Laboratory services are professional and technical laboratory services in one of the following four categories. Independent lab services are:

- Ordered, provided by, or under the direction of a provider within the scope of their practice as defined by state law
- Ordered by a physician but provided by a referral laboratory
- Provided in an office or similar facility other than a hospital outpatient department or clinic
- Provided by a laboratory that meets the requirements for participation in Medicare

The policy provisions for Independent Laboratory providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 9.

20.1 Enrollment

EDS enrolls Independent Laboratory providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an independent laboratory is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for laboratory-related claims.

NOTE:
All nine digits are required when filing a claim.

Independent laboratory providers are assigned a provider type of 09 (Independent Laboratory). The valid specialties for Independent Lab providers include the following:

- Independent Lab (69)
- Department of Public Health Lab (L3)

Enrollment Policy for Independent Laboratories

To participate in the Alabama Medicaid Program, Independent Laboratories must meet the following requirements:

- Possess certification as a Medicare provider
- Possess certification as a valid CLIA provider if a clinical lab
- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state

20.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

20.2.1 Covered Services

Medicaid reimburses Independent Labs for services described by procedures that fall between ranges 80049-89399 in the CPT manual. Medicaid also pays for procedures defined in the locally assigned Healthcare Common Procedural Coding System (HCPCS) to supplement the listing in the CPT manual.

Medicaid only pays Independent Lab providers for covered services which they are certified to perform and which they actually perform.

Independent Lab providers may only bill for routine venipuncture for collection of laboratory specimens when sending blood specimens to another site for analysis. Labs may not bill the collection fee if the lab work and specimen collection is performed at the same site. Labs may not bill the collection fee if they perform analysis in a lab owned, operated, or financially associated with the site in which the specimen was drawn.

20.2.2 Non-Covered Services

Medicaid does not pay packing and handling charges for referred laboratory services.

The referred laboratory receives payment for referred tests only at the normal rate. Medicaid shall monitor this policy through post-payment review.

20.2.3 Clinical Laboratory Improvement Amendments (CLIA)

All laboratory testing sites providing services to Medicaid recipients, either directly by provider, or through contract, must be CLIA certified to provide the level of complexity testing required. The Independent Lab must adhere to all CLIA regulations. As regulations change, Independent Labs must modify practices to comply with the changes. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

Laboratories which do not meet CLIA certification standards are not eligible to provide services to Medicaid recipients or to participate in Medicaid.

NOTE:

The Health Care Financing Administration (HCFA), now known as CMS, implemented the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective for dates of service on or after September 1, 1992. The CLIA regulations were published in the February 28, 1992 Federal Register. More detailed information regarding CLIA can be found at http://www.cms.hhs.gov/clia/

CLIA Certificates

CLIA certificates may limit the holder to performing only certain tests. Medicaid bills must accurately reflect those services authorized by the CLIA program and no other procedures. There are two types of certificates that limit holders to only certain test procedures:

- Waiver certificates – Level 2 certification
- Provider Performed Microscopy Procedure (PPMP) certificates – Level 4 certification

A complete listing of laboratory procedures limited to waived certificates (level 2 certification) and PPMP certificates (level 4 certification) may be accessed via the web at www.cms.hhs.gov/clia/.

20.3 Prior Authorization and Referral Requirements

Laboratory procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

20.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided for laboratory services.

20.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent Laboratory providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

20.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Laboratory providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

20.5.2 Diagnosis Codes

Claims for lab services must contain a valid diagnosis code. The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

20.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Medicaid denies claims without procedure codes or with codes that are invalid.

Medicaid also recognizes modifiers when applicable. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following sections describe procedure codes and modifiers that apply when filing claims for independent lab services.

Repeat Laboratory Procedures

Modifier '91' may be utilized to indicate that a laboratory test was performed multiple times on the same date of service for the same recipient. Modifier '91' may not be used when laboratory tests are rerun:

- To confirm initial results
- Due to testing problems encountered with specimens or equipment
- For any other reason when a normal, one-time, reportable result is all that is required.

Distinct Procedural Service

Modifier '59' (distinct procedural service) may be utilized to identify a distinct service. When laboratory services are performed, modifier '59' should be used to report procedures that are distinct or independent, such as performing the same procedure (which uses the same procedure code) for a different specimen. Modifier '59' should not be used when a more descriptive modifier is available.

Blood Specimens

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities.

A hospital lab may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. It is the responsibility of the referring lab (hospital) to make sure that the reference lab does not bill these services to Medicaid.

Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Laboratory Paneling and Unbundling

A *panel* is a group of tests performed together or in combination. Medicaid follows the CPT guidelines for panel tests.

The term "unbundling" refers to the practice of using more than one procedure code to bill for a procedure that can more appropriately be described using fewer codes. The use of unbundled codes results in denial of payment, with the exception of organ and disease panels.

All organ and disease oriented panels must include the tests listed with no substitutions. If only part of the tests included in a defined panel is performed, the panel code should not be reported. If additional tests to those indicated in a panel are performed, those tests should be reported separately in addition to the panel code. If two panels overlap, the physician or laboratory will be required to unbundle one of the panels and bill only for the tests that are not duplicative.

Urinalysis – Claims for the same recipient billed by the same provider that contain two or more of the following services (81000, 81001, 81002, 81003, 81005, 81007, 81015, and 81020) for the same date of service will be considered an unbundled service and will be denied.

During post-payment review, Medicaid may recoup payment from providers for claims submitted containing unbundling of laboratory services.

Modifiers

Modifier	***HCPCS-Modifier(s)***	***Description***	***Note***
26	26	Professional Component	Labs providing professional component services include modifier 26 with the procedure code on the claim
59	59	Distinct Procedural Service	To indicate a distinct procedure (using the same procedure code) performed on the same date of service.
77	77	Repeat Procedure by another physician	To indicate that a basic procedure performed by another physician had to be repeated
91	91	Repeat Clinical Diagnostic laboratory Test	To indicate a repeat clinical laboratory test performed on the same date of service for the same recipient.
TC	TC	Technical Component	

NOTE:

Claims submitted for a repeat of the same procedure on the same date of service without modifiers will be denied as duplicate services.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.
- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The professional component is billed by adding modifier 26 to the procedure code.

- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

20.5.4 Place of Service Codes

The only valid Place of Service Codes for Independent Laboratory providers is 81.

POS Code	*Description*
81	Independent Laboratory

20.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.9, Required Attachments, for more information on attachments.

20.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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21 Independent Certified Registered Nurse Practitioner (CRNP)

Independent certified registered nurse practitioners (CRNP) who are certified by the appropriate national organization as a family nurse practitioner, pediatric nurse practitioner, or neonatal nurse practitioner may participate in the Alabama Medicaid Program.

The policy provisions for nurse practitioners can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 49.

21.1 Enrollment

EDS enrolls nurse practitioners and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

A CRNP may not enroll with Medicaid if he or she is employed and reimbursed by a facility, such as a hospital or rural health clinic, that receives reimbursement from the Alabama Medicaid Program for services provided by the nurse practitioner. In this case, the CRNP services are already being paid through that facility's cost report.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Independent CRNP is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for CRNP-related claims.

NOTE:

All nine digits are required when filing a claim.

Independent CRNPs are assigned a provider type of 58 (Independent Nurse Practitioner). Valid specialties for Independent CRNPs include the following:

- EPSDT Screening (E3)
- Family Practice (08)
- Neonatology (NI)
- Nurse Practitioner (N3)
- Pediatrics (37)

Enrollment Policy for Independent CRNP Providers

To participate in the Alabama Medicaid Program, nurse practitioners must meet the following requirements:

- Proof of current Alabama registered nurse licensure card
- Copy of current certification as a certified registered nurse practitioner in the appropriate area of practice (family, pediatric or neonatal) from a national certifying agency recognized by Medicaid

21.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Independent CRNPs may only bill and be directly reimbursed for those services that are listed in this manual.

For services performed by a CRNP to be covered, a CRNP must be under the supervision of a licensed, active Medicaid physician.

NOTE:

Payment will be made only for injectable drugs, select CPT codes identified in Appendix O, and all CLIA-certified laboratory services. EPSDT services will be covered only if the CRNP is enrolled in the EPSDT program.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP can not make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. CRNP and PA services have been expanded. Please refer to Chapter 28, Physician, and Appendix O for additional information.

21.3 Prior Authorization and Referral Requirements

CRNP procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

Some procedure codes are limited as EPSDT-referred services only. Those services require an EPSDT referral form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program. Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form (form 362).

21.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

21.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Nurse practitioners who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

21.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent CRNPs to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

21.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

21.5.3 Procedure Codes and Modifiers

CRNP services are **limited** to the CPT codes found in Appendix O, CRNP and PA Services, injectable drug codes found in Appendix H, Alabama Medicaid Physician Drug Listing, and all laboratory services, which are CLIA certified.

Refer to Appendix A, EPSDT, for procedure codes for Vaccines for Children (VFC). The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

21.5.4 Place of Service Codes

The following place of service codes apply when filing claims for CRNP services:

POS Code	*Description*
11	Office
12	Home
22	Outpatient Hospital
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic

21.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

21.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

22

22 Independent Radiology

The policy provisions for radiology providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 34.

22.1 Enrollment

EDS enrolls Independent Radiology providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Independent Radiology provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for radiology-related claims.

NOTE:

All nine digits are required when filing a claim.

Independent Radiology providers are assigned a provider type of 10 (Independent Radiology). Valid specialties for Independent Radiology providers include the following:

- Mammography (M7)
- Nuclear Medicine (36)
- Physiological Lab (Independent Diagnostic Testing Facility) (66)
- Portable X Ray Equipment (63)
- Radiology (30)

Enrollment Policy for Independent Radiology Providers

To participate in Medicaid, Independent Radiology providers must meet the following requirements:

- Possess certification as a Medicare provider
- Possess a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies if a physiological labs
- Exist independently of any hospital, clinic, or physician's office

- Possess licensure in the state where located, when it is required by that state
- For mammography services, possess a certification issued by the FDA.

22.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Radiology services are professional and technical radiological services, ordered and provided under the direction of a physician or other licensed practitioner of the healing arts. Within the scope of his practice as defined by state law and are provided in an office or similar facility other than an outpatient department of a hospital or clinic and meets the requirements for participation in Medicare. Radiology services are restricted to those that are described by procedures in the CPT manual. Providers will be paid only for covered services, which they actually perform.

An Independent Radiology provider may perform diagnostic mammography, a radiological procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. A diagnostic mammogram includes a physician's interpretation of the results of the procedure. Services are unlimited, but should be billed with procedure codes 77055 and 77056.

An Independent Radiology provider may perform screening mammography, a radiological procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. A screening mammogram includes a physician's interpretation of the results of the procedure. Services are limited to one screening mammogram every 12 months for women ages 50 through 64. This screening should be billed under procedure codes 77052 and 77057.

An Independent Radiology provider may bill for obstetrical ultrasounds. Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient's documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- EDS-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

22.3 Prior Authorization and Referral Requirements

Radiology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to chapter 4, Obtaining Prior Authorization, for general guidelines.

Services performed by an independent radiologist for those recipients enrolled in the Patient 1st Program **do not require a referral** from the Primary Medical Provider (PMP).

Procedure codes performed as a result of an EPSDT screening require an EPSDT screening referral form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program.

22.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Independent Radiology providers.

22.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Radiology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

22.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Radiology providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

22.5.2 Diagnosis Codes

For dates of service 01/01/99 and after, valid diagnosis codes **are required**. The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P. O. Box 10950, Chicago, IL 60610.

For dates of service prior to 01/01/99, Independent Radiology providers are not required to provide valid diagnosis codes. Providers must bill diagnosis code V729 on hard copy and electronically submitted claims.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

22.5.3 Procedure Codes and Modifiers

Radiology providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Radiology Facilities are limited to billing CPT radiology procedure codes. The range of codes is 70010 through 79999. Physiological labs are **restricted** to the codes listed in their contract with Medicaid.

The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.
- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient)
  - 22 (outpatient)
  - 23 (emergency room - hospital)
  - 24 (ambulatory surgical center)
  - 32 (nursing facility)
  - 51 (inpatient psychiatric facility)

- 61 (comprehensive inpatient rehab facility)
- 62 (comprehensive outpatient rehab facility)
- 65 (end stage renal disease facility)

- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

22.5.4 Place of Service Codes

The following place of service code applies when filing claims for radiology services:

POS Code	*Description*
11	Clinic

22.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

22.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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23 Licensed Social Workers

Medicaid enrolls Licensed Social Workers but limits services to those provided to Medicare QMB recipients. Medicaid reimburses only as a crossover claim.

23.1 Enrollment

EDS enrolls Licensed Social Workers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Licensed Social Worker is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for social work-related claims.

NOTE:
All nine digits are required when filing a claim.

Licensed Social Workers are assigned a provider type of 41 (Crossovers Only). The valid specialty for Licensed Social Workers is Medicare/Medicaid Crossover Only (M4).

Enrollment Policy for Licensed Social Workers

To participate in the Alabama Medicaid Program, Licensed Social Workers must meet the following requirements:

- Possess certification as a Medicare provider
- Submit a copy of current certification as a licensed social worker from the Board of Social Work Examiners

23.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Licensed Social Workers are limited to crossover claims for those services to QMB recipients only.

23.3 Prior Authorization and Referral Requirements

Prior Authorization and referral requirements do not apply to Licensed Social Workers because all services are limited to Medicare crossover claims.

23.4 Cost Sharing (Copayment)

Copayment does not apply to Licensed Social Workers.

23.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Licensed Social Workers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a Medical Medicaid/Medicare-related Claim Form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

23.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Licensed Social Workers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

23.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

23.5.3 Procedure Codes and Modifiers

When filing Medicare/Medicaid crossovers, be sure to use the same procedure codes and modifiers as filed to Medicare. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

23.5.4 Place of Service Codes

When filing Medicare/Medicaid crossovers, be sure to use the same place of service code as filed to Medicare.

23.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

23.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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24 Maternity Care Program

The Alabama Medicaid Maternity Care Program allows Medicaid to establish locally coordinated systems of care, in which targeted populations receive maternity care in environments that emphasize quality, access, and cost-effective care.

The purpose of this managed care effort is to ensure that every Medicaid eligible pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health.

In most cases the Primary Contractor develops subcontracts with other providers capable of providing the requisite services. The responsibility remains with the Primary Contractor to assure qualitative and quantitative adequacy of the service.

Policy provisions for Maternity Care are found in the *Maternity Care Operational Manual* published by the Alabama Medicaid Agency and in the *Alabama Medicaid Agency Administrative Code,* Chapter 45. Both of these documents are available on the Medicaid web page.

24.1 Enrollment

The Alabama Medicaid Agency selects Primary Contractors for the Maternity Care Program through a competitive State bid process. Contractors must meet the licensure certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Provider Number, Type, and Specialty

Primary Contractors are enrolled by Medicaid's Medical Services Division as maternity care providers and issued a nine-digit Alabama Medicaid provider number that enables them to submit requests and receive reimbursements for maternity care services.

NOTE:

All nine digits are required when filing a claim.

Maternity care providers are assigned a provider type of Maternity Care (87). The valid specialty for maternity care providers is Maternity Care Program (M6).

Districts

Medicaid has established fourteen maternity care districts. Potential Primary Contractors must show that a care system operates in the entire district. Contractors are required to provide maternity care services to most women eligible for maternity care in the specified district.

Providers should advise recipients that if they intentionally go outside of the provider network for non-emergency care, the recipient must pay the bill if they do not get approval from the Primary Contractor.

District	***Counties***
District 1	Colbert, Franklin, Lauderdale, Marion
District 2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
District 3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
District 4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
District 5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
District 6	Clay, Coosa, Randolph, Talladega, Tallapoosa
District 7	Greene, Hale
District 8	Choctaw, Marengo, Sumter
District 9	Dallas, Wilcox, Perry
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
District 11	Barbour, Chambers, Lee, Macon, Russell
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
District 13	Coffee, Dale, Geneva, Henry, Houston
District 14	Mobile

District	***Primary Contractor***	***Phone Number For Recipients***	***Phone Number For Providers***	***1-800 Phone Number***	***Start Date***
District 1	HealthGroup of Alabama	(256) 265-7155	(256) 265-7458 Laura Thompson	1 (888) 500-7343	08/01/05
District 2	HealthGroup of Alabama	(256) 265-7155	(256) 265-7458 Laura Thompson	1 (888) 500-7343	08/01/05
District 3	Viva Health Administration LLC	(205) 558-7405 or 1(877) 997-8377	(205) 558-7439 Lisa Barger	1 (877) 997-8377	08/01/05
District 4	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 533-4485	08/01/05
District 5	Alabama Maternity, Inc. (VIVA Health)	(205) 558-7405	(205) 558-7439 Lisa Barger	1 (877) 997-8377	08/01/05
District 6	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1 (877) 826-2229	08/01/05
District 7	Tombigbee Healthcare Authority LLC	(334) 287-2673	(334) 287-2579 Marcia Lankster	1 (888) 531-6262	08/01/05
District 8	Tombigbee Healthcare Authority LLC	(334) 287-2673	(334) 287-2579 Marcia Lankster	1 (888) 531-6262	08/01/05
District 9	Viva Health Administration LLC	(205) 558-7405 or 1(877) 997-8377	(205) 558-7439 Lisa Barger	1 (877) 997-8377	08/01/05
District 10	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1 (877) 826-2229	08/01/05
District 11	Maternity Services of District 11	(334) 291-5300	(334) 291-5324 Donna Guinn-Taylor	1 (877) 503-2259	08/01/05

District	Primary Contractor	Phone Number For Recipients	Phone Number For Providers	1-800 Phone Number	Start Date
District 12	Southwest Alabama Maternity Care Program	(334) 743-7498	(251) 575-7062 Jeanette Gibson	1 (877) 826-2229	08/01/05
District 13	Southeast Alabama Maternity Care Program	(334) 712-3784	(334) 712-3784 Gary Bennett	1 (800) 735-4998	08/01/05
District 14	USA Medical Center	(251) 415-8585	(251) 415-8585 Susan Eschete	n/a	08/01/05

24.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

24.2.1 Eligibility

The following recipients are required to participate in the Maternity Care Program:

- Those certified through the SOBRA Program
- Those certified through the Medicaid for Low Income Families (MLIF) Program (formerly AFDC)
- Refugees
- SSI eligible women

The following recipients are not required to participate and should not be enrolled:

- Dual eligibles (Medicare/Medicaid)
- Illegal Immigrants

Recipients are notified at the time of application of the requirement to participate in the program.

24.2.2 Covered Services

The Primary Contractor is responsible for all pregnancy-related care including high-risk care from the 1st of the month in which the woman is certified until the end of the month in which the 60th postpartum day falls. This section contains information about the following services covered under the global fee:

- Antepartum care
- Outpatient care (except for services received in an emergency room)
- Delivery
- Hospitalization (except in instances where the recipient exceeds in-patient days)
- Postpartum care
- Care coordination services

- Assistant Surgeon Fees
- Associated services
- Anesthesia services
- Home visits
- Ultrasounds

Antepartum Care

Antepartum care includes the following usual prenatal services:

- Initial visit at the time pregnancy is diagnosed
- Initial and subsequent histories
- Maternity counseling
- Risk assessments
- Physical exams
- Recording of weight
- Blood pressure recordings
- Fetal heart tones
- Lab work appropriate to the level of care including hematocrit and chemical urinalysis

Delivery

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee **may not** be billed for a multiple birth delivery. Delivery includes, but is not limited to, hospitalization, and professional services, such as anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number. Please refer to Chapter 28 for charges that are billable fee-for-service by physicians

Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations, as defined in the *Maternity Care Operational Manual*, that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-92), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during hospitalization

NOTE:

Sterilization procedures performed during delivery stays are included as covered services under the global fee and may not be billed separately by the hospital. Physician sterilization charges may be billed fee-for-service.

Outpatient

Outpatient includes any pregnancy-related outpatient services.

Postpartum Care

Postpartum care includes office visits, home visits, and in-hospital visits following delivery for routine care through the end of the month of the 60-day postpartum period. The postpartum exam should be accomplished four to eight weeks after delivery.

Care Coordination Services

The care coordinator arranges a coordinated system of obstetrical care for pregnant women. Refer to the *Maternity Care Operational Manual* for specifics on care coordination services requirements.

Assistant Surgeon Fees

The global rate includes assistant surgeon fees for cesarean (c-section) deliveries.

Associated Services

The global fee includes all services associated with treatment of the pregnancy during the antepartum and postpartum period including, but not limited to colposcopy, EKGs, cerclages, and medical services performed in an outpatient setting (except lab and radiology procedures other than ultrasounds). Refer to table on 25.5.4 for details.

Anesthesia Services

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

Home Visits

Postpartum Home visits are not skilled care nursing visits. Maternity Care Program home visits are for evaluation, assessment and referral and are accomplished by social workers or nurses. These visits are performed in accordance with the priority criteria provided in *the Maternity Care Operational Manual*.

Ultrasounds

Medicaid pays for obstetrical ultrasounds for reasons of medical necessity. Ultrasound payment is limited to one per day. Payment will **not** be made to determine only the sex of the infant.

Primary Contractors in each district are financially responsible for the first seven ultrasounds for reasons of medical necessity for each pregnancy. It is the Primary Contractor's responsibility to maintain a record of the dates of all ultrasounds for each pregnancy. Medicaid's Prior Authorization Unit (PA) has the ability to authorize additional ultrasounds (number 8 and above) based on the recipients medical condition. The ultrasounds approved for payment by the PA Unit will be paid fee-for-service by Medicaid.

The following required information shall accompany all ultrasound requests for authorization:

- Date of the requested ultrasound
- Date of the request
- A list of **all dates of prior ultrasounds** for the current pregnancy
- Recipient's date of birth and Medicaid number
- EDC-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

PA requests shall be submitted to EDS following normal PA procedures.

Separately Billable Services

Services provided outside the scope of the global fee that may be billed separately are listed below:

Separately Billable Service	***Description***
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron).
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests.
Dental	Dental services are covered for recipients under 21 years of age. For SOBRA-eligible recipients, services must be pregnancy-related.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, standby and infant resuscitation may be billed under the mother's name and number on a fee-for-service basis.

Separately Billable Service	***Description***
Family Planning Services	Any claim with a family planning procedure code or indicator, with the exception of hospital claims for sterilization procedures performed during the delivery stay may be billed on a fee-for-service basis.
Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the global fee. Access to emergency services will not be restricted by the Maternity Care Program.
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.
Fees for Dropouts	All services provided to dropouts should be billed fee-for-service. However, the provider of service must submit the claims to the Primary Contractor for Administrative Review. Appropriate claims will then be referred to Medicaid by the Primary Contractor.
Mental Health	Mental health visits for the purpose of outpatient mental health services may be billed on a fee-for-service basis.
Miscarriages less than 21 weeks	All services may be billed fee-for-service. If the claim does not contain the miscarriage diagnosis code, it must be sent to the Primary-Contractor, who must submit an Administrative Review Form to the Alabama Medicaid Agency prior to the services being billed fee-for-service.
Referral to Specialists	Services provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner or perinatologist is not considered a specialty provider.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service. The Primary contractor must submit an Administrative Review Form to the Alabama Medicaid Agency and get approval for the exemption prior to the claims being billed.
Non-Pregnancy Related Care	Services provided that are not pregnancy-related are the responsibility of the beneficiary unless she is eligible under regular Medicaid benefits.

24.3 Prior Authorization and Referral Requirements

Prior authorization is required for SOBRA recipients that receive eight ultrasounds and above. Prior authorization is required for fee-for-service recipients receiving ultrasound number three and above. Referrals to specialty providers for a pregnancy related care (i.e., Cardiology, Endocrinology, etc.) are paid fee-for-service, if the condition is pregnancy related for the SOBRA recipients and are billable fee-for-service for any medical condition covered by Medicaid for full-Medicaid recipients.

24.4 Cost Sharing (Copayment)

Copayment does not apply to services provided for pregnant women.

24.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Primary Contractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

24.5.1 Time Limit for Filing Claims

Medicaid requires all claims from Primary Contractors to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

24.5.2 Diagnosis Codes

Primary Contractors are to bill all claims to EDS utilizing the appropriate CPT code. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services**.

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

24.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Claims for maternity care services are limited to the following five procedure codes and modifiers:

Code	*Modifier*	*Description*
59400		Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy or forceps) and postpartum care.
59410		Vaginal delivery and postpartum care only.

Code	Modifier	Description
59510		Routine obstetric care including antepartum care, cesarean delivery and postpartum care.
59515		Cesarean delivery and postpartum care only
99199		Maternity Care Drop-Out Fee. Patient must have enrolled with their district of residence Primary Contractor prior to delivery.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full. Recipients may not be billed for any services **covered** under this program. Delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full for all services provided from the time of delivery through the postpartum period. Recipients may be billed for services provided prior to the time of delivery.

For recipients who receive total care through the Primary Contractor network, a global fee should be billed.

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period.

24.5.4 Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	Description
99212-HD	Prenatal Visit
59430	Postpartum Care
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00850	To report use 01961
00587	To report use 01968
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium)
00942	Anesthesia for colpotomy, vaginectomy, colporrhaphy, and open urethral procedures)
00948	Anesthesia for cervical cerclage)
00950	Anesthesia for culdoscopy)
00952	Anesthesia for hysteroscopy and/or hysterosalpingography)
00955	To report use 01967
01960	Anesthesia for; vaginal delivery only
01961	Anesthesia for; cesarean delivery only
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for c-section delivery following neuraxial labor . . .
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
49020	Drainage of peritoneal abscess or localized peritonitis
49060	Drainage of retroperitoneal abscess; open
49320	Laparoscopy

Procedure Code	Description
49322	Laparoscopy with aspiration of cavity or cyst (e.g., ovarian cyst) (single or multiple)
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56441	Lysis of labial adhesions
56820	Coloscopy of the vulva
56821	Coloscopy of the vulva with biopsy
57000	Colpotomy; with exploration
57010	Colpotomy
57020	Colpocentesis (separate procedure)
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57150	Irrigation of vagina and/or application of medicament
57400	Dilation of vagina under anesthesia
57410	Pelvic examination under anesthesia
57415	Removal of impacted vaginal foreign body (separate procedure) under anesthesia
57460	Colposcopy of the cervix including upper/adjacent vagina
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
59000	Amniocentesis, any method
59001	Therapeutic amniotic fluid reduction
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling any method
59020	Fetal contraction stress test
59025	Fetal non-stress test
59030	Fetal scalp blood sampling
59050	Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; interpretation only
59051	Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; supervision and interpretation
59160	Curettage, postpartum
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin)
59300	Episiotomy or vaginal repair by other than attending physician
59320	Cerclage of cervix, during pregnancy
59325	Cerclage of cervix, during pregnancy; abdominal
59350	Hysterorrhaphy of ruptured uterus
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only (4 to 6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean

Procedure Code	Description
	delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only , following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
59871	Removal of cerclage suture under anesthesia
59898	Unlisted laparoscopy procedure, maternity care and delivery
76801	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76802	Ultrasound, pregnant uterus, real time image documentation, with fetal and maternal evaluation
76805	Ultrasound, pregnant uterus, B-scan and/or real time with imagine documentation; complete
76810	Ultrasound, complete, multiple gestation, after the first trimester
76811	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76812	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76813	Ultrasound pregnant uterus, real time with image documentation, 1st trimester
76814	Ultrasound for each additional gestation use in conjunction with 76813
76815	Ultrasound, limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76816	Ultrasound, follow-up or repeat
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile
76819	Fetal biophysical profile; without non-stress testing
76825	Echocardiography, fetal
76826	Echocardiography, fetal, follow-up or repeat study
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal, follow-up or repeat study
81000	Urinalysis, by dipstick or tablet reagent
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dip stick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test

Procedure Code	Description
81099	Unlisted urinalysis procedure
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, glycated
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
99050	Services requested after office hours in addition to basic
99052	Services requested between 10:00 PM and 8:00 AM
99054	Services requested on Sundays and holidays in addition
99058	Office services provided on an emergency basis
99201	Office or other outpatient visit for E&M
99202	Office or other outpatient visit for E&M
99203	Office or other outpatient visit for E&M
99204	Office or other outpatient visit for E&M
99205	Office or other outpatient visit for E&M
99211	Office or other outpatient visit for E&M
99212	Office or other outpatient visit for E&M
99213	Office or other outpatient visit for E&M
99214	Office or other outpatient visit for E&M
99215	Office or other outpatient visit for E&M
99217	Observation care discharge day management
99218	Initial observation care, per day, for E&M
99219	Initial observation care, per day, for E&M
99220	Initial observation care, per day, for E&M
99221	Initial hospital care, per day, for E&M
99222	Initial hospital care, per day, for E&M
99223	Initial hospital care, per day, for E&M
99231	Subsequent hospital care, per day, for E&M
99232	Subsequent hospital care, per day, for E&M
99233	Subsequent hospital care, per day, for E&M
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99241	Office consultation for a new or established patient
99242	Office consultation for a new or established patient
99243	Office consultation for a new or established patient
99244	Office consultation for a new or established patient
99245	Office consultation for a new or established patient
99251	Initial inpatient consultation for a new or established patient
99252	Initial inpatient consultation for a new or established patient
99253	Initial inpatient consultation for a new or established patient
99254	Initial inpatient consultation for a new or established patient
99255	Initial inpatient consultation for a new or established patient
99261	Follow-up inpatient consultation for an established patient

Procedure Code	Description
99262	Follow-up inpatient consultation for an established patient
99263	Follow-up inpatient consultation for an established patient
99271	Confirmatory consultation for a new or established patient
99272	Confirmatory consultation for a new or established patient
99273	Confirmatory consultation for a new or established patient
99274	Confirmatory consultation for a patient
99275	Confirmatory consultation for a patient
99354	Prolonged physician service in the office or other outpatient setting; first hour
99355	Prolonged physician service in the office or other outpatient setting; each additional 30 minutes
99356	Prolonged physician service in the inpatient setting; first hour
99357	Prolonged physician service in the inpatient setting; each additional 30 minutes

NOTE:

The global fee includes the associated codes and the maternity care codes.

24.5.5 Place of Service Codes

The following place of service code applies when filing claims for maternity care services:

POS Code	*Description*
21	Inpatient Hospital

24.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

24.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
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25 Nurse Midwife

Nurse Midwives manage the care for normal healthy women and their babies in the areas of prenatal; labor and delivery; postpartum care; well-woman gynecology, including family planning services; and normal newborn care.

The practice of Nurse Midwifery must be performed under appropriate physician supervision.

The policy provisions for nurse midwife providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 21.

25.1 Enrollment

EDS enrolls nurse midwives and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a nurse midwife is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for claims related to nurse midwifery.

NOTE:
All nine digits are required when filing a claim.

Nurse Midwives are assigned a provider type of 99 (Other). The valid specialty for nurse midwives is Nurse Midwife (N2).

Enrollment Policy for Nurse Midwives

Providers in this program must possess a license as a Registered Nurse and also a license as a Certified Nurse Midwife.

Nurse midwives must submit the following documents for participation in Medicaid:

- Copy of the current licensure or licensure renewal card
- Copy of the American College of Nurse-Midwife certificate
- Copy of the current enrollment in the American College of Nurse Midwives

- Continuing Competency Assessment Program
- Copy of the Certified Nurse Midwifery Protocol signed by your collaborating physician
- Letter from the hospital granting admitting privileges for deliveries

If the application is approved, Medicaid offers the applicant a one-year renewable contract.

25.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. The following policy refers to maternity care billed as fee for service and not as a part of the Maternity Care Program. Refer to Chapter 24, Maternity Care, for more details.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for nurse midwife providers.

The services provided by nurse midwives must be within the scope of practice authorized by state law and regulations. Alabama law provides rules under which properly trained nurses can be licensed to practice Nurse Midwifery. Federal law requires that Medicaid include the services of nurse midwives.

A hospital-based nurse midwife who is employed with and paid by a hospital may not bill Medicaid for services performed at the hospital and for which the hospital is reimbursed.

To prevent double payment, a nurse midwife who has a Medicaid provider number should inform Medicaid of the name of the hospital(s) with whom employed, regardless of regularity and frequency.

A nurse midwife who is not employed with and paid by a hospital may bill Medicaid using a CMS-1500 claim form.

25.2.1 Covered Services

The maternity services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a nurse midwife provides total obstetrical care, the claim form should reflect the procedure code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery.

When a nurse midwife provides eight or more prenatal visits, performs the delivery, and provides postpartum care, the midwife uses a "global" obstetrical code in billing the services. If a nurse midwife submits a "global" code for maternity services, the visits covered by this code are not counted against the recipient's limit of physician office visits per calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time that she is eligible are covered.

Antepartum Care

Antepartum care includes all usual prenatal services, such as the initial office visit when the pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, and maternity counseling. Additional claims for routine services should not be filed. Antepartum care also includes routine lab work (such as hemoglobin, hematocrit, and chemical urinalysis). Additional claims for routine lab work should not be filed.

In order to bill for Antepartum Care Only services, nurse midwife providers must use the appropriate procedure codes when billing for the services (i.e., CPT code 59425 for four to six visits or CPT code 59426 for seven or more visits). Antepartum Care Only services filed in this manner do not count against the recipient's annual office visit benefit limits.

Nurse midwives who provide fewer than four visits for antepartum care must use office visit procedure codes when billing for the services. The office visit procedure codes count against the recipient's annual benefit limits for office visits.

Delivery

Delivery includes vaginal delivery (with or without episiotomy) and postpartum care or Vaginal Delivery Only services. The nurse midwife will use the appropriate CPT code when billing delivery services. Do not bill more than one delivery fee for a multiple birth (i.e., twins, triplets). Delivery fees include all professional services related to the hospitalization and delivery services provided by the nurse midwife. Additional claims for the nurse midwife's services in the hospital (e.g., admission) may not be filed.

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

Postpartum Care

Postpartum care includes office visits following vaginal delivery for routine postpartum care within 60 days after delivery. Additional claims for routine visits during this time should not be filed. Family planning services preformed by the delivering provider on the day of the postpartum exam or within five days of the postpartum exam are noncovered as they are included in the postpartum exam. The only exception to this is Extended Contraceptive Counseling visits, which are performed at the same time as the postpartum exam.

If the provider does not perform the delivery but does provide the postpartum care, family planning services rendered within five days of the postpartum exam are noncovered, as they are included in the postpartum exam.

Family Planning

Family planning services include services that prevent or delay pregnancy. Such services include office visits for evaluation and management of contraceptive issues, including procedures and supplies as appropriate for effective birth control. Nurse midwives are not authorized to perform sterilization procedures. Other surgical procedures such as diaphragm fittings,

IUD insertions or removals, and contraceptive implant procedures, are covered when provided according to state laws and regulations.

The nurse midwife may be reimbursed for well-woman gynecological services including the evaluation and management of common medical or gynecological problems such as menstrual problems, Pap smear screenings, menopausal and hormonal treatments, treatment of sexually transmitted diseases, and treatment of minor illnesses (e.g., a minor pelvic inflammatory disease).

25.2.2 Required Written Records

When a patient is accepted for maternity services, the midwife's care must include plans to accomplish the delivery in a licensed hospital. In an emergency, delivery may be accomplished elsewhere. The plans need not be submitted to Medicaid, but the midwife's file should contain written evidence that such plans exist for each patient accepted for global care.

All nurse midwife services must be rendered under appropriate physician supervision. The physician may not bill for these supervisory services. Midwives' written records should include records naming the supervisory physician(s) and stating the working arrangement. The statement of the working arrangement need not be a formal contract, but it must contain the signature of both parties and must show the date on which it was signed.

Nurse midwives must maintain a complete medical record for each recipient for whom the nurse midwife provides services.

25.2.3 Payment to Physicians

The supervising physician may not bill for supervisory services. The physician may bill Medicaid, however, if it becomes necessary for the physician to perform the delivery or complete a delivery service for the nurse midwife. When the physician bills the delivery-only service, the midwife may bill antepartum care, postpartum care, or both, depending on which service(s) the nurse midwife performed. If the physician bills for delivery only, including postpartum care, the nurse midwife may bill only for the antepartum care provided.

Medicaid covers sterilization at the time of delivery only if the physician performs the procedure, and only if all other Medicaid requirements for sterilization are met. Refer to Chapter 28, Physician, for sterilization requirements.

25.3 Prior Authorization and Referral Requirements

Nurse midwife procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

25.4 Cost Sharing (Copayment)

The copayment does not apply to antepartum care, delivery, and postpartum care and family planning provided by nurse midwives. Copayment is required for well-woman gynecological services except for those recipients under the age of 18.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

25.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Nurse midwives providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

25.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

25.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

Family Planning diagnosis codes are in the V25 category and maternity care diagnosis codes are in the 600 category of the ICD-9-CM.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

25.5.3 Procedure Codes and Modifiers

Nurse midwife providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Nurse midwives may submit claims and receive reimbursements for Family Planning services, excluding sterilization procedures. See Appendix C, Family Planning, for these procedure codes. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Maternity Care

Code	*Procedure Description*
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps), and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery only (with or without episiotomy, and/or forceps), including postpartum
59414	Delivery of placenta following delivery of infant outside of hospital
59425*	Antepartum care only (4-6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
54150	Circumcision

NOTE:

* For three or fewer visits, use office visit codes: 99201-99233

GYN Services

Nurse midwives may bill office procedure codes 99201-99233.

25.5.4 Place of Service Codes

The following place of service codes apply when filing claims for nurse midwife services:

POS	*Description*
21	Inpatient Hospital
11	Physician's Office
12	Patient's Home
22	Outpatient
23	ER-Hospital
25	Birthing Center

25.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

25.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
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26 Nursing Facility

Medicaid reimburses medically necessary nursing facility services. Nursing facilities must meet the licensure requirements of the Alabama Department of Public Health and the certification requirements of Title XIX and XVIII of the Social Security Act, and must comply with all applicable state and federal laws and regulations.

A nursing facility is an institution that primarily provides one of the following:

- Nursing care and related services for residents who require medical or nursing care
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons
- Health care and services to individuals who require a level of care available only through institutional facilities

A facility may not include any institution for the care and treatment of mental disease except for services furnished to individuals age 65 and over or any institutions for the mentally retarded or persons with related conditions.

The policy provisions for nursing facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10, and Part 483 of the Code of Federal Regulations.

26.1 Enrollment

EDS enrolls nursing facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a nursing facility is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for nursing facility-related claims.

NOTE:

All eight characters are required when filing a claim.

Nursing facility providers are assigned a provider type of 11 (Nursing Facility). The valid specialty for nursing facility providers is Nursing Facility (S5).

Enrollment Policy for Nursing Facility Providers

To participate in the Alabama Medicaid Program, nursing facility providers must meet the following requirements:

- Possess certification for Medicare Title XVIII
- Submit a budget to the Provider Reimbursement Section at Medicaid for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Resident Agreement with Medicaid

The Provider Agreement details the requirements imposed on each party to the agreement. It is also the document that requires the execution of the Nursing Facility/Resident Agreement.

The Nursing Facility/Resident Agreement must be executed for each resident on admission and annually thereafter. If the liability amount changes for the resident or if there are policy changes, the agreement must be signed and dated as these changes occur. One copy of the agreement is given to the resident/personal representative and a copy is retained by the nursing facility. The completed Nursing Facility/Resident Agreement becomes an audit item by Medicaid.

EDS is responsible for enrolling all nursing facility providers including any Medicare certified nursing facilities who wish to enroll as a QMB Medicare only provider.

Renewal Process for Nursing Facilities

The Alabama Department of Public Health conducts annual recertification of all nursing facility providers and provides the recertification information to Medicaid.

26.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Nursing facilities must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and the Disabilities Act of 1990.

Nursing facilities must maintain identical policies and practices regarding transfer, discharge, and covered services for all residents regardless of source of payment.

Nursing facilities must have all beds in operation certified for Medicaid participation.

Nursing facilities must not require a third party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nursing facilities may require an individual who has legal access to a resident's income or available resources to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Covered Services

The following services are included in basic covered nursing facility charges:

- All nursing services to meet the total needs of the resident, including treatment and administration of medications ordered by the physician
- Personal services and supplies for the comfort and cleanliness of the resident. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance such as hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, basic personal laundry and incontinence care.
- Room (semiprivate or ward accommodations) and board, including special diets and tube feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.
- All services and supplies for incontinent residents, including diapers and linen savers
- Bed and bath linens
- Nursing and treatment supplies as ordered by the resident’s physician as required, including needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W)
- Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents
- Materials for prevention and treatment of bed sores
- Medically necessary over-the-counter (non-legend) drug products when ordered by a physician. Generic brands are required unless brand name is specified in writing by the physician
- OTC drugs are covered under the nursing facility per diem rate with the exception of insulin covered under the Pharmacy program

Non-covered Services

Special (non-covered) services, drugs, or supplies not ordinarily included in basic nursing facility charges may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between the resident, or their personal representative and the nursing facility

- Prosthetic devices, splints, crutches, and traction apparatus for individual residents

If payment is not made by Medicare or Medicaid, the facility must inform the resident/personal representative that there will be a charge, and the amount of the charge. Listed below are general categories and examples of items:

- Telephone;
- Television/radio for personal use;
- Personal comfort items, including smoking materials, notions and novelties, and confections;
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- Personal clothing;
- Personal reading matter;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and entertainment offered outside the scope of the required activities program;
- Noncovered special care services such as privately hired nurses or aides;
- Private room, except when therapeutically required (for example: isolation for infection control);
- Specially prepared or alternative foods request instead of the food generally prepared by the facility;
- Beauty and barber services provided by professional barbers and beauticians;
- Services of licensed professional physical therapist;
- Routine dental services and supplies;
- Tanks of oxygen.

Medicaid provides other services under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

Payment for Reservation of Beds

Neither Medicaid residents, nor their families, nor their personal representative, may be charged for reservation of a bed for the first four days of any period during which a Medicaid resident is temporarily absent due to admission to a hospital. Prior to discharge of the resident to the hospital, the resident, the family of the resident, or the personal representative of the resident is responsible for making arrangements with the nursing home for the reservation of a bed and any costs associated with reserving a bed for the resident beyond the covered four-day hospital reservation period. The covered four-day hospital stay reservation policy does not apply to:

- Medicaid-eligible residents who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
- Any non-Medicaid residents;
- A resident who has applied for Medicaid but has not yet been approved; provided that if such a resident is later retroactively approved for Medicaid and the approval period includes some or all of the hospital stay, then the nursing home shall refund that portion of the bed hold reservation charge it actually received from the resident, family of the resident, or personal representative of the resident for the period that would have been within the four covered days policy; or
- Medicaid residents who have received a notice of discharge for non-payment of service.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the resident will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held in accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

Therapeutic Visits

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 nursing facility must ensure that each therapeutically indicated visit by a resident to home, relatives, or friends is authorized and certified by a physician.

Payments to ICF/MR facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid is not responsible for the record-keeping process involving therapeutic leave for the nursing facility. Medicaid will track the use of therapeutic leave through the claims processing system.

The nursing facility must provide written notice to the resident and a family member or legal representative of the resident, specifying the Medicaid policy when a resident takes therapeutic leave and when a resident transfers to a hospital.

The nursing facility or ICF/MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility. Residents are readmitted immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

Residents with Medicare Part A

Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.

An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. Medicaid will make no payment for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

Nursing facilities must ensure that Medicaid recipients eligible for Medicare Part A benefits first use Medicare benefits before accepting a Medicare/Medicaid recipient as a Medicaid resident.

Residents who do not agree with adverse decisions regarding level of care determinations by Medicare should contact the Medicare fiscal intermediary.

Application of Medicare Coverage

Nursing facility residents, either through age or disability may be eligible for Medicare coverage up to 100 days.

Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.

Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

Individuals with income in excess of the Federal Benefit Rate (FBR) can become eligible for Medicaid after they have been in an approved medical institution for 30 continuous days. After completing 30 continuous days the individual is entitled to retroactive coverage to the first day of the month of entry provided the recipient meets all other points of eligibility.

Individuals entering the nursing facility who are Medicaid eligible through SSI will be eligible for the month in which they enter the nursing facility. Eligibility after the first month must be established through the Medicaid District Office unless the individual's income is less than $50. An individual with income less than $50 must be certified for SSI by the Social Security Administration.

An applicant must be medically approved by Medicaid or Medicare prior to financial approval.

Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 25.

Retroactive Medicaid coverage is an exception to the above. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.

For a determination of medical eligibility for retroactive Medicaid coverage, the nursing facility should furnish Medicaid with Form MED-54, attaching all physician's orders, physician's progress notes, and nurse's notes for the period of time in question.

Resident Records

Medicaid monitors the admission and discharge system and maintains a record for each active resident in the nursing facility.

An active file is kept for six years on each resident.

Nursing Aide Training

A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility for more than four months unless the individual has completed training and a competency evaluation program approved by the state.

The Alabama Department of Public Health is responsible for the certification of the Competency Evaluation programs and maintains a nurse aide registry.

Pre-admission Screening and Resident Review

All individuals seeking admission into a nursing facility must be evaluated to determine if there is an indication of mental illness, mental retardation, or a related condition and whether the individual's care and treatment needs would most appropriately be met in the nursing facility or in another setting.

An accurate Level I screening document (LTC-14) must be completed for each person applying for admission to a nursing facility. This document is completed by the referral source, such as the attending physician or the referring agency/hospital.

The Alabama Department of Mental Health and Mental Retardation provides pre-admission screening and resident reviews on all nursing facility residents with a diagnosis of mental illness and/or mental retardation.

The Alabama Department of Mental Health and Mental Retardation conducts the Level II Screenings on each resident with a primary or secondary diagnosis of MI/MR and determines the resident's need for active treatment.

For all residents with a primary or secondary diagnosis of MI/MR, the Alabama Department of Mental Health determines appropriate placement in a nursing facility based on the results of the Level II Screening and Medicaid medical criteria.

Admission Criteria

The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person receives covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for nursing facility care under the following circumstances:

- The physician must certify the need for admission and continuing stay.
- The recipient requires nursing care on a daily basis.
- The recipient requires nursing services that as a practical matter can only be provided in a nursing facility on an inpatient basis.
- Nursing services must be furnished by or under the supervision of a RN and under the general direction of a physician.

A nursing care resident must require **two or more** of the following specific services:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
- Nasopharyngeal aspiration required for the maintenance of a clear airway
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube
- Care of extensive decubitus ulcers or other widespread skin disorders

- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Comatose resident receiving routine medical treatment

NOTE:

The above criteria apply to all admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing facility. These residents need to meet only **one** of the above criteria.

Medical Director

The nursing facility shall retain a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full time basis as is appropriate for the needs of the residents and the facility.

- If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.
- A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, or a hospital medical staff, or through another similar arrangement.

The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents.

The medical director is responsible for the development of written bylaws, rules, and regulations that are approved by the governing body and include delineation of the responsibilities of attending physicians.

The medical director coordinates medical care by meeting with attending physicians to ensure that they write orders promptly upon admission of a resident, and periodically evaluating the professional and supportive staff and services.

The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety. The medical director gives the administrator appropriate information to help ensure a safe and sanitary environment for residents and personnel.

The medical director is responsible for the execution of resident care policies.

Conditions Under Which Nursing Facility Is Classified as Mental Disease Facility

If the facility under examination meets one of the following criteria, Medicaid considers the facility to be maintained primarily for the care and treatment of individuals with mental disease:

- It is licensed as a mental institution.
- More than fifty percent (50%) of the residents receive care because of disability in functioning resulting from a mental disease.

Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and *Statistical Manual of Mental Disorders, Current Edition, International Classification of Diseases*, adopted for use in the United States, (ICD 9) or its successor, except mental retardation.

Conditions Under Which Nursing Facility Is Not Classified as Mental Disease Facility

Nursing facilities located on grounds of state mental hospitals or in the community must meet specific conditions in order to qualify for federal matching funds for care provided to all individuals eligible under the state plan.

Medicaid is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet any of the following criteria:

- The facility is established under state law as a separate institution organized to provide general medical care, and provides such care.
- The facility is licensed separately under state law governing licensing of medical institutions other than mental institutions.
- The facility is operated under standards that meet those for nursing facilities established by the responsible State authority.
- The facility is dually certified under Title XVIII and XIX.
- The facility is not maintained primarily for the care and treatment of individuals with mental disease.
- The facility is operated under policies that are clearly distinct and different from those of the mental institutions, and the policies require admission of residents from the community who need the care it provides.

Nursing facilities in the community must meet all but the last of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

Nursing facilities on the grounds of mental hospitals must meet all of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

The facilities that do not meet the conditions listed above are classified as institutions for mental diseases for Medicaid payment purposes. In such facilities, unless the facility is JCAHO-accredited as an inpatient psychiatric facility, payments are limited to Medicaid residents who are 65 years of age and older. If the facility is JCAHO-accredited as an inpatient psychiatric facility, payments may be made on behalf of the individuals who are under age 21 or are 65 years of age and older.

Medicaid Per Diem Rate Computation

The Medicaid per diem rate is determined under reimbursement methodology contained in the *Alabama Medicaid Agency Administrative Code*, Chapter 22. The rates are based on the cost data contained in cost reports (normally covering the period July 1 through June 30).

Reimbursement and Payment Limitations

Reimbursement is made in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 22*.*

Each nursing facility has a payment rate assigned by Medicaid. The resident's available monthly income minus an amount designated for personal maintenance (and in some cases, amounts for needy dependents and health insurance premiums) is first applied against this payment rate, and then Medicaid pays the balance.

- The nursing facility may bill the resident for services not included in the per diem rate (non-covered charges) as explained in this section.
- Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

Medicaid defines a ceiling for operating costs for nursing facilities. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, or contact the Provider Audit Division at the Agency for more details.

Nursing Facility Records

Nursing facilities are required to keep the following minimum records:

- Midnight census by resident name at least one time per calendar month (more frequent census taking is recommended)
- Ledger of all admissions, discharges, and deaths
- Complete therapeutic leave records
- A monthly analysis sheet that summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days

Cost Reports

Each provider is required to file a complete uniform cost report for each fiscal year ending June 30. Medicaid must receive the complete uniform cost report on or before September 15. Should September 15 fall on a state holiday or weekend, the complete uniform cost report is due the next working day. Please prepare cost reports carefully and accurately to prevent later corrections or the need for additional information.

Review of Medicaid Residents

Medicaid or its designated agent will perform a review of Medicaid nursing facility/ICF/MR facility residents' records to determine appropriateness of admission.

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 Admissions/Records 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 Admissions/Records 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 Admissions/Records Unit with supporting documentation.

26.3 Establishment of Medical Need

The Medicaid Agency has delegated authority for the initial and subsequent level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

The process to establish medical need includes medical and financial eligibility determination.

- The determination of level of care will be made by an RN of the nursing facility staff.
- Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the LTC file.

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

- New Admissions

  XIX LTC-9 Form 161. If criterion unstable medical condition is one of the established medical needs the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission.

  A fully completed Minimum Data Set.

  PASRR screening information.

- Readmissions

  XIX-LTC-9 Form 161

  Updated PASRR screening information as required.

All Medicaid certified nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

- New Admissions

  Medicaid Patient Status Notification (Form 199).

  Form XIX LTC-9.

All Medicaid certified ICF/MR facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/MR level of care needs.

- New Admissions

  A fully completed Medicaid Patient Status Notification (Form 199).

  A fully completed ICF/MR Admission and Evaluation Data (Form XIX-LTC-18-22).

  The resident's physical history.

  The resident's psychological history.

  The resident's interim rehabilitation plan.

  A social evaluation of the resident.

- Readmissions

  Medicaid Patient Status Notification (Form 199).

  ICF/MR Admission and Evaluation Form.

A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings: (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the LTC-9 on new admissions.

- Authorization of eligibility by Medicaid physician

  For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Medicaid Long Term Care Admissions/Records Unit. The Alabama Medicaid Agency physician will review and assess the documentation submitted and make a determination based on the total condition of the applicant. The physician will approve or deny medical eligibility.

Application Denials

On each denied admission application, Medicaid advises the resident and/or personal representative, the attending physician, and the facility of the resident's opportunity to request a reconsideration of the decision and that they may present further information to establish medical eligibility.

If the reconsideration results in an adverse decision, the resident and/or personal representative are advised of the resident's right to a fair hearing. If the reconsideration results in a favorable decision, normal admitting procedures are followed.

26.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by nursing facility providers.

26.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Nursing facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

26.5.1 Time Limit for Filing Claims

Medicaid requires all claims for nursing facilities to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

26.5.2 Diagnosis Codes

The *International Classification of Diseases - Current Edition - Clinical Modification* (ICD-9-CM) manual or its successor, lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

26.5.3 Covered Revenue Codes

The type of bill for nursing facilities is 21X.

Nursing facilities are limited to the following revenue codes:

Code	Description
101	All inclusive room & board
183	Therapeutic leave

26.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

26.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

26.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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27 Pharmacy

The Alabama Medicaid Agency pays for certain legend and non-legend drugs that meet both of the following criteria:

- Prescribed by medical doctors and other practitioners including, but not limited to, nurse practitioners, dentists, and optometrists who are legally authorized to prescribe these drugs
- Dispensed by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws

The policy provisions for Pharmacy providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

27.1 Enrollment

EDS enrolls Pharmacy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Pharmacy provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for pharmacy-related claims.

NOTE:
All nine digits are required when filing a claim.

Pharmacy providers are assigned a provider type of 07 (Pharmacy). Valid specialties for Pharmacy providers include the following:

- Government Pharmacy (PA)
- Institutional Pharmacy (PB)
- Retail Pharmacy (P2)

Enrollment Policy for Pharmacy Providers

To participate in the Alabama Medicaid Program, Pharmacy providers must meet the following requirements:

- Operate under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered.
- Agree to abide by the rules and regulations of third party billing procedures. Refer to Section 3.3.6, Third Party Liability, for more information.
- Maintain records, including prescriptions, to fully disclose the extent of services rendered. Pharmacies should maintain records, such as purchase invoices and recipient signature logs, within the state of Alabama. At a minimum, prescription files and invoices must be available for examination.

Out-of-State Pharmacies

Under State and Federal regulations, a pharmacy must sign an agreement with Alabama Medicaid Agency. However, when a recipient is in another state and requires service, the following procedure has been adopted.

Pharmacies Bordering Alabama

- Pharmacies bordering Alabama may participate in the Alabama Medicaid Program by completing an application for out-of-state pharmacies, and upon certification of the State Board of Pharmacy in that state that the pharmacy is registered and has been issued a permit.
- The pharmacy must then sign a Pharmacy Vendor Agreement with Alabama Medicaid Agency and agree to abide by the State pharmacy provider tax law.
- Pharmacies bordering Alabama are defined as those pharmacies located not more than 30 miles from the border of Alabama.

Pharmacies Not Bordering Alabama

- Drugs dispensed must be in concurrence with the limitations in place for in-state providers.
- Reimbursement will be made only for hemophilia products and specialty drugs which are not readily available in-state, and drugs dispensed to Medicaid recipients who may be traveling outside the state of Alabama.
- Providers of specialty drugs shall list the names of the drugs for which they intend to request reimbursement as well as the GCN or NDC numbers for each drug in the letter requesting enrollment with the Alabama Medicaid Agency.
- Pharmacies not bordering Alabama will be enrolled by the Medicaid fiscal agent on a temporary basis.
- Pharmacies not bordering Alabama are defined as those pharmacies located more than 30 miles from the border of Alabama.

27.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid pays for approved drug items when they are properly prescribed for eligible Medicaid recipients and dispensed in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

The number of outpatient pharmacy prescriptions for all recipients except as specified below is limited to four brand name drugs per month per recipient. In no case can total brand name prescriptions exceed ten per month per recipient. There is no limit on generic and covered over-the-counter prescriptions. Prescriptions for Medicaid eligible recipients under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and prescriptions for Medicaid eligible nursing facility residents are excluded from these limitations.

Brand name anti-psychotic and anti-retroviral agents may be paid up to ten prescriptions per month but in no case can total brand name prescriptions exceed ten per month per recipient.

Coverage of up to ten brand name prescriptions per month may be allowed through overrides for drugs classified by American Hospital Formulary Services (AHFS) as Antineoplastic Agents, Antiarrhythmic Agents, Cardiotonic Agents, Nitrates and Nitrites, Alpha Adrenergic Blocking Agents, Beta Adrenergic Blocking Agents, Dihydropyridines, Miscellaneous Calcium Channel Blocking Agents, Diuretics, Potassium Sparing Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists, Mineralocorticoid (Aldosterone) Receptor Antagonists, Central Alpha Agonists, Direct Vasodilators, Peripheral Adrenergic Inhibitors, Miscellaneous Hypotensive Agents, Hemostatics, Calcium Replacements, Electrolyte Depleters, Immunosuppresives, Alpha Glucosidase Inhibitors, Biguanides, Insulins, Meglitinides, Sulfonylureas, and Thiazolidinediones. Overrides will be granted only in cases in which the prescribing physician documents medical necessity for the recipient to be switched from a product in one of the above named classes to a brand name product within the same therapeutic class in the same calendar month. The first product must have been covered by Medicaid.

Medicaid will not compensate pharmacy providers for:

- DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act
- Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency
- Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency
- Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency
- Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency
- Agents when used to promote smoking cessation

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency
- Nonprescription drugs except for those specified by the Alabama Medicaid Agency
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Barbiturates and Benzodiazepines except for those specified by the Alabama Medicaid Agency
- Agents when used for the treatment of sexual or erectile dysfunction unless prior approved through medical necessity.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 16 for drugs not covered by Alabama Medicaid.

Unit Dosing in Nursing Facilities

Covered drug items may be dispensed to recipients, using an approved unit dose system for solid oral forms of the prescribed drug. Only one claim per drug per recipient may be submitted each month by any pharmacy using an approved unit dose system. Only the amount of the prescribed drug actually consumed by the patient may be billed.

Each dose of a drug dispensed using an approved unit dose system must be individually packaged in a sealed, tamper proof container and carry full disclosure labeling, including, but not limited to, product name and strength, manufacturer's or distributor's name, lot number and expiration date.

Prescriptions for controlled drugs must be filled or dispensed from a signed original or direct copy of the physician's prescription order.

27.2.1 Prescription Requirements

Medicaid reimburses for prescriptions documented and dated appropriately for legend and over-the-counter drugs covered by Medicaid.

Schedule II drug prescriptions require the manual signature of the prescribing physician before dispensing. Stamped or typewritten signatures are not acceptable. In accordance with the Code of Federal Regulations, § 1306.05, all prescriptions for schedule II substances shall be dated and signed by the prescribing physician the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name and address and registration number of the practioner.

Prescriptions dispensed by telephone for drugs other than Schedule II drugs are acceptable without subsequent signature of the practitioner.

Pharmacy providers should document any changes to the original prescription, such as physician approved changes in dosage, on the original prescription.

The pharmacy may refuse to accept Medicaid reimbursement for a Medicaid-covered item and bill the recipient as a regular paying patron if the provider informs the recipient prior to dispensing the prescription. The recipient has the right to have the prescription filled by any other authorized Medicaid pharmacy.

27.2.2 Quantity Limitations

Claims must be submitted in the units specified on the prescription by the prescribing physician up to a 34 day supply. Medications supplied in a dosage form that would prevent the dispensing of an exact 30-34day supply for chronic medications, such as insulin, may require quantities that exceed the 34 day maximum and would not be subject to recoupment as long as the pharmacist can provide appropriate documentation.

Pharmacies may not split a 34 day supply into small units and submit them as separate claims.

A pharmacist should not change quantities (units) of drugs prescribed by a physician except by authorization of the physician. The pharmacist must contact the prescribing physician for authorization to reduce the quantity of any Medicaid prescription and note physician authorization on the prescription form.

If the prescription to be paid by Medicaid exceeds the limit, the pharmacist must request an override for the prescribed quantity. If the override is not approved, then the excess number above the limit is noncovered and the pharmacist can charge the recipient for that amount in excess of the Medicaid limit.

NOTE:

A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service.

If the full quantity prescribed is not available at the time of dispensing, the pharmacist may dispense the quantity available. In this case the pharmacist must note on the prescription the number of units dispensed and retain the claim until the balance of medication is dispensed. Only one claim with one dispensing fee may be billed.

27.2.3 Prescription Refill

Prescriptions cannot exceed eleven refills for non controlled prescriptions and five refills for Control III-V prescriptions. Medicaid will deny claims for prescription refills exceeding eleven for non controlled prescriptions and five for Control III-V prescriptions. Prescriptions may be refilled only with the prescribing provider’s authorization. Failure of the prescribing provider to designate refills on a prescription will be interpreted as no refills authorized. If a prescription is refilled, the date the prescription is refilled must appear on the prescription.

Pharmacy providers should refill all prescriptions only in quantities corresponding to dosage schedule and refill instructions.

The use of automatic refills (the practice where a pharmacy automatically refills a patients prescription without a request from the prescriber, patient, or patient’s authorized representative) by pharmacies or their software

systems is not supported by the Medicaid Agency. Prescriptions that have been filled but not picked up by the patient or patient's authorized representative should be credited back to pharmacy stock and Medicaid through claims reversal within sixty days.

Violations of these policies may result in unauthorized charges. The pharmacy may be held liable or Medicaid may cancel the pharmacy vendor agreement.

Early Refills

Pharmacies should not dispense refill medication to recipients until the recipient has used at least 75% of the original supply. Pharmacists must document on the original prescription that the prescribing physician was consulted and the physician approved dispensing early refills.

NOTE:

Medicaid may recoup payments for early refills.

Health Information Designs (HID) is contracted with the Alabama Medicaid Agency to assist pharmacists receiving hard denials, such as early refills, therapeutic duplication and excessive quantity. Pharmacies must receive an override from HID before payment will be made. **Contact HID at 1 (800) 748-0130**. Only HID can issue the necessary override.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the patient will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held in accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

27.2.4 Reimbursement for Covered Drugs

This section describes reimbursement for multiple source drugs, over-the-counter medications and other drugs, dispensing fees, and pricing.

Multiple Source Drugs

Medicaid reimbursement for covered multiple source drugs will not exceed the lowest of the:

- Federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS, plus a reasonable dispensing fee

- Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee
- Provider's Usual and Customary Charge to the general public for the drug
- Calculated State Maximum Allowable Cost (MAC)

NOTE:

AEAC is defined as Medicaid's best estimate of the price providers generally pay for a drug. Medicaid establishes the AEAC for each drug based on the package size providers most frequently purchase.

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases "brand medically necessary" must be indicated on the prescription in the physician's handwriting and the pharmacist must maintain the prescription on file.

Medicaid may recoup payments if the dispensing pharmacist does not have the original or faxed prescription with "brand medically necessary" written in the physician's own handwriting from the pharmacist's record.

Prescription Compounding

Alabama Medicaid pays for prescription drugs through the billing of NDCs. Pharmacists may dispense compounded medications when prescribed and can bill for each ingredient with a valid NDC.

Pharmacists may also bill for the time spent compounding the medication if approved by Medicaid or its Contractor prior to dispensing. One or more of the legend ingredients within the compounded medication must be a covered ingredient with a valid NDC in order for the pharmacist to bill Medicaid for the time spent compounding the medication. The finished compound must not be available as a legend or over-the-counter product in an equivalent dosage form/route of administration. Compounded products are subject to review, must meet medical criteria and may require peer-reviewed medical literature before being covered. Compounding time approval requests should be referred to HID at 1(800) 748-0130. Reimbursement will be calculated by the minute and will not exceed a maximum monthly amount. Pharmacists must bill utilizing NDC 99999999999 for the minutes expended compounding.

In addition, pharmacists will receive a dispensing fee for each valid NDC billed. Please ensure that any compounding performed is consistent with Public Law 105-115.

Other Drugs

Reimbursement for covered drugs other than multiple source drugs will not exceed the lower of the Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee, OR the provider's Usual and Customary Charge to the general public for the drug.

Dispensing Fees

Medicaid maintains dispensing fees. A differential dispensing fee will be paid for non-retail providers.

Only one dispensing fee is allowed for a 34 day supply of the same drug per month unless the recipient qualifies for an “early refill”. To qualify for an “early refill”, the recipient must have used 75% of the original supply or there is a documented consultation with the prescribing physician authorizing the refill.

Over-the-Counter Medications (OTCs)

Medicaid pays for certain (OTCs) through the Medicaid pharmacy program dispensed to an eligible Medicaid recipient may be submitted for payment by utilizing the appropriate NDC number.

Over-the-counter medications require a prescription from a physician or other practitioner legally licensed by the State of Alabama to prescribe the drugs authorized under the program. Telephone prescriptions are acceptable for OTCs.

Long term care facilities may bill OTC insulins covered by the Medicaid pharmacy program by submitting for payment the NDC number utilized. All other OTCs should be billed by the nursing facility using the facility cost report.

If a prescribing physician writes a prescription that requires a pharmacist to break a bottle of medication, the pharmacist should bill Medicaid for the package size closest to the amount actually dispensed. For example, a bottle of ibuprofen is packaged with 100 tablets at a cost of $4.50. A recipient has a prescription for 90 tablets. The pharmacist should break the bottle, dispense 90 tablets, and bill $4.50.

Do not dispense more medication than indicated on the prescription unless authorized by the prescribing physician to do so.

Medicaid will reimburse for covered OTCs as stated under Multiple Source Drugs.

Non-Drug Items

Alabama Medicaid Agency reimburses for certain non-drug items, including but not limited to spacers, syringes, and tablet splitters, through the pharmacy program with a valid prescription and NDC number. Other supplies such as blood glucose testing strips and lancets may be billed through Durable Medical Equipment. Please refer to chapter 14.2 for complete information.

Total Parenteral Nutrition

Alabama Medicaid Agency may reimburse for total parenteral nutrition (TPN) through the pharmacy program if the order/prescription and recipient meets certain requirements. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN) and intraperitoneal nutrition (IPN). Please refer to chapters 35.2 and 28.2 for complete information.

27.2.5 Primary Pharmacy Audit Components

The following information serves as a general guide to the components of a Medicaid Pharmacy Audit. Although the list provided may not be all-inclusive, it covers approximately 95% of discrepancies found through on-site and desk review audits. Questions regarding this information may be directed to Medicaid at (334) 242-5051.

- **DAW Audits** - Use of the Dispense As Written (DAW) code 1 requires "Brand Medically Necessary" (BMN) certification. The words "Brand Medically Necessary" must be handwritten by the physician on the original prescription before dispensing. In absence of certification in the physician's own handwriting on the prescription, recoupments may be initiated.
- **Usual & Customary (U&C)** - For specified products, submitted charge will be compared to cash price to general public. Adjustments may be initiated.
- **Inaccurate Billing** - The NDC number of the product actually dispensed should be billed. The NDC number is package size and manufacturer specific. Days supply should be clinically appropriate according to prescription or physician's instructions.
- **Multiple Dispensing Fees** - Providers must have documentation to include call-in and hard copy prescriptions to support the multiple dispensing of the same product, same strength to the same patient within a 30 day period.
- **Drug Name, Form Strength & Quantity Differs From Prescription –** On CII prescriptions, the prescribing physician must authorize all changes from the original prescription before dispensing. Any change must be documented on the prescription.
- **Requirements for Signatures and Prescriptions** - Schedule II and BMN products require original prescription and signature. Other drugs may be called in without the subsequent signature of the physician as allowed by State law.
- **Changing Claim Information to Force Payment** - The system recognizes and denies exact duplicates. Providers may not alter NDC number, date of service, prescription number, or any other claim requirement to force payment through duplicate edits.
- **Timely Prescription Reversal-** If a patient or a patient's authorized representative has not picked up his/her prescription within sixty (60) days, the pharmacy is required to reverse the claim and credit Medicaid the amount originally billed.
- **Total Parenteral Nutrition (TPN)-** TPN prescriptions/orders include those used for hyperalimentation intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). A certification statement of medical necessity must be written or stamped on the prescription/order, or accompany all TPN prescriptions/orders.

Continued violations of Medicaid claims processing policies may result in recoupment and referral to the Alabama Attorney General's Office for investigation of fraud.

27.2.6 Drug Utilization Review (DUR)

The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes.

This section contains information about the components of the DUR Program:

- General Information
- Prospective Drug Utilization Review (Pro DUR)
- Online Drug Utilization Review (Online DUR)
- National Council for Prescription Drug Programs (NCPDP) Standards
- Retrospective Drug Utilization Review (Retro DUR)

General Information

The DUR Program uses educational tools directed to physicians and pharmacists in order to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care by addressing:

- Potential and actual drug reactions
- Therapeutic appropriateness
- Over-utilization
- Under-utilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug/disease contraindications
- Drug interactions
- Incorrect drug dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

The DUR Program reviews, analyzes and interprets patterns of drug usage against standards consistent with the American Medical Association Drug Evaluations, United States Pharmacopoeia Drug Index, American Hospital Formulary Service Drug Index, and peer reviewed medical literature.

DUR will be conducted for drugs dispensed to residents of nursing facilities.

NOTE:

Pharmacists should refer cases of possible fraud or abuse to the Medicaid Program Integrity Division. Information may be provided through the Medicaid Agency's Fraud hotline by calling 1(866) 452-4930. Calls may be made anonymously.

Prospective DUR

Prospective DUR (Pro-DUR) is required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include screening, patient counseling, and use of patient profiles.

Pro-DUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement for participation in the program.

Online DUR

Medicaid provides an online system to assist the dispensing pharmacist. Incoming drug claims are compared to the patient's medical and pharmacy claims history files to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist for significant problems discovered by this review.

Potential problems identified include:

- Therapeutic duplication – Examples of therapeutic duplication, involving overlapping periods of time where such therapy is not medically indicated, include:
  - Two or more doses of the same drug
  - At least two drugs from the same therapeutic class
  - At least two drugs from different therapeutic classes with similar pharmacological effects being used for the same indication
- Drug/Disease contraindications
- Drug interactions
- Incorrect dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse or misuse
- Preferred drug status

Medicaid distributes criteria and standards to providers in Medicaid Provider Notices and Bulletins.

Pharmacists must respond to prospective DUR alerts to continue claims processing through EDS.

Pharmacies without computers must screen based on guidelines provided by the Alabama State Board of Pharmacy Practice Act and criteria and standards endorsed by Medicaid’s DUR Board.

National Council for Prescription Drug Programs (NCPDP) Standards

Pharmacy claim telecommunication standards dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert. Displaying these fields to the pharmacist facilitates communication when health care providers discuss the potential therapeutic problems discovered by online prospective DUR.

This section explains DUR fields and information, lists standard response fields and codes, shows example DUR alert messages, and lists DUR alerts in order of priority.

Field Name	***Information Displayed in the Field***
Conflict Code	Alerts the pharmacist that the incoming drug claim conflicts with information in the patient's history file or with predetermined screening criteria ER = Early Refill TD = Therapeutic duplication DD = Drug Interaction EQ = Excessive Quantity
Clinical Significance/Severity Index Code	Indicates database-assigned significance of the conflict. 0 = Not applicable 1 = Major 2 = Moderate 3 = Minor
Other Pharmacy Indicator	Informs the pharmacist of the originating location of the claim with which the incoming drug claim conflicts. 0 = Not applicable 1 = Your Pharmacy 3 = Other Pharmacy
Previous Date of Fill	The last recorded date of the active medication in the patient's history file with which the incoming drug claim conflicts.
Quantity of Previous Fill	Quantity of previously filled prescription with which the incoming drug claim conflicts
Database Indicator	Identifies source of DUR conflict information 0 = Not applicable 1 = First DataBank. 4 = Processor Developed
Other Prescriber Indicator	Identifies the prescriber of the previously filled prescription with which the incoming drug claim conflicts. 0 = Not applicable 1 = Same Prescriber 2 = Other Prescriber
Free Text Message	30-character field that transmits decoded information regarding the DUR conflict.

To respond to an alert, the pharmacist must enter the corresponding codes to describe the action taken on the alert in the response fields. For a claim that generates multiple alerts, the pharmacist's response indicates that each alert has been considered and the response should be applied to all alerts generated by this claim.

The pharmacist should respond to alerts with the appropriate conflict code. For example, enter TD for Therapeutic Duplicate in response to a therapeutic duplication alert.

Do not change any claim information such as the NDC code or Quantity unless you are indicating your change with the appropriate Outcome Codes listed in the table below**.** Changing claim information could cause your claim to deny online.

Response fields and codes are listed in the following table:

Response Field	***Response Codes***
Conflict Codes	HD – High Dose ER – Early Refill LR – Late Refill DD – Drug-Drug Interaction TD – Therapeutic Duplication PS – Product Selection
Intervention Codes	M0 – Prescriber consulted P0 – Patient consulted

Response Field	*Response Codes*
	R0 – Pharmacist consulted other source
Outcome Codes	1A - Filled As Is, False Positive 1B - Filled Prescription As Is 1C - Filled, with Different Dose 1D - Filled, with Different Directions 1E - Filled, with Different Dose 1F - Filled, with Different Quantity 2A - Prescription Not Filled 2B - Not Filled, Directions Clarified

NOTE:

Intervention codes contain the number zero, not the letter O. Using the letter O will cause your claim to deny online.

Proprietary pharmacy software for prescription processing systems may display DUR alerts in different formats. Examples of standard content of DUR messages are presented below. These may differ from the message actually displayed on the pharmacist's computer screen.

Example DUR Alert Messages	
On April 2, 1998, the pharmacist attempts to dispense an aspirin-containing product to a patient currently receiving welrfar in prescribed by the same physician and filled at another pharmacy:	
CONFLICT CODE:	DD - DRUG INTERACTION
SEVERITY:	1 = Major
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980315 (March 15, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
MESSAGE:	Coumadin
On April 19, the pharmacist attempts to dispense a refill for which the previous prescription has greater than 25 percent of days supply remaining:	
CONFLICT CODE:	ER - OVERUTILIZATON
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980301 (March 1, 1998)
QUANTITY OF PREVIOUS FILL:	90
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
The pharmacist attempts to dispense a refill of levothyroxine on May 15, a date equal to greater than 125 percent of previous prescription's days supply:	
CONFLICT CODE:	LR - UNDERUTILIZATION
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980401 (April 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
On May 12, the pharmacist attempts to dispense flurazepam to a patient with an active prescription for triazolam:	
CONFLICT CODE:	TD - THER. DUPLICATION
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980501 (May 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	2 = Other Prescriber
MESSAGE:	Triazolam
The pharmacist attempts to dispense acetaminophen w/codeine, three tablets every 4 hours (dose exceeds usual adult daily maximum):	
CONFLICT CODE:	HD - HIGH DOSE
DATABASE INDICATOR:	1 = First DataBank
The pharmacist attempts to dispense an NDC that is not a preferred drug.	
CONFLICT CODE:	PS - PRODUCT SELECT OPPORTUNITY
DATABASE INDICATOR:	4 = Processor Developed

The system displays up to three DUR alerts for a prescription. To access additional alerts pertaining to the prescription, the pharmacist may call the EDS Help Desk at 1(800) 456-1242.

Multiple alerts on a prescription are prioritized according to the following hierarchy:

1. Drug-drug interactions
2. Therapeutic duplication
3. Overutilization (early refill)
4. Incorrect dose (high dose)
5. Underutilization (late refill)
6. Preferred drug

Retrospective DUR

The retrospective DUR Program reviews, analyzes and interprets patterns of recipient drug usage through periodic examination of claims data to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care.

27.3 Prior Authorization and Referral Requirements

Pharmacy providers must contact Health Information Designs (HID) at 1(800) 748-0130 for prior authorization of drugs requiring prior approval. Only HID can issue prior authorizations.

HID should respond within 24 hours of receipt of requests for prior authorization. In cases of emergency, HID will make provisions for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug.

Federal Law also makes a provision for a 72-hour supply by using the following authorization number: 0000999527. This number is to be used only in cases of emergency. Utilization of this code will be strictly monitored and recoupments will be initiated when the code is found to have been used inappropriately.

27.4 Cost Sharing (Copayment)

Copayment amounts vary and are described in this section. **Copayments do not apply to services provided for pregnant women, long term care (nursing home) residents, emergencies, recipients under 18 years of age, or family planning**.

A provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost sharing (copayment) amount imposed.

- If the physician has indicated on the prescription that the recipient is pregnant, enter "P" in the copay block.

NOTE:
Do not enter a dollar amount in the copay block.

The copayment schedule is based on the total charge amount (ingredient cost plus dispensing fee):

Pharmacy Charge	***Copay Amount***
$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

NOTE:

Copayment amount should be collected on the original prescription as well as any refills.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by EDS
- Automated Voice Response System (AVRS) at 1(800) 727-7848
- Contacting the EDS Provider Assistance Center at 1(800) 688-7989

Appendix B, Electronic Media Claims Guidelines, provides an overview of the EDS Provider Electronic Solutions software, which providers may use to verify recipient eligibility and submit claims. Instructions for requesting the software are also included in this appendix.

Providers who use a billing service may be able to verify eligibility through the billing service's software, providing the service obtained a copy of the vendor specification. Please refer to Appendix B for contact information.

Appendix L, AVRS Quick Reference Guide, provides instructions for using AVRS to verify recipient eligibility. Providers can obtain a faxed response verifying eligibility by following the instructions provided.

27.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Pharmacy providers who bill Medicaid claims electronically receive the following benefits:

- Faster claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Most pharmacy claims are submitted electronically for online adjudication. Claims filed electronically use Provider Electronic Solutions software from EDS or Point of Sale proprietary pharmacy software.

NOTE:

When filing a claim on paper, an XIX-DC-10-093 pharmacy claim form is required.

Paper claims may also be filed. The pharmacist must initiate a two-part Medicaid Pharmacy Claim. The pharmacy must retain the original claim for State and audit purposes, and submit a duplicate claim to EDS for payment. EDS will furnish pharmacy claim forms upon request. Pharmacy claim forms can be purchased from EDS for $35.44 per 1,000 forms. Claim forms will be mailed after receipt of payment.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

27.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Pharmacy providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

27.5.2 Diagnosis Codes

Diagnosis Codes do not apply when filing the pharmacy claim form.

27.5.3 Procedure Codes and Modifiers

Procedure Codes and Modifiers do not apply to Pharmacy billing.

27.5.4 Place of Service Codes

Place of service codes do not apply when filing the pharmacy claim form.

27.5.5 Required Attachments

Attachments are not required for pharmacy claims.

27.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
XIX-DC-10-093 Claim Filing Instructions	Section 5.6
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

27.7 Alabama Medicaid Pharmacy Questions and Answers (Q&A)

The Medicaid Pharmacy Q&A has been developed to provide guidance and clarification on pharmacy issues. Questions may be submitted to:

Medicaid Program Management, Fax (334) 353-7014

Responses will be published in the quarterly Medicaid Pharmacy Newsletter.

Are original prescriptions and signatures required for all drugs?

Medicaid requires original, signed prescriptions for Schedule II drugs and Brand Medically Necessary drugs. Schedule III, IV, and V drugs may be called in, as allowed by state pharmacy regulations.

Can a call-in prescription be accepted for a MAC drug when brand necessary certification is required?

No. The MAC price may only be waived when a pharmacy has a prescription with “Brand Medically Necessary” written in the prescribing physician’s own handwriting. Therefore, a written prescription is necessary. For example, because Zantac is a MAC drug and requires brand medically necessary certification on the prescription, a telephone prescription would not be acceptable in order to receive brand reimbursement.

Can I make a therapeutic or strength substitution without calling the prescribing physician?

No. Alabama State law requires the pharmacist to have the approval of the prescribing physician before dispensing anything other than what has been indicated on the prescription. If the physician has indicated product selection is allowed, the pharmacist may dispense generic substitution without subsequent contact with the physician.

What is the appropriate action when a physician writes a prescription that exceeds the Medicaid monthly dosing units?

When a prescription is denied for excessive quantity or monthly limit exceeded, claims will deny. In order to receive an override, providers (either the pharmacy or physician) should contact the HID help desk at 1(800) 748-0130 for consideration of an override.

How long is a prescription valid?

In accordance with state law, controlled substance prescriptions are valid for up to six months from the original issue date. Non-controlled prescriptions are reimbursable by Medicaid for up to 12 months from the date of the original dispensing date.

Can I receive authorization for additional refills from the prescribing physician after the 12 months have expired?

No. A new prescription should be obtained after 12 months from the date of the original dispensing date. Medicaid will make payment for up to 5 refills on an original prescription for Control III-V prescriptions and 11 refills on non controlled prescriptions.

Why is it important that I bill the exact NDC number dispensed if the product is a generic?

According to the State Board of Pharmacy, pharmacies dispensing controlled substances and submitting claims with different NDC numbers would have problems with the Drug Enforcement Agency (DEA). Additionally, Medicaid provider contracts require that claims be submitted accurately. Under federal law, manufacturers rebate Medicaid for use of their drugs. When an NDC is submitted on a claim that is not the actual NDC dispensed, Medicaid may incorrectly invoice the manufacturer for the rebate. Rebate dollars provide a significant source of money to offset pharmacy benefit costs. Therefore, NDC numbers reported on pharmacy claims should be the exact NDC number dispensed to the patient.

Can referrals be made to the Medicaid Agency when a provider believes a recipient is defrauding the program?

Yes. Any information regarding inappropriate and/or illegal drug-related activity by Medicaid recipients can be referred to the **Medicaid Fraud Hotline** at **1(866)452-4930**. All complaints are researched. If evidence is found to support recipient abuse or fraud, recipients can be locked in to one physician and one pharmacy or removed from the Medicaid program.

Does Medicaid make payment for benefits when a patient is in a state or county correctional facility?

Medicaid benefits are not available for individuals who are inmates of public institutions as defined by CFR 435.1009. It is the responsibility of the correction facility to provide medical care. Incarcerated recipients still receiving Medicaid benefits may be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**.

If a provider receives multiple dispensing fees for the same patient, same drug and strength within the same month, will the additional dispensing fees be recouped?

Medicaid auditors look specifically for providers who split 30-day prescriptions into shorter time periods and amounts. Intentionally splitting prescriptions to receive multiple dispensing fees is fraud and monies paid will be recouped. Multiple dispensing fees within the same month for the same patient and same drug are acceptable if the provider has documentation supporting the need for multiple dispensings. Example: A child needs a 10 mg tablet for school and a 20 mg tablet for home to take at night; the provider should have in his documentation prescriptions for both.

If a provider is audited and can not produce documentation while Medicaid auditors are in the store, is there a period of time allowed to provide the documentation before recoupments are initiated?

If an auditor requests documentation that is not present in the provider's facility, the provider should indicate to the auditor where the documentation is and when it can be provided for review. If additional information is needed by the state as a result of discrepancies identified in an audit, the provider should submit the requested information within 30 days of the request. Failure to submit documentation within 30 days may result in recoupment.

Is it important to bill the correct days supply?

Yes, days supply is an instrumental portion of a legitimate claim. Retroactive audits may consider the day supply billed, along with quantity of medication billed, in regards to the original prescription. Day supply billed should be clinically appropriate according to the physician's instructions on the prescription.

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28 Physician

Physician's services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, refer to services provided by a physician:

- Within the scope of practice of medicine or osteopathy as defined by state law; and
- By or under the personal supervision of an individual licensed under state law to practice medicine of osteopathy.

The policy provisions for physicians can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 6.

28.1 Enrollment

EDS enrolls physicians and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*. For the purpose of enrollment, a physician is defined as: a physician who is fully licensed and possesses a current license to practice medicine.

EDS also enrolls Physician Assistants (PA), Certified Registered Nurse Practitioners (CRNP), Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician. Physician-employed includes physicians practicing in an independent practice or in a group practice relationship.

Refer to Chapter 38, Anesthesiology, for more information on CRNA and AA services.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a physician is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursement for physician-related claims.

NOTE:

All nine digits are required when filing a claim.

Physicians are assigned a provider type of 01 (Physician). Physician-Employed Nurse Practitioners or Physician-Employed Physician Assistants are assigned a provider type of 06 (Physician-Employed Practitioners), and Certified Registered Nurse Anesthetists and Anesthesiology Assistants are assigned a provider type of 92 (CRNA).

Valid specialties for physicians and physician-employed practitioners are listed below:

Specialty	***Code***
Allergy/Immunology	03
Anesthesiology	05
Anesthesiology Assistant	N7
Cardiac surgery	S1
Cardiovascular disease	06
Certified Registered Nurse Anesthetist	C3
Cochlear implant team	C9
Colon and rectal surgery	S2
Dermatology	07
EENT	XA
Emergency medicine	E1
Endocrinology	E2
EPSDT	E3
Family practice	08
Gastroenterology	10
General practice	01
General surgery	02
Geriatrics	38
Hand surgery	21
Hematology	H2
Infectious diseases	55
Internal medicine	11
Mammography	M7
Neonatology	N1
Nephrology	39
Neurological surgery	14
Neurology	13
Nuclear medicine	36
Nutrition	40
Obstetrics/Gynecology	16
Oncology	XI
Ophthalmology	18
Oral and maxillofacial surgery	SE
Orthopedic	X6
Orthopedic surgery	20
Otorhinolaryngology	X9
Pathology	22
Pediatrics	37
Physician-Employed Nurse Practitioner	N3
Physician-Employed Physician Assistant	N6
Plastic, reconstructive, cosmetic surgery	24
Primary care provider (not a screening provider but can refer patients)	AE
Proctology	28
Psychiatry	26
Pulmonary disease	29
Radiology	30
Rheumatology	R4
Thoracic surgery	33
Urology	34
Vascular surgery	S4

Enrollment Policy for Physicians

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board in order for the PA or CRNP to be added to the Provider License File for the purpose of reimbursing the pharmacist for the prescriptions written by the PA or CRNP. This copy must be sent to EDS Provider Enrollment, P.O. Box 241685, AL 36124-1685.

EDS will not enroll physicians having limited licenses unless complete information as to the limitations and reasons are submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

28.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

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

Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, physicians within the same group are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year.

A physician enrolled in and providing services through an approved residency training program will be assigned a pseudo Medicaid license number, but may not bill for services performed as part of the residency training program. A pseudo Medicaid license number is required on written prescriptions issued to Medicaid recipients. To request a pseudo Medicaid license number, please refer to Chapter 2, Becoming a Medicaid provider for additional information.

Written medication prescriptions should have a typed or printed name of the prescriber on the prescription, handwriting should be legible, and the pseudo license number for a resident should be clearly indicated. Pharmacists **must have the physician's license number** prior to billing for prescriptions. Pharmacies shall use the correct physician license number when submitting a pharmacy claim to Medicaid.

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

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

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

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

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

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

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

Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement as long as block 19 on the claim identifies the physician who actually furnished the service. Both physicians should be enrolled as Medicaid providers. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement should be enrolled with the Alabama Medicaid Agency.

The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered when benefit limitations are exhausted for the year or when the service is a Medicaid non-covered benefit. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

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

A physician enrolled in a residency training program and whose practice is limited to the institution in which that resident is placed shall not bill Medicaid for services performed therein for which the institution is reimbursed through the hospitals' cost reports. For tracking purposes, these physicians will be assigned pseudo Medicaid license numbers.

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

- All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, will bill Medicaid on a CMS-1500 claim form, or assign their billing rights to the hospital, which shall bill Medicaid on a CMS-1500 claim form.
- Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual provider number on a physician claim form). This includes services provided by a radiologist and/or pathologist.

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

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

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

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

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

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

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

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

    (i) Eyeglasses,

    (ii) Comprehensive Audiological services,

    (iii) Comprehensive Opthalamological services,

    (iv) Patient 1st and EPSDT Referrals,

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

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

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

NOTE:

If a provider routinely accepts Medicaid assignments, he/she may not bill Medicaid or the recipient for a service he/she did not provide, i.e., "no call" or "no show".

28.2.1 Physician-Employed Practitioner Services

Medicaid payment may be made for the professional services of the following physician-employed practitioners:

- Physician Assistants (PAs)
- Certified Registered Nurse Practitioners (CRNPs)

Nurse Practitioner is defined as a Registered Professional Nurse who is currently licensed to practice in the state, who meets the applicable State of Alabama requirements governing the qualifications of nurse practitioners.

Physician Assistant means a person who meets the applicable State of Alabama requirements governing the qualifications for assistants to primary care physicians.

All services requiring additional education and training beyond the scope of practice billed by a CRNP/PA must be documented in the approved collaborative agreement from the Board of Medical Examiners (BME) and the Alabama Board of Nursing (ABN) between the practitioner and physician. The only exception is for those “routine” services within the scope of practice approved by the applicable licensing and governing boards. Services billed outside a CRNP/PA scope of practice and/or collaborative agreement are subject to post-payment review.

Medicaid will make payment for services of Physician Assistants (PAs) and Certified Registered Nurse Practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with payment made to the employing physician. Medicaid will not make payment to the PA or CRNP. Generally, CRNPs and PAs are reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

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

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

Covered services furnished by the PA or CRNP must be billed under the PA’s or CRNP’s name and Alabama Medicaid provider number.

The covered services for PAs and CRNPs are limited to injectable drugs, laboratory services in which the laboratory is CLIA certified to perform, and the CPT codes identified in Appendix O, CRNP & PA Services.

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

The PA or CRNP may make physician-required visits to nursing facilities.

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

CRNP and PA services have been expanded. Please refer to Appendix O for a list of covered services and references.

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

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

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

28.2.2 Covered Services

In general, Medicaid covers physician services if the services meet the following conditions:

Added: or

Deleted: ~~or designated by…its own use~~

- Considered medically necessary by the attending physician
- Designated by procedure codes in the Physicians' Current Procedural Terminology (CPT), or HCPCS. This table contains details on selected covered services.

Service	***Coverage and Conditions***
Add-on Code	Add-on Code definition in the CPT is recognized and allowed for payment with the appropriate primary code.
Administration Fee	Please refer to Appendix H, Medicaid Physician Drug List, section H.1 (Policy) for information regarding office visits, chemotherapy, and administration fees. When an Evaluation and Management Code (E & M) is billed, medical record documentation must support the medical necessity of the visit as well as the level of care provided. CPT Guidelines are utilized to determine if the key components of an Evaluation and Management Code are met. When an Evaluation and Management service is provided *and* a Drug Administration code (90772, 90773, 90774, and 90775) is provided at the same time, the E & M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. However, when no E & M service is actually provided at the time of a Drug Administration, an E & M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without an E & M service being provided. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).
Allergy Treatments	Please refer to Appendix H, Medicaid Physician Drug List for information.

Anesthesia	Anesthesia is covered. See Chapter 38, Anesthesiology.
Artificial Eyes	Artificial eyes must be prescribed by a physician.
Bariatric Procedures	Considered cosmetic unless specific medical criteria are met and with Prior Authorization.
Breathing or Inhalation Treatments	Breathing or inhalation treatments are a covered service. Any medication provided during a breathing treatment (e.g., Albuterol) is considered a component of the treatment charge.
Cardiac Catheterization	Cardiac Catheterization codes may be subject to the multiple procedure/surgery reductions. See exceptions listed within Chapter 28.
Cerumen Removal	Code 69210 (which requires skill and use of forceps, suction, or cerumen spoon) is a covered service.
Chemotherapy Administration	Please refer to Appendix H for 01-01-2006 changes in codes, modifiers, and coverage. There have been 2006 CPT Code changes to describe other Administration Codes for Hydration (90760, 90761), Therapeutic, Prophylactic, and Diagnostic Infusions (90765, 90766, 90767, 90768) and Chemotherapy Administration Codes (96401-96542). A Significant Separately Identifiable Service must be performed in conjunction with these administration codes for consideration of payment for an Evaluation and Management Code to occur. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Code 99211 will not be allowed with a modifier 25 or when billed in conjunction with the above administration codes. Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.
Computerized Axial Tomograph (CAT) Scans	CAT scans are covered as medically necessary.
Chiropractors	Chiropractic services are covered only for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Circumcision	Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.
Diet Instruction	Diet instruction performed by a physician is considered part of a routine visit.
Drugs	Non-injectable drugs must be billed by a pharmacy to be covered. HCPCs drug codes are intended for use in Physician Offices and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for Compounded medications by the billing of NDC numbers through the Pharmacy Program directives. Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose.
Examinations	Physician visits for examinations are counted as part of each recipient's benefit limit of 14 physician visits per year. Exception: Certified Emergencies. Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, physicians within the same billing group are considered a single provider. Annual routine physical examinations are not covered except through EPSDT. Refer to Appendix A, EPSDT, for details. Medical examinations for such reasons as insurance policy qualifications are not covered. Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered. Medicaid requires a physician's visit once every 60 days for patients in a nursing facility. Patients in intermediate care facilities for the mentally retarded must receive a complete physical examination at least annually.

Eyecare	Eye examinations by physicians are a Medicaid covered service. Physician visits for eyecare disease are counted as part of each recipient's benefit limit of 14 physician visits per year.
Foot Devices	See Chapter 14, Durable Medical Equipment (DME), for details
Gastric bypass	Covered with prior authorization approval when specific medical criteria are met
Hearing Aids	See Chapter 10, Audiology/Hearing Services, for details.
Hyperbaric Oxygen Therapy	Topically applied oxygen is not hyperbaric and is not covered. HBO therapy should not be a replacement for other standard successful therapeutic measure. Medical necessity for the use of hyperbaric oxygen for more than two months must be prior approved (see Chapter 4, Obtaining Prior Authorization). Physician attendance should be billed using procedure code 99183. Prior approval for HBO for diagnoses not listed below or for treatments exceeding the limitations listed may be submitted to EDS for consideration on an individual recipient basis. Please note that no approval will be granted for diagnoses listed in the exclusion section. Program reimbursement for HBO therapy is limited to that which is administered in a chamber for the diagnoses found in Chapter 19 Hospital, under Outpatient Hyperbaric Oxygen Therapy (HBO).
Hyperalimention Parental TPN IDPN IPN	Please refer to Section 28.2.9 for documentation requirements for parental, TPN, IDPN, and IPN nutrition.
Immunizations	The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program. Medicaid reimburses administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program. Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT-4 codes. Refer to Appendix A, EPSDT, for more information. The single antigen vaccines may be billed only when medically justified and prior authorized. These vaccines are listed below: • Diphtheria • Measles • Mumps • Rubella Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service.
Infant Resuscitation	Newborn resuscitation (procedure code 99440) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.
Mammography Diagnostic	Diagnostic mammography is furnished to a man/woman with signs or symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, and includes a physician's interpretation of the results of the procedure. Services are not limited.
Mammography Screening	Furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedures. Services are limited to one screening mammography every 12 months for women ages 50 through 64.
Medical Materials and Supplies	Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

Medical Necessity	The Alabama Medicaid Agency is mandated to only reimburse for services, procedures, and surgeries that are medically necessary. Medical necessity must be documented in the recipient's medical record with supporting documentation such as: Laboratory test results, diagnostic test results, history (past attempts of management if applicable), signs and symptoms, etc.. All Medicaid services are subject to retrospective review for medical necessity. EXAMPLE: Endometrial Ablation is covered by Medicaid when it is considered medically necessary and should not be performed when an alternative outcome is intended such as cessation of menses. Medical necessity must be clearly documented in the medical record.
Newborn Claims	Five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital may be filed under the mother's name and number or the baby's name and number: 1. Routine newborn care (99431, 99433, and discharge codes 99238 or 99239) 2. Circumcision (54150 or 54160) 3. Newborn resuscitation (99440) 4. Standby 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 standby in the operating or delivery room during a caesarian section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. Use CPT codes when filing claims for these five kinds of care. If these services are billed under the mother's name and number and the infant(s) 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.
Newborn Hearing Screening	Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Outpatient facility services for newborn hearing screenings are considered non-covered. Limited hearing screen codes 92586 and 92587 (CPT 2002) may be billed in an outpatient setting provided: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center. These codes are reimbursable for audiologists, pediatricians, otolaryngologists, and EENT. Comprehensive hearing screen codes 92585/92588 may be billed for: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge. Code 92585 is reimbursable for otolaryngologists, audiologists, pediatricians, and EENT. Code 92588 is reimbursable for otolaryngologists, audiologists, pediatricians, EENT, and neurologists.
Obstetrical Services	Refer to Section 28.2.10
Obstetrical Ultrasounds	Obstetrical Ultrasounds are allowed up to two per pregnancy without prior authorization. All ultrasounds must be for reasons of medical necessity. Greater than two OB Ultrasounds per pregnancy must be supported with a medical diagnosis, benefit, and prior authorized.
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.

Podiatrist Service	Covered for QMB or EPSDT referred services only. See Chapter 29, Podiatrist, for more details.
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately the day of, or up to 90 days after surgery. Please refer to section 28.5.3 for listing of 10 day surgical global packages
Prosthetic Devices	Internal prosthetic devices (e.g., Smith Peterson Nail or pacemaker) are a covered benefit.
Psychiatric Services	Physician visits for psychiatric services are counted as part of each recipient's benefit limit of 14 physician visits per year. Psychiatric evaluation or testing are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations are limited to one per calendar year, per provider, per recipient. Psychotherapy visits are included in the office visit limit of 12 visits per calendar year. Office visits are not covered when billed in conjunction with psychotherapy codes. Psychiatric services under the Physicians' Program are confined to use with psychiatric diagnosis (290-319) and must be performed by a physician. Hospital visits are not covered when billed in conjunction with psychiatric therapy on the same day. For services rendered by psychologist, see Chapter 34 for details. Psychiatric day care is not a covered benefit under the Physicians' Program.
Radiation Treatment Management	Radiation treatment management services do not need to be furnished on consecutive days. Up to two units may be billed on the same date of service as long as there has been a separate break in therapy sessions.
Second Opinions	Physician visits for second opinions are counted as part of each recipient's benefit limit of 14 physician visits per year. Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.
Self-inflicted injuries	Self-inflicted injuries are covered.
Sleep Studies	Covered when billed through the enrolled physician's provider number or Outpatient hospital provider number. Medicaid does not enroll sleep study clinics. Unattended sleep studies (95806) are not covered by Medicaid. Please refer to Medicaid's LCD on the website at www.medicaid.alabama.gov for additional limitations.

	Surgery	Cosmetic surgery is covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member. Elective surgery is covered when medically necessary. Multiple surgeries are governed by the following rules: When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will not be made for procedures considered to be mutually exclusive or incidental. When multiple and/or bilateral procedures are billed in conjunction with one another that meet the definition of bundled, subset, CPT's "Format of Terminology", and/or comprehensive/component (bundled) codes, then, the procedure with the highest allowed amount will be paid while the lesser procedure will not be considered for payment as the procedure is considered an integral part of the covered service.. Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered/billable. Please note special coding exceptions listed at the end of this section. When billing multiple surgeries on the same date of service and same operative session, the primary procedure should be billed without a modifier 51 and subsequent surgical procedures should be billed with a modifier 51 appended. The exception is "Add-On" codes which do not require a modifier 51. Effective April 1, 2007, Medicaid adopted the CPT Modifier 51 Exempt Policy. Therefore, all CPT designated Modifier 51 Exempt procedures are NOT subject to rule of 50 percent reduction. The other exception to the 50 percent reduction is "Add-On" codes. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated or incidental surgical procedure. Surgeons performing laparoscopic procedures on recipients where a laparoscopic procedure code (PC) has not been established should bill the most descriptive PC with modifier 22 (unusual procedural services) until the new PC is established. 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. CPT defined Add-on codes are considered for coverage when billed with the appropriate primary procedure code. Effective January 1, 2005, code 69990 (operating microscope) may be paid separately only when submitted with the following CPT codes: 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907. Certain relatively small surgical procedure codes designated as "zero" global days, may be billed in addition to an office visit. Additionally, these codes do not carry the global surgical package concept of inclusion of post-operative care. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. Please refer to Section 28.5.3 Procedure Codes and Modifiers NOTE: Surgeons are responsible for submitting hard copy hysterectomy and tubal ligation consent forms to EDS at PO Box 244032, Montgomery, AL 36124 Attn: Desiree Nelson.

Added: Unlisted CPT codes…a modifier 22.

Service	***Coverage and Conditions***
Surgery, Breast Reconstruction	Breast reconstruction surgery is reimbursable following a medically necessary mastectomy when performed for the removal of cancer. All reconstructive procedures require prior authorization. The term "reconstruction" shall include augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Breast reconstruction surgeries are governed by the following rules: • The reconstruction follows a medically necessary mastectomy for the removal of cancer • The recipient is eligible for Medicaid on the date of reconstruction surgery • The recipient elects reconstruction within two years of the mastectomy surgery • The diagnosis codes used are appropriate • The surgery is performed in the manner chosen by the patient and the physician in accordance with guidelines consistent with Medicare and other third party payers • For more information regarding prior authorization, please refer to Chapter 4 Obtaining Prior Authorization. For more information related to breast prosthesis, please refer to Chapter 14 Durable Medical Equipment.
Therapy	Physician visits for therapy are counted as part of each recipient's benefit limit of 14 physician visits per year. See Rule No. 560-X-6.14 for details about this benefit limit in the *Alabama Medicaid Agency Administrative Code,* Chapter 6. Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. Refer to Chapter 19, Hospital, for more information. Group Therapy is a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally. Group Therapy is not covered when performed by a caseworker, social services worker, mental health worker, or any counseling professional other than physician. Group Therapy is included in the physician visit limit of 14 visits per year. Speech Therapy for a speech related diagnosis, such as stroke (CVA) or partial laryngectomy, is a covered benefit when prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting or in a nursing facility is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Family Therapy is a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation that justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is not covered when performed by a caseworker, social service worker, mental health worker, or any counseling professional other than a physician. Family Therapy is included in the physician visit limit of 14 visits per year.
Transplants	See Chapter 19, Hospitals, for transplant coverage.
Ventilation Study	Ventilation study is covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record must contain all of the following: • Graphic record • Total and timed vital capacity • Maximum breathing capacity Always indicate if the studies were performed with or without a bronchodilator.

Service	*Coverage and Conditions*
Well Baby Coverage	Well baby coverage is covered only on the initial visit, which must be provided within eight weeks of the birth. When the well-baby checkup is done, the physician should bill procedure code 99432. Only one well-baby checkup can be paid per lifetime, per recipient. Refer to Appendix A, EPSDT, for information on additional preventive services.

NOTE:

For newborn hospital discharge services performed on a subsequent admission date, use code 99238. Please use code 99435 when filing claims for newborns assessed and discharged from the hospital or birthing room on the same date.

Coding Exceptions

Specific codes sets in an audit were identified with an explanation as to why they should be removed or modified in the audit process. Medicaid agrees these codes sets can be billed together as an exception to CCI and/or CPT policy. As indicated, the multiple surgery rule will be applied.

Code Sets									*Multiple Surgery*
Right Heart Cath and Cath Placement 93526 and 36245									Yes
Bronchoscopy and Laryngscopy 31622-31525									Yes
Heart Cath and Endomyocardial Biopsy 93501 and 93505									Yes
Stents 92980 and 92981									No
Nerve block/Circumcision 54150 and 64450									Yes
Layer Closures 11000-11646; 12031-12057; 13100-13160									Yes
Cultures 87086 – 87070, 87086 – 87071 and 87086 – 87073									No
Venous vs. Arterial Codes 36600 and 36000									Yes
Chest x-ray code range (71010-71035) and abdomen range (74000-74022)									No
Operating Microscope 69990 (application of CPT rules instead of CCI. Effective 1/1/05, Medicare guidelines were applied)									No
93975 duplex scan and 76770 US retroperitoneal ultrasound									No
Tympanostomy 69436 – codes below									Yes
Allowed with 69436	11900	21030	30545	31238	31511	31615	40819	42720	42831
11300	12052	21555	30801	31240	31515	31622	40820	42806	42835
11305	14040	21556	30802	31254	31525	31624	41010	42810	42836
11401	15120	30115	30901	31255	31526	31625	41110	42815	42870
11420	15760	30130	30903	31256	31535	31641	41115	42820	42960
11440	17000	30140	31000	31267	31540	38510	41520	42821	42961
11441	17017	30200	31020	31276	31541	38542	42140	42825	43200
11444	17250	30310	31231	31287	31575	38724	42145	42826	43202
11900	20922	30520	31237	31288	31613	40808	42200	42830	43830

28.2.3 Non-covered Services

Service	Coverage and Conditions
Acupuncture	Acupuncture is not covered.
After Office Hours	The following services are not covered: After office hours, services provided in a location other than the physician's office, and office services provided on an emergency basis.
Autopsies	Autopsies are not covered.
Bariatric Procedures	Considered cosmetic unless specific medical criteria are met
Biofeedback	Biofeedback is not covered.
Blood Tests	Blood tests are not covered for marriage licenses.
Casting and Supplies	Some surgical codes are considered an inclusive package of professional services and/or supplies and are not considered separately allowable or reimbursable as the fracture repair or surgical codes is inclusive of these services. An example of this would be a surgical code for a fracture repair which is inclusive of any casting and strapping services or supplies.
Cerumen Removal	When a simple instrument is used, such as a curette, or a solvent or lavage is used, and the cerumen comes out easily, it is considered a component of an evaluation and management charge.
Chiropractors	Chiropractic services are not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Dressing and Compression Wrap	Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered/billable.
Experimental Treatment or Surgery	Experimental treatment or surgery is not covered.
Filing Fees	Filing Fees are not covered.
Hypnosis	Hypnosis is not covered.
Laetrile Therapy	Laetrile therapy is not covered.
Mutually Exclusive Procedures	Mutually exclusive procedures are those codes that cannot reasonably be done in the same session and are considered not separately allowable or reimbursable. For example, a vaginal and abdominal hysterectomy on the same date of service.
Oxygen and Compressed Gas	Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.
Pulse Oximetry	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.
Surgery	When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPTs definition of "Format of Terminology" (bundled or subset) and/or comprehensive/component (bundled) codes, then the procedure with the highest amount will be paid while the procedure with the lesser amount will not be considered for payment as the procedure is considered an integral part of the covered service. Please refer to Section 28.5.3 Procedure Codes and Modifiers. Incidental surgical procedures are defined as those codes that are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery.

Service	*Coverage and Conditions*
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Surgical visits cannot be billed separately the day of surgery or up to 90 days after surgery. Visits by Assistant Surgeon or Surgeons are not covered.
Preventive Medicine	Medicaid does not cover preventive medicine other than those specified elsewhere, including but not limited to, EPSDT screening.
Syntocin	Syntocin is not covered.
Telephone Consultations	Telephone consultations are not covered.
Therapy	Occupational and Recreational Therapies are not covered.

28.2.4 Limitations on Services

Within each calendar year each recipient is limited to no more than a total of 14 physician visits in offices, hospital outpatient settings, nursing facilities, rural health clinics or Federally Qualified Health Centers. Visits not counted under this benefit limit will include, but not be limited to, visits for: EPSDT, prenatal care, postnatal care, and family planning. Physicians services provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year. If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

Office visits are limited to one per day per recipient per provider. For purposes of this limitation, physicians within the same group are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year.

For further information regarding outpatient maintenance dialysis and ESRD, refer to Chapter 35, Renal Dialysis Facility.

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

28.2.5 Physician Services to Hospital Inpatients

In addition to the 14 physician visits, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider.

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

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

Physician(s) may bill for inpatient professional interpretation(s), when that interpretation serves as the official and final report documented in the patient's medical record. Professional interpretation may be billed in addition to a hospital visit if the rounding physician also is responsible for the documentation of the final report for the procedure in the patient's medical record. Professional interpretation may not be billed in addition to hospital visits if the provider reviews results in the medical record or unofficially interprets medical, laboratory, or radiology tests. Review and interpretation of such tests and results are included in the evaluation and management of the inpatient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit for most services. Professional interpretations are allowed in the inpatient setting for the following services:

Echocardiography (i.e., M-mode, transthoracic, complete and follow up)

Echocardiography (i.e., 2D, transesophageal)

Echocardiography (i.e., Doppler pulsed or continuous wave with spectral display, complete and follow up)

Cardiac Catheterizations

Comprehensive electrophysiologic evaluations and follow up testing

Programmed stimulation and pacing

Intra-operative epicardial and endocardial pacing and mapping

Intracardiac catheter ablations; intracardiac echocardiography

Evaluation of cardiovascular function

Plethysmography, total body and tracing

Ambulatory blood pressure monitoring

Cerebrovascular arterial studies, extremity arterial studies, venous studies, and visceral and penile studies

Circardian respiratory pattern recording (i.e., pediatric pneumogram), infant

Needle electromyography

Ischemic limb exercise test

Assessment of aphasia

Developmental testing

Neurobehavioral status exam and neuropsychological testing battery

Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting can only be billed by pathologists and radiologists. The only exception is for professional interpretations by cardiologists for catheterization or arterial studies and for select laboratory procedures by oncologists and hematologists. Professional interpretations/components done by other physicians for services in this procedure code range are included in the hospital visit if one is done. If no hospital visit is made, professional interpretation by physicians other than radiologists, pathologists, oncologists, hematologists, and cardiologists should not be billed as these services are covered only for the above-mentioned specialties.

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

Professional interpretations performed for an inpatient are counted by dates of service rather than the number of interpretation performed.

An office visit and an inpatient visit shall not be paid to the same physician on the same day. If both are billed, then the first Procedure Code billed will be paid.

Physician consults are limited to one per day per recipient.

28.2.6 Critical Care

When caring for a critically ill patient, for whom the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. Critical care guidelines are defined in the Current Procedural Terminology (CPT) and Provider Manual. Critical care is considered a daily global inclusive of all services directly related to critical care. These codes can only be billed for a recipient age 25 months and older.

Coverage of critical care may total no more than four hours per day.

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

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except:

- An EPSDT screening may be billed in lieu of the initial hospital care (P/C 99221, 99222, or 99223). If screening is billed, the initial hospital care cannot be billed.
- Procedure code 99082 (transportation or escort of patient) may also be billed with critical care (99291 and/or 99292). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.

LIMITATIONS:

- Procedure codes 99291 and 99292 may be billed by the physician providing the care of the critically ill or injured patient in place of service 41, Ambulance, if care is personally rendered by the physician providing the care of the critically ill or injured patient.

28.2.7 Pediatric and Neonatal Critical Care

CPT Code	Description	Criteria
99293	Initial Inpatient Pediatric Critical Care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Not valid for ages 28 days or less, can be billed by any physician provider type
99294	Subsequent Inpatient Pediatric Critical Care per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age.	Not valid for ages 28 days or less, can be billed by any physician provider type
99295	Initial Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for ages 29 days or older, can be billed by any physician provider type
99296	Subsequent Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for ages 29 days or older, can be billed by any physician provider type

The pediatric and neonatal critical care codes (99293-99296) include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

Routinely these codes may include any of the following services, therefore these services should not be billed separately from the critical care codes 99293-99296: umbilical venous or umbilical arterial catheters, central or peripheral vessel catheterization, other arterial catheters, oral or nasal gastric tube placement, endotracheal intubation, lumbar puncture, suprapubic bladder aspiration, bladder catheterization, initiation and management of mechanical ventilation or CPAP, surfactant administration, intravascular fluid administration, transfusion of blood components (excluding exchange transfusions), vascular puncture, invasive or non-invasive electronic monitoring of vital signs, beside pulmonary function testing, and/or monitoring or interpretation of blood gases or oxygen saturation.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the critically ill neonate/infant. Only one criterion is required to be classified as critically ill.

- Respiratory support by ventilator or CPAP
- Nitric oxide or ECMO
- Prostaglandin, Indotropin of Chronotropic or Insulin infusions

- NPO with IV fluids
- Acute Dialysis (renal or peritoneal)
- Weight less than 1,250 grams
- Acute respiratory distress in a pediatric admission requiring oxygen therapy with at least daily adjustment and FIO2>35% oxygen by oxyhood.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99293-99296 except:

- Chest tube placement
- Pericardiocentesis or thoacentesis
- Intracranial taps
- Initial hospital care history and physical or EPSDT screen may be billed in conjunction with 99295. Both may not be billed. NOTE: One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.
- Standby (99360), resuscitation (99440), or attendance at delivery (99436) 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.

LIMITATIONS:

- Code 99293 (initial inpatient pediatric critical care) is reported for the initial evaluation and management on the first day for infants 29 days through 24 months of age.
- Code 99294 (subsequent inpatient pediatric critical care) is reported for subsequent days (per day) for infants 29 days through 24 months of age.
- Code 99295 (initial inpatient neonatal critical care) is reported for subsequent days (per day) for neonates, 28 days of age or less.
- Code 99296 (subsequent inpatient neonatal critical care) is reported for subsequent days (per day) for neonates, 28 days of age or less.
- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight service codes are reported once per day per recipient.
- Subsequent Hospital Care codes (99231-99233) cannot be billed on the same date of service as neonatal critical care codes (99293-99296)

- Only one unit of critical care can be billed per child per day in the same facility. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).

- Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria, should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU critical care codes to be billed again.
- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).

- Transfers to the pediatric unit from the NICU cannot be billed using critical care codes. Subsequent hospital care would be billed in these instances.

- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined above. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

28.2.8 Intensive (Non-Critical) Low Birth Weight Services

CPT Code	Description	Criteria
99298	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth	May only be billed by a neonatologist
99299	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)	May only be billed by a neonatologist

These codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting. Services provided to these infants exceed those available in less intensive hospital areas of medical floors. These infants require intensive cardiac and respiratory monitoring, continuous and/or frequent vital signs monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct supervision.

Restrictions:

No individual procedures related to critical care may be billed in addition to procedure codes 99298-99299 except:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps

Limitations:

- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as per the setting. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.
- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight services codes are only reported once per day per recipient.

28.2.9 End-Stage Renal Disease (ESRD)

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these service, For example, an attending physician who provides evaluation and management (E & M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E & M services for ipatient visits.

- Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

Refer to Chapter 35, Renal Dialysis Facility, for further details.

Parenteral Nutrition

The Alabama Medicaid Agency may reimburse for total parenteral nutritional (TPN) solutions through the pharmacy program if the recipient meets certain requirements as listed below. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). Requirements must be met and clearly documented in the medical record for coverage of all TPN. All services rendered are subject to post payment review.

Statement of Medical Necessity

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyperalimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient's medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of the initial order and updated yearly in accordance with Medicaid billing practice.

Hyperalimentation

Medicaid covers hyperalimentation for recipients who meet certain requirements of medical necessity and documentation in the medical record is sufficient based on the following:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. The following are considered conditions which could cause insufficient absorption:
  1. Crohn's disease
  2. Obstruction secondary to stricture or neoplasm of the esophagus or stomach
  3. Loss of ability to swallow due to central nervous system disorder, where the risk of aspiration is great
  4. Short bowel syndrome secondary to massive small bowel resection
  5. Malabsorption due to enterocolic, enterovesical or enterocutaneous fistulas (TPN temporary until the repair of the fistula)
  6. Motility disorder (pseudo-obstruction)
  7. Prolonged paralytic ileus following a major surgical procedure or multiple injuries
  8. Newborn infants with catastrophic gastrointestinal anomalies such as tracheoesophageal fistulas, gastroschisis, omphalocele or massive intestinal atresia
  9. Infants and young children who fail to thrive due to systemic disease or secondary to insufficiency associated with short bowel syndrome, malabsorption or chronic idiopathic diarrhea.
- Medical record documentation must include supporting evidence that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, hyperalimentation must be given in order to meet 100% of the patient's nutritional needs.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include BUN, serum albumin, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

IDPN and IPN involves infusing hyperalimentation fluids as part of dialysis, through the vascular shunt or intraperitoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN

- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication
- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.
- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol level, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Restrictions

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist; these are as follows:

- Glucose
- Dextrose
- Trace Elements
- Multivitamins

28.2.10 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth in Rule No. 540-X-7-.34 of the Alabama Board of Medical Examiners. The AA must enroll and receive a provider number to bill the Alabama Medicaid Program. Refer to Chapter 38, Anesthesiology, for more information.

28.2.11 Obstetrical and Related Services

The following policy refers to maternity care billed as fee-for-service and not as a part of the Maternity Care program. Refer to Chapter 24, Maternity Care Program, for more details.

Physician visits for obstetrical care are counted as part of each recipient's benefit limit of 14 physician visits per year under the conditions listed below.

Maternity Care and Delivery
The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered.

NOTE:

When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code in billing.

If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of 14 physician office visits a calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

NOTE:

The date of service on the “global” OB claim must be the date of delivery.

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

To justify billing for global antepartum care services, physicians must utilize the CPT-4 antepartum care global codes (either 4-6 visits or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's limit of 14 office visits per year.

NOTE:

Physicians who provide less than four (4) visits for antepartum care must utilize CPT-4 codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's limit of 14 physician visits a calendar year.

Billing for antepartum care services in addition to "global" care is not permissible. However, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high-risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's limit of 14 physician office visits a calendar year.

Delivery and Postpartum Care

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

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

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

Delivery Only

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

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

Ultrasounds

Obstetrical ultrasounds are limited to two per pregnancy and one (1) per day per recipient. For patients covered under the maternity care waiver, refer to Chapter 24, Maternity Care Program. Generally, first ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations. Second ultrasounds may be conducted to detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

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

- Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patient compliance)
- Failure to gain weight, evaluation of fetal growth
- Pregnancy-induced hypertension
- Vaginal bleeding of undetermined etiology
- Coexisting adnexal mass
- Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios)
- Pregnant trauma patient
- Congenital diaphragmatic hernia (CDH)
- Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement
- Assist in operations performed on the fetus in the uterus
- Detection of fetal abnormalities with other indicators or risk factors (Low human chronic gonadotrophin (HCG) and high-unconjugated estriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21)
- Determination of fetal presentation
- Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation
- Suspected hydatidiform mole
- Suspected fetal death
- Suspected uterine abnormality
- Suspected abrupt placenta
- Follow-up evaluation of placental location for identified placenta previa
- Maternity Care subcontractors should contact the Primary Contractor for information regarding obstetrical ultrasounds.

To determine if a procedure requires prior authorization, providers should use the AVRS line at EDS, 1(800) 727-7848.

Emergency Services For Non-Citizens

Miscarriages

Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid continue to be processed manually, until further notice. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the Sobra worker, who determines eligibility; then forwards information to Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.

Delivery Services Billable Through EDS

Procedure code 01967 has been added to the list of codes billable through EDS for medical claims.

For CMS-1500 (formerly HCFA-1500) medical claims, the following procedures are covered:

- 59409-vaginal delivery only
- 59612-vaginal only, after previous c-section
- 59514-c-section only
- 59620-c-section only, after attempted vaginal, after previous c-section
- 01960-vaginal anesthesia
- 01961-c-section anesthesia
- 01967-neuraxial labor analgesia/anesthesia
- 62319-epidurals

For UB-92 inpatient claims, the following per diem is covered:

- Up to 2 days for vaginal delivery
- Up to 4 days for c-section delivery.

Allowable diagnoses codes for CMS-1500 or UB-92:

V270 - V279	V300 - V3921	650
65100-65993	6571 - 6573	

Allowable Surgical codes for UB-92 are 740-7499.

28.2.12 Vaccines For Children (VFC)

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

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

28.2.13 Lab Services

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected. The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected. Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Lab Tests Performed in Physician's Offices

When performing laboratory tests in the physician's office:

1. The Physician must be CLIA certified to perform the test,
2. The Physician must have the appropriate equipment to perform the test, and
3. The Physician's office bills for the tests performed but not the collection fee.

When specimens are sent to an outside lab:

1. The Physician's office should not bill the laboratory code, and
2. The Physician's office may bill a collection fee with a "90" modifier for blood specimens.

EXAMPLE:
Lead Levels

Procedure Code 83655 (Lead) should only be billed when the office has the equipment to perform the test. When collecting a specimen only and then sending the blood sample to an outside lab for analysis, you must bill Procedure Code 36415 with modifier 90. The utilization of procedure code 36415-90 will enable you to receive a collection and handling fee for the specimen obtained.

Procedure code 36415-90 should not be billed when lab procedures are performed in the office. The appropriate lab procedure code(s) must be billed when actually performing the lab test. Again, the correct equipment must be utilized to perform the test. These services are subject to post-payment review. Medical record documentation must support the performance and medical necessity of the laboratory test.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (e.g., finger, heal, ear stick) and Q0091-90 for collection of Pap smear specimen.

Repeat Lab Procedures

Modifier 91 may be utilized to denote a repeat clinical laboratory test performed on the dame date of service for the same recipient. Providers should use modifier 91 instead of modifier 76 for repeat lab procedures.

NOTE:

A physician CANNOT bill the following pathology/laboratory procedure codes, however the above collection fee can be billed, if applicable:

82775 Galactose – 1 – phosphate uridyl transferase; quantitative
83498 Hydroxyprogesterone, 17 – d
84030 Phenylalanine (PKU) blood
84437 Thyroxine; total requiring elution (e.g., neonatal)

28.2.14 Supply Code

The procedure code 99070 is utilized by physicians to bill for supplies and materials over and above those usually included with the office visit. Examples of supplies and materials over and beyond usual supplies include elastic wraps, disposable tubing for bronchial dilating equipment or post-operative dressing changes when no office visit is allowable.

28.3 Prior Authorization and Referral Requirements

Medical care and services that require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers, e.g., organ transplants and select surgical procedures. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

Unlisted services and procedure codes are not covered by the Alabama Medicaid Agency, with the exception of Medicare crossover claims and rare instances when approval is granted prior to service provision after the agency has determined that the service is covered and that no other procedure code exists for reimbursement.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

28.4 Cost Sharing (Copayment)

The copayment amount for physician office visit (including crossovers, and optometric) is $1.00 per visit. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost-sharing (copayment) amount imposed.

28.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Physicians who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

28.5.1 Time Limit for Filing Claims

Medicaid requires all claims for physicians to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

28.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

28.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

Filing Claims with Modifiers

Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites.

Appropriate Use of Modifiers

Modifier 51

When billing multiple surgeries on the same date of service and same operative session, the primary procedure should be billed without a modifier 51 and subsequent surgical procedures should be billed with a modifier 51 appended. The exception is “Add-On” codes which do not require a modifier 51.

Effective April 1, 2007, Medicaid adopted the CPT Policy for Modifier 51 Exempt procedure codes. Therefore, all Modifier 51 Exempt procedures are NOT subject to rule of 50 percent reduction. The other exception to the 50 percent reduction is “Add-On” codes.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as rebundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled, or allowed separately, in certain situations. If the two services are performed at two different times of day or the services are performed in two different anatomical sites, then modifier 59 can be submitted with the component procedure code.
In order to communicate the special circumstances of the component/comprehensive code pair unbundling, diagnoses codes and anatomical modifiers must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a copy of the Operative Report to further explain the reason for the unbundling of code pairs.

Modifier 76 (Repeat Procedure)

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure/service. From a coding perspective, modifier 76 is intended to describe the same procedure or service repeated, rather than the same procedure being performed at multiple sites.

Prior to January 1, 2004, providers were advised to file multiple services with modifiers Y2-Y9 and Z2-Z3 to avoid services being denied as duplicates. Since these modifiers have been eliminated, we are revising instructions for filing multiple services that are performed on the same day. The appropriate use of CPT and HCPCS codes is required when filing claims. In addition, *diagnosis codes* and *modifiers* should assist with accurately describing services billed. It is necessary to append the appropriate anatomical modifiers to procedure codes to differentiate between multiple sites. If a claim drops for manual review, the appropriate use of *diagnosis codes* and *modifiers* may assist claim reviewers in determining the intent of billing <u>without having to request documentation.</u> As always, providers can continue to file modifiers RT and LT when two of the same procedure is performed and one is on the right side and one is on the left side of the body. However, if more than one service is performed on the right or left side, services could be denied as duplicates if more than one RT or LT modifier is filed on the same procedure code. Modifier 76 is defined by the CPT as “Repeat Procedure by Same Physician”. Therefore, we are providing the following instructions with examples to educate providers on how to submit those services.

1) If multiple services are performed on the same side, anatomical modifiers must be filed in addition to modifier 76 on the second line item.

Date of Service	Place	Procedure	Number of Services
2/4/03-2/4/03	11	73580-RT	1
2/4/03-2/4/03	11	73580-RT76	1

2) If multiple services are performed on different sides and anatomical modifiers are descriptive, the use of modifier 76 is optional.

Date of Service	Place	Procedure	Number of Services
2/4/04-2/4/03	11	28820-T8	1
2/4/03-2/4/03	11	28820-TA	1

3) Modifier 76 is defined as “repeat procedures by the same physician”. The Agency requires claims for repeat procedures to be submitted as shown below.

The first line must be submitted with only one unit of service with no modifier and lines two through six with modifier 76 with one unit on each line. Any units greater than six must be submitted to Medicaid for administrative review.

Date of Service	Place	Procedure	Number of Services
2/1/06-2/1/06	22	25260	1
2/1/06-2/1/06	22	25260-76	1

Some services may be billed with multiple units of service, depending on the maximum number of units allowed by Medicaid.

Date of Service	Place	Procedure	Number of Services
3/1/06-3/1/06	11	88305	6

Bilateral Procedures

Effective for dates of adjudication October 1, 2006 and thereafter the procedure 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. The reimbursement was adjusted to 150% of Medicaid’s fee schedule.

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

- 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; 50 (Optional use of modifier 50)

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

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

Procedure Codes

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

NOTE:
Unlisted procedure codes are not covered by the Agency unless the provider requested and received approval for a prior authorization before the service is rendered. The Agency will deny all requests for payment of unlisted codes after the fact.

Physician-Employed Physician Assistants (PA) and Certified Registered Nurse Practitioners (CRNP)

Payment will be made only for physician drugs identified in Appendix H, Alabama Medicaid Physician Drug List, CPT codes identified in Appendix O, CRNP and PA Services, and laboratory services, which are CLIA certified. EPSDT screenings will be covered only if the provider is enrolled in that program. Refer to Appendix A, EPSDT, for EPSDT program requirements.

The Physician's Assistant or CRNP can make physician required inpatient visits to nursing facilities. However, physician required inpatient visits to hospitals or other institutional settings cannot be made by a PA or CRNP. CRNP and PA services have been expanded. Please refer to Appendix O for additional information.

Surgical Procedure Code Modifiers

When submitting claims for procedures done on the same date of service, a modifier is required to indicate that the repeated service is not a duplicate. If the **same** provider performs the repeat procedure, use modifier 76.

For repeat procedures done on the same date of service by a **different** provider, use modifier 77. Claims submitted for repeat procedures on the same date of service without modifiers are denied as duplicate services.

Modifier	***Description***
76	Repeat Procedure By Same Physician. Modifier indicates a procedure of service is repeated by the same physician subsequent to the original service. This situation may be reported by adding modifier 76 to the five-digit procedure code.
77	Repeat Procedure By Another Physician modifier indicates that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the five-digit procedure code.

Modifier	*Description*
59	Distinct procedural service modifier indicates that a service or procedure was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury in extensive injuries).

Global Surgical Packages

Effective for dates of adjudication 10/1/06 and thereafter, Medicaid will adopt Medicare's RVU file designation for global surgical days. In the past and through date of adjudication September 30, 2006, Medicaid has used a 62 day post op period after major surgeries.

Effective for dates of adjudication 10/1/06 and thereafter, Medicaid will use a zero, 10 day, and 90 day post op period for routine surgical care. The codes in the following list include a 10 day post op period and an office, hospital, or outpatient visit for routine post op care should not be billed within 10 days of surgery. Claims for these services will be subject to post payment review.

The major surgery codes that include a 90 day post op period will not be published. Post operative office visits for routine surgical care should not be billed as they are considered inclusive of the global surgical package.

Procedure Codes that include 10 day post op care:

FROM	TO	FROM	TO	FROM	TO
10040	10180	31000	31002	54505	
11010		31239		54620	
11043	11044	31290	31294	54700	
11200		36470	36471	55100	
11400	11446	36557	36566	55450	
11600	11646	36570	36571	55705	
11750	11752	36576	36578	56405	56515
11760	11770	36581	36583	56700	
12001	13101	36585	36590	56740	56800
13120	13121	38230		56810	
13131	13132	38300		57000	
13150	13152	38500		57022	57065
15340		38510		57105	
15786		38570	38572	57130	57135
17000		39400		57180	
17004		40800	40805	57415	
17110	17111	40808	40812	57505	57513
17260	17286	40820	40831	57820	
17340	17360	41000	41005	58120	
19101		41010		58345	
20000	20005	41100	41110	58350	58356
20100	20103	41115		58615	
20240	20251	41250	41252	58661	
20500		41800	41806	59160	
20520	20525	41822		59840	59841
20615	20650	41825	41826	60000	
20665	20670	41828	41830	61888	
21076		42000	42106	62194	

FROM	TO	FROM	TO	FROM	TO
21085		42160	42182	62263	62264
21315	21320	42280	42281	62280	62282
21355	21356	42310	42330	64446	
21550		42405		64448	64449
21920		42700	42720	64553	64565
22505	22521	42800	42809	64585	64622
22523	22524	42900		64626	
23030	23031	42960		64630	64640
23065		43750		64680	64681
23075		45005		65270	
23330		45900	45915	65855	
23700		46020	46030	66020	66030
23930	23931	46050		67345	
24065		46080	46083	67700	67805
24200		46220	46230	67825	67830
24640		46320	46505	67840	67850
25065		46706		67930	
26010	26011	46754		67938	
27040		46900	46924	68020	
27086		46935		68110	68115
27256	27257	46940	46942	68135	
27275		47382		68371	
27323		47525		68400	68440
27570		48102		68530	
27605	27606	49320	49322	68705	
27613		49422		68760	68761
27860		49428	49429	68801	68840
28001	28002	50592		69000	69020
28190		50688		69205	
28630	28636	51010		69222	
28660	28666	51705	51710	69405	69421
30000	30020	53000		69433	69436
30110		53060		69540	
30210	30310	53260	53275	69610	
30560		54000	54065		
30801	30802	54105			
30930		54152	54200		

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed one of three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component. NOTE: Not all providers are allowed to bill any or all of the three ways to bill. Specific coverage questions should be addressed to the Provider Assistance Center.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers. The Global component should be billed only for the following place of service locations:
  - 11 (Office)
  - 81 (Independent Laboratory)

- **Professional component**, the provider does not own or operate the equipment. The provider reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient hospital)
  - 22 (outpatient hospital)
  - 23 (emergency room - hospital)
  - 51 (inpatient psychiatric facility)
  - 61 (comprehensive inpatient rehab facility)
  - 62 (comprehensive outpatient rehab facility)
  - 65 (end-stage renal disease facility)
  - 81 (Independent Laboratory)
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code. The technical component can only be billed by facilities.

28.5.4 Billing for Patient 1st Referred Service

Please refer to Chapter 39 for information regarding the Patient 1st Program and Patient 1st referrals. Please refer to Chapter 5, Filing Claims, for information regarding filing claims for a Patient 1st referral.

28.5.5 Place of Service Codes

The following place of service codes apply when filing claims for physicians:

POS	***Description***
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or water
51	Inpatient Psychiatric Facility
52	Psy. Fac. Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Fac./Mentally Retarded
55	Residential Substance Abuse Treatment Facility

POS	Description
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

28.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

28.5.7 Consent Forms Required Before Payments Can Be Made

NOTE:

EDS will NOT pay any claims to ANY provider until a correctly completed original of the appropriate form is on file at EDS.

Abortions

In accordance with federal law, abortions are covered only (1) if the pregnancy is the result of an act of rape or incest; or (2) where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Please refer to Appendix E, Medicaid Forms, for a copy of the PHY-96-2 Certification and Documentation for Abortion form, which is used when the pregnancy is causing the life of the mother to be in danger. In the case of abortions performed secondary to pregnancies resulting from rape or incest, the documentation required is a letter from the recipient or provider certifying that the pregnancy resulted from rape or incest.

- The original copy of the PHY-96-2 form (for life of the mother in danger) signed by the attending physician, or the certification letter regarding rape or incest, and a copy of the medical records (history and physical, operative report and discharge summary) must be submitted to EDS.
- The second copy of the consent form or certification letter must be placed in the recipient's medical record.

- Copies of the consent form or certification letter may need to be provided to hospital, laboratory or other providers as applicable in order for them to submit billing for their services.

All claims relating to abortions must have the above-specified documentation on file at EDS prior to payment.

This documentation is not required when a recipient presents with a spontaneous abortion.

If the recipient does not qualify for payment by Medicaid and elects to have the abortion, providers may bill the recipient for the abortion as a non-covered service.

Sterilization

EDS must have on file the Medicaid-approved sterilization form. Refer to Appendix C, Family Planning, for more information.

Sterilization by Hysterectomy

Payment is not available for a hysterectomy if:

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

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are not covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

NOTE:

Sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Refer to Appendix E, Medicaid Forms, for a sample of the sterilization form.

Hysterectomy

The hysterectomy consent form was recently revised. The form was revised to include a section for unusual circumstances. Now this form can be used by a physician to certify a patient was already sterile when the hysterectomy was performed; a hysterectomy was performed under a life threatening situation; or a hysterectomy was performed under a period of retroactive Medicaid eligibility. In all of these circumstances, medical records must be forwarded to EDS along with the hysterectomy consent form and claim(s) in order for a State review to be performed.

NOTE:

The **doctor's explanation** to the patient that the operation will make her sterile and the **doctor's and recipient's signature** must precede the operation except in the case of medical emergency.

It is also important to note that certain fields on the hysterectomy consent form are non-correctable. The non-correctable fields include the recipient's signature and date of signed informed consent, the provider's signature and date of informed consent and the representative's signature and date of informed consent (if the recipient requires a representative to sign for them). If a non-correctable field is missing, contains invalid information or indicates the recipient/representative or physician signed after the date of surgery, EDS will deny the consent form.

EDS must have on file a Medicaid-approved Hysterectomy Consent Form. The revised hysterectomy consent form (form # PHY-81243) becomes effective January 1, 2004. Instructions for completing the consent form will be on the back of the consent form. See Appendix E, Medicaid Forms, or visit our website for a sample copy of this form.

Please note, only the surgeon should submit a hysterectomy consent form to EDS. All other providers should not request and submit copies of the consent form. Multiple copies slow down the consent form review and claims payment process.

Exceptions That Do Not Require Consent

If the following situations, the consent form is not required. If consent is not required, **the reason must be stated on the claim.**

1. The physician who performed the hysterectomy certifies in writing that the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated in this written statement.
2. The physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. This written statement must include a description of the nature of the emergency.
3. The hysterectomy was performed during a period of retroactive Medicaid eligibility, and the physician who performed the hysterectomy submits, in lieu of the consent form, a written statement certifying that the individual was informed before the operation that the hysterectomy would make her sterile.

NOTE:

Medicaid payment cannot be made for any claims for services provided in connection with an abortion, a sterilization procedure or a hysterectomy for medical reasons unless an approved consent form is on file. Please be aware consent for sterilization is different from consent for hysterectomy. See Appendix M, Medicaid Forms, for examples of each.

28.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Anesthesiology	Chapter 38
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

29

29 Podiatrist

Podiatrists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

The policy provisions for podiatrists can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 11.

29.1 Enrollment

EDS enrolls podiatrists and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a podiatrist is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for podiatry-related claims.

NOTE:
All nine digits are required when filing a claim.

Podiatrists are assigned a provider type of 17 (Podiatrist). Valid specialties for podiatrists include the following:

- Podiatry (48)
- QMB/EPSDT (EQ)

Enrollment Policy for Podiatrists

To participate in the Alabama Medicaid Program, podiatrists must meet the following requirements:

- Possess a current license issued to practice podiatry
- Operate within the scope of practice established by the appropriate state's Board of Podiatry

29.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Podiatry services are covered only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

For more information regarding the EPSDT program, refer to Appendix A, EPSDT.

29.3 Prior Authorization and Referral Requirements

Podiatrists may provide services for QMB recipients or to recipients referred as a result of an EPSDT screening.

For podiatry services to be paid by Medicaid for non-QMB recipients (i.e., EPSDT), the service must be medically necessary and the result of a referral from a contracted Medicaid EPSDT screening provider. Screening providers will complete and forward an Agency Referral Form (form 362), which must identify the reason for referral and serve as documentation that the services provided were the result of an EPSDT screening.

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

29.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

29.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Podiatrists who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

29.5.1 Time Limit for Filing Claims

Medicaid requires all claims for podiatrists to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

29.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

29.5.3 Procedure Codes and Modifiers

Podiatry providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Podiatry CPT codes describing procedures performed on the foot and toes range from 28001 - 29909. In addition to the 28001-29909 CPT codes, podiatrists may also use the evaluation and management codes 99201-99215 and nail codes 11719-11765. Procedure code coverage, maximum units and prior authorization requirements should be checked through AVRS prior to rendering service. Refer to Appendix L, AVRS Quick Reference Guide, for more details on verifying this information.

29.5.4 Place of Service Codes

The following place of service codes apply when filing claims for podiatry services:

POS Code	Description
11	Office
21	Inpatient Hospital

POS Code	Description
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

29.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

29.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

30

30 Preventive Health Education

Preventive Health Education Services are services provided by a physician or other licensed practitioner of the healing arts (within the scope of practice), or by other qualified providers, designed to prevent disease, disability, or other health conditions or their progression; to prolong life; and to promote physical and mental health and efficiency.

The purpose of these services is to reduce unintended adolescent pregnancies; decrease the rate of infant mortality; and decrease the incidence of maternal complications, low birth weight babies, and deaths among infants and small children.

The policy provisions for preventive health education services can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 50.

30.1 Enrollment

EDS enrolls preventive health education providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a preventive health education provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for preventive health education-related claims.

NOTE:

All nine digits are required when filing a claim.

Preventive health education providers are assigned a provider type of 99 (Other). The valid specialty for preventive health education providers is Preventive Health Education (P9).

Enrollment Policy for Preventive Health Education Providers

Providers include clinics or other organizations that use licensed practitioners of the healing arts within the scope of practice under state law and federal regulations.

Professional instructors of the provider must meet the following qualifications (according to specialty) as listed below:

- A health educator must have graduated from an accredited four-year college or university with major course work in public health, health education, community health, or health/physical education/recreation with a concentration in health.
- A social worker must be licensed by the Alabama Board of Social Work Examiners.
- A registered nurse must be licensed by the Alabama Board of Nursing as a Registered Nurse.
- A nurse practitioner must have successfully completed a supplemental program in an area of specialization, and must be licensed by the Alabama Board of Nursing as a Registered Nurse and be issued a certificate of approval to practice as a Certified Registered Nurse Practitioner in the area of specialization.
- A nurse midwife must be licensed by the Alabama Board of Nursing as a Registered Nurse and a Certified Nurse Midwife.
- A nutritionist must be licensed as a Registered Dietitian by the American Dietetic Association.
- A nutritionist associate must have graduated from a four-year college or university with major course work in nutrition or dietetics.
- A professional counselor must be licensed by the Alabama Board of Examiners in Counseling.
- A health instructor must have a bachelor's degree with extensive experience in providing instruction in preventive health education supplemented by a training program approved by the Alabama Medicaid Agency.

In cases where there is no licensing board for the instructors listed above, the instructor must work under the personal supervision of a physician or work in a facility that provides the services under the direction of a physician, such as in a clinic or outpatient hospital. "Under the supervision of" denotes that the physician is familiar with the Medicaid approved preventive information being presented to recipients and is available to the preventive health instructor by telephone, fax, or in person at the time the instructor is providing the preventive health education service. Providers must supply Medicaid with the name and resume of the physician supervising the instructor and maintain documentation sufficient to demonstrate their availability to the instructors.

All provider instructors must have successfully completed a training program, which is designed to prepare them to provide educational services. This training program must be approved by the Alabama Medicaid Agency.

Providers must develop a specific written curriculum for their educational services, including specific course content and objectives for each class. This curriculum must be approved by the Alabama Medicaid Agency.

30.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Eligibility of recipients for preventive health education services varies according to the type of service being provided.

- Prenatal Education services are limited to pregnant Medicaid eligible females (as evidenced by physical examination or a positive pregnancy test).
- Adolescent Pregnancy Prevention Education is available to all Medicaid eligible individuals who are of childbearing age, who are not pregnant, and who are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy.

Covered Services

Preventive Health Education Services are covered when provided by a Medicaid enrolled preventive health education service provider.

Prenatal and Pregnancy Prevention Education

Prenatal Education consists of a series of classes that teach pregnant women about the process of pregnancy, healthy lifestyles, and prenatal care. These services are covered for Medicaid eligible pregnant women only. Prenatal Education visits are limited to 12 visits per recipient during each two-year period beginning with the first date of service.

Adolescent Pregnancy Prevention Education

Adolescent Pregnancy Prevention Education consists of a series of classes which teach non-pregnant adolescents (male or female) about consequences of unintended pregnancy, methods of family planning, and decision-making skills. These services are covered for all Medicaid eligible non-pregnant individuals of child bearing age who are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy. Adolescent Pregnancy Prevention Education visits are unlimited.

Reimbursement

Reimbursement to providers is based on Medicaid's established fee schedule, not to exceed the prevailing rate in the locality for comparable services offered under comparable conditions.

30.3 Prior Authorization and Referral Requirements

Preventive health education procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

30.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by preventive health education providers.

30.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Preventive health education providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

30.5.1 Time Limit for Filing Claims

Medicaid requires all claims for preventive health education to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

30.5.2 Diagnosis Codes

Prenatal Education services are limited to diagnosis code V220 - V222. Adolescent Pregnancy Prevention Education services are limited to diagnosis code V2509.

30.5.3 Procedure Codes and Modifiers

The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Services are **limited** to the billing of the following two procedure codes:

Procedure Code	*Description*
S9445	Prenatal Education – Limited to pregnant female recipients. Limited to diagnosis code V220 - V222.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509.

30.5.4 Place of Service Codes

The following place of service code applies when filing claims for preventive health education services:

Code	*Description*
99	Other Unlisted Facility

30.5.5 Required Attachments

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

30.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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31 Private Duty Nursing

The purpose of the Private Duty Nursing Program is to provide payment for quality, safe, cost-efficient skilled nursing care to Medicaid recipients who require a minimum of four consecutive hours of continuous skilled nursing care per day. Skilled nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is medically necessary to treat or ameliorate medical conditions identified as a result of an EPSDT screening. The medical criteria herein must be present when the specified condition listed below is found. For conditions not found in the Alabama Medicaid Administrative Code, medical necessity review will be conducted by the Medicaid Medical Director. Medicaid recipients who do not meet the medical necessity requirements for the Private Duty Nursing Program have access to a variety of nursing and related community services. The Agency will make referrals to the appropriate programs based on the level of care needed.

A private duty-nursing agency is a public agency, voluntary non-profit organization, or proprietary agency that provides a minimum of four hours per day of continuous skilled nursing care in the recipient's home. Recipients eligible for in-home private duty-nursing services may be considered for services when normal life activities take the recipient outside the home.

The recipient must be under 21 years of age and referred as the result of an EPSDT screening.

NOTE:

Providers of private duty nursing services under the Technology Assisted (TA) Waiver for Adults should refer to the Alabama Medicaid Provider Manual, Chapter 107 for policy provisions.

The policy provisions for private duty-nursing providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

31.1 Enrollment

EDS enrolls private duty-nursing providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a private duty-nursing provider is issued a eight-character Medicaid provider number that enables the provider to submit requests and receive reimbursements for nursing-related claims.

NOTE:
All eight characters are required when filing a claim.

Private duty-nursing providers are assigned a provider type of 38 (Private duty-nursing). The valid specialty is Private duty-nursing (P6).

Enrollment Policy for Nursing Providers

Private duty-nursing providers enroll as EPSDT only. Only in-state private duty-nursing providers and out-of-state providers within 30 miles of the state line qualify for participation in the Medicaid program. Private duty-nursing providers must have a RN on staff.

31.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Nursing services must be prescribed as medically necessary by a licensed physician as a result of an EPSDT screening referral, based on the expectation that the recipient's medical needs are adequately and safely met in the home.

The EPSDT screening is valid for up to one year. If the need for services continues beyond the valid date, a new EPSDT screening is required.

All private duty-nursing services require prior authorization. Additionally, the recipient must be under 21 years of age to qualify and must be Medicaid eligible. The recipient must require skilled nursing care which exceeds the caregiver's ability to care for the recipient without the assistance of at least four consecutive hours of skilled nursing care.

Qualified Caregiver

Major commitment on the part of the recipient's family is mandatory to meet the recipient's needs. The primary caregiver must sign the *Private Duty Nursing Agreement for Care* form agreeing to participate in and complete training. Additional caregivers identified for training must be indicated on the *Private Duty Nursing Agreement for Care* form (Form 388). In the event that multiple caregivers exist, an adjustment in the hours approved for PDN will occur.

- The family must have at least one member capable of and willing to be trained to assist in the provision of care for the recipient in the home.
- The family must provide evidence of parental or family involvement, and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).

- Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

Hours Allowed For Continuation of Private Duty Nursing Services Under the Following Circumstances:

- Temporary Illness: Private duty nursing hours may be provided for a period up to 90 days if the primary caregiver is incapacitated due to personal illness or illness of another family member who is dependent upon the caregiver and there is no other trained caregiver available in the home. Temporary illness includes a required surgical procedure due to illness/disease, an illness which would be a danger to the child because of contagion, or an illness which is debilitating for a limited period. Medical documentation from the caregiver's attending physician is required. The number of hours approved is dependent upon the specific circumstances.
- Patient at Risk: Private duty nursing hours may be approved if the patient appears to be at risk of abuse, neglect, or exploitation in the domestic setting and a referral for investigation has been made to the appropriate state agency. The number of hours approved is dependent upon the specific circumstances.
- Sleep: Private duty nursing hours may be provided up to eight hours depending on the situation of the primary care giver. For example, a single parent with no other family support may be granted a full eight hours while two parents serving as primary caregivers may require fewer hours or only hours on an occasional basis.
- Work: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is at work plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. *A Private Duty Nursing Verification of Employment/School Attendance* form (Form 387) providing documentation of work hours must be completed.
- School: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is attending class plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. A current course selection guide published by the school, validated class schedule from school, curriculum guide and transcripts of previous courses taken must be provided along with a completed *Private Duty Nursing Verification of Employment/School Attendance form (Form 387)*. The coursework must be consistent with the requirement for obtaining a GED, college degree, or some other type of certification for employment. Courses selected must follow a logical approach with class hours being taken one after the other unless the course has been indicated by school officials as "closed".

NOTE:

The private duty-nursing program does not cover recipients receiving skilled nursing care through the home health program. Nursing care covered by Medicaid in both programs would result in duplicate reimbursements.

NOTE:

Any private duty nursing hours approved will be reduced by the number of hours of care which are provided or are available from other resources. Hours provided by sources other than Medicaid must be reported on the Private Duty Nursing Agreement for Care form (Form 388). In the event a child eligible for Medicaid is already attending or plans to attend public school, the case manager should contact the Special Education Coordinator within the appropriate school district to request that the child's Individual Education Program (IEP) committee meet to determine the student's need for related services. The names and contact information for the coordinators are on the education website at www.alsde.edu**.** The Individuals with Disabilities Education Act (IDEA) guarantees every child the right to a free, appropriate public education and related services in the least restrictive environment. The case manager may be asked to be part of the client's IEP team to facilitate the coordination of necessary related services. Related services needed in the school that are the same as services provided in the home should be closely coordinated. For example, a child needing nursing services should be evaluated and recommended for the appropriate level of care to ensure no break in services if services previously provided by Medicaid are subsequently provided by the school district. For children attending public school, the number of approved hours may be modified during the summer months and school breaks.

31.2.1 Criteria for Non-Ventilator-Dependent Recipients

High technology non-ventilator-dependent recipients may qualify for private duty-nursing services if they meet either of the following criteria and at least one qualified caregiver has been identified:

- Any one of the primary requisites is present.
- Two or more secondary requisites are present.

Primary Requisites

Primary requisites include, but may not be limited to, the following as qualifying criteria for nursing recipients:

- Tracheotomy - Coverage up to four months for acute (new) tracheotomy with up to an additional two months with documentation of continuing acute problems. Continuation of nursing services may be approved after initial certification for those periods of time when the primary caregiver is away from the home for work or school or otherwise unable to provide the necessary care.
- Total Parenteral Nutrition (TPN) - Coverage up to two months for acute phase with additional certification based upon the need for continuing therapy

- Intravenous Therapy - Coverage up to two months for a single episode. The number of hours required for a single infusion must be at least four continuous hours and require monitoring and treatment by a skilled nurse. An additional period of certification may be approved based on medical necessity for continuing therapy. Additional hours may also be approved for secondary criteria requisites listed below in conjunction with the primary criteria requisites.

Secondary Requisites

Secondary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Decubitus ulcers - coverage for stage three or four ulcers
- Colostomy or ileostomy care - coverage for new or problematic cases
- Suprapubic catheter care - coverage for new or problematic cases
- Internal nasogastric or gastrostomy feedings - coverage for new or problematic cases

31.2.2 Criteria for Ventilator-Dependent Recipients

Ventilator dependent recipients may qualify for private duty-nursing services if any one of the primary requisites is present and at least one qualified caregiver has been identified.

Primary Requisites

Primary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Mechanical ventilator support is necessary for at least six hours per day and appropriate weaning steps are in progress on a continuing basis.
- Frequent ventilator checks are necessary. Frequent ventilator checks are defined as daytime versus nighttime setting changes, weaning in progress, or parameter checks a minimum of every eight hours with subsequent ventilator setting changes.
- Oxygen supplementation for ventilator dependent recipients is at or below an inspired fraction of 40 percent (Fi02 of 0.40).

31.2.3 Scope of Services

This section lists the scope of services provided by professional nurses and licensed practical nurses.

Registered Nurse Services (RN)

A registered nurse employed by a Medicaid-enrolled private duty-nursing agency may provide continuous skilled nursing services to the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization.

The RN completes an in-home assessment to determine if services may be safely and effectively administered in the home. The registered nurse establishes a nursing care plan complying with the plan of treatment.

The RN must make monthly supervisory visits to evaluate the appropriateness of services rendered by a licensed practical nurse (LPN). An RN must be on call 24 hours a day, seven days a week.

Licensed Practical Nurse Services (LPN)

The LPN may provide continuous skilled nursing services for the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization. The LPN works under the supervision of the RN.

The RN evaluates the recipient and establishes the plan of care prior to assigning recipient services to the LPN.

The Medicaid program requires that the RN on a monthly basis provides direct or indirect supervisory visits of the LPN in the home of each recipient the LPN serves. Direct supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is present. Indirect supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is not present.

31.2.4 Documentation of Services

The private duty-nursing agency is responsible for establishing and maintaining a permanent medical record for each recipient including the following:

- Home Health Certification and Plan of Care form (HCFA-485) for certification and re-certification signed by the physician
- Medical Update and Patient Information form (HCFA-486) signed by the physician
- Private Duty Nursing Agreement for Care form (Form 388)
- EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services (Form 345), or Alabama Medicaid Agency Referral form (Form 362)
- Any additional physician orders
- Signature log with dates, duration of visits, types of service, and signature of the RN/LPN and the caregiver (a copy must be provided to the recipient or recipient's representative).
- Continuous progress reports
- Documentation of in-home RN visits to supervise the LPN

Medical records shall be retained for at least three years plus the current year.

Plan of Care

A plan of care must be developed and submitted with each request for service documenting the extent of nursing needs. Each professional participating in the recipient's care must carefully review the recipient's status and needs. Each discipline must formulate goals and objectives for the recipient and develop daily program components to meet these goals in the home. This plan must also include the following:

- Designation of a home care service coordinator
- Involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate
- Family access to a telephone
- A plan for monitoring and adjusting the home care plan
- A defined backup system for medical emergencies
- A plan to meet the educational needs of the recipient
- A clearly shown planned reduction of private duty hours
- Criteria and procedures for transition from private duty-nursing care, when appropriate

At each certification, the care plan will be denied, approved, or returned to request additional information. The recipient should transition to the most appropriate care when the recipient no longer meets the private duty-nursing criteria. The most appropriate care may be home care services, nursing facility placement, or the Home and Community Based Waiver Program.

31.2.5 Non-Covered Private Duty Nursing Services

When the recipient does not meet the medical need and diagnosis criteria or does not require at least four consecutive hours of continuous skilled nursing care per day, Medicaid will not cover private duty-nursing services.

Medicaid does not provide private duty-nursing services under the following circumstances:

- Observational care for behavioral, eating disorders, or for medical conditions that do not require medically necessary intervention by skilled nursing personnel
- Services not prescribed to treat or improve a condition identified as a result of an EPSDT screening
- Custodial, sitter, and respite services
- Services after the recipient is admitted to a hospital or a nursing facility
- Services after the recipient is no longer eligible for Medicaid

If the provider fails to comply with agency rules and program policies, Medicaid may recoup payments and terminate the provider contract.

Please refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 11, for detailed policy information.

31.3 Prior Authorization and Referral Requirements

All private duty-nursing services require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Private duty-nursing providers are required to submit to EDS the following forms for consideration of authorization for services:

- Alabama Prior Review and Authorization Request form (Form 342)
- EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362)
- Home Health Certification and Plan of Care form (HCFA-485) for certification and recertification signed by the physician.
- Medical update and Patient Information form (HCFA-486) signed by the physician
- Private Duty Nursing Agreement for Care form (Form 388)
- Any additional physician orders

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

The EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362) is valid for one year from date of screening. If the recipient continues to be approved for services beyond the one year screening date, a new EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362) indicating the current screening date and appropriate information must be submitted.

Re-certification

Every three months, documentation must be submitted to EDS to support the need for continuation of private duty-nursing services. Providers must submit re-certification requests to EDS **at least** 14 days prior to the re-certification due date. Re-certifications not received timely will be approved when criteria are met based on date of receipt. The request for re-certification will be approved or denied based on Medicaid criteria. EDS denies claims for services rendered after the cancellation date.

Emergency Change Authorizations

In an emergency situation where the delay of adjustment of prior authorization hours would endanger the health of the recipient, the case manager, private duty-nursing agency, or parent should initiate a change request within 24 hours of the onset of the emergency by contacting The Alabama Medicaid Agency Prior Approval Unit at (334) 242-5141.
If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message left at (334) 242-5141 or a fax sent to (334) 353-4917 or (334) 353-4914 will be accepted for consideration. The message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- Provider number of Private Duty Nursing Agency
- Phone number of Private Duty Nursing Agency
- Phone number and name of case manager, if applicable
- Nature of emergency and number of hours involved
- Contact person and contact telephone number for follow-up

The Addendum to the Care Plan (HCFA-487) and a Medical Update and Patient Information Form (HCFA-486) must be received by Medicaid Prior Approval Unit within ten calendar days of the voice message/fax request. Form HCFA-486 should indicate the reason for the emergency request (example; "child is ill and did not report to school") giving the date and the number of hours involved. If the documentation is not received within ten calendar days, the authorized START DATE will be the Julian (receipt) date of approval. To be approved, the request must meet established guidelines and criteria as set forth in Chapter 31 of the Provider Manual. Initiation of the Emergency Procedures does not guarantee approval, but establishes the earliest start date.

31.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by private duty-nursing providers.

31.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Private duty-nursing providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. When completing the UB-92, enter type of bill 331. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form (Form 341).

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

31.5.1 Time Limit For Filing Claims

Medicaid requires all claims for private duty-nursing providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

31.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

31.5.3 Procedure Codes

Private duty-nursing providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The following revenue codes and procedure codes apply when filing claims for private duty-nursing services:

Revenue Code	*Procedure Code*	*Description*
551	S9123/Modifier EP	Private Duty Nurse/RN
551	S9124/Modifier EP	Private Duty Nurse/LPN

31.5.4 Place of Service Codes

Place of services codes do not apply when filing the UB-92 claim form.

31.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more details about these attachments.

31.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.7.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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32 Provider-Based Rural Health Clinics

Rural health clinics are defined as clinics located in a rural area designated by the Bureau of Census as non-urbanized and medically under-served. Rural health clinics are designed to meet the needs of those recipients who might otherwise be unable to access medical attention.

Provider based rural health clinics are clinics that are an integral part of hospital, home health agency, or nursing facility. Provider-based rural health clinics are reimbursed on an encounter rate for services provided to Medicaid recipients.

Refer to the following chapters of the *Alabama Medicaid Agency Administrative Code*:

- Chapter 59 for policy for provider-based rural health clinics
- Chapter 60 for reimbursement policy

32.1 Enrollment

EDS enrolls rural health clinic providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is issued nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for claims.

NOTE:
All nine digits are required when filing a claim.

Rural health clinics are assigned a provider type of 29 (rural health clinics). The valid specialty for provider-based rural health clinics is Provider Based Rural Health Clinic (R2).

NOTE:

Physicians affiliated with rural health clinics are assigned their own Alabama Medicaid provider number, which links them to the clinic. The provider type for the physician is 29 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic provider number, and are not assigned individual provider numbers.

Enrollment Policy for Provider-Based Rural Health Clinics

In order to participate in the Title XIX (Medicaid) Program, and to receive Medicaid payment, a provider-based rural health clinic must:

- Receive certification for participation in the Title XVIII (Medicare) Program
- Obtain certification by the appropriate State survey agency
- Comply with the Clinical Laboratory Improvement Amendment (CLIA) testing for all laboratory sites
- Operate in accordance with applicable federal, state and local laws.

All clinics must enroll separately and execute a separate provider contract with Alabama Medicaid.

The effective date of enrollment of a provider-based rural health clinic will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

The provider based rural health clinic must be under the medical direction of a physician. The physician must be physically present at the clinic for sufficient periods of time to provide medical care services, consultation, and supervision in accordance with Medicare regulations for rural health clinics. A *sufficient period* is defined as follows:

- No less than once every 72 hours for non-remote sites
- At least once every seven days for remote sites

Remote sites are defined as those more than 30 miles from the primary supervising physician's principal practice location.

This requirement must be accommodated except in extraordinary circumstances. The clinic must fully document any extraordinary circumstances that prevent it from meeting this requirement.

When not physically present, the physician must be available at all times through direct telecommunication for consultation, assistance with medical emergencies or patient referral.

Change of Ownership

Medicaid must be notified within 30 calendar days of the date of a PBRHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within the 30 day timeframe.

Patient 1st Requirements for Provider-Based Rural Health Clinics

- The clinic must be a licensed federally recognized RHC enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, but not limited to, patient management, 24-hour coverage, and other program requirements.
- The RHC and or site must be opened a minimum of 40 hours per week and the physician must practice at the location of 40 hours per week to be considered a Full Time Equivalent (FTE)
- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of a total patient caseload will be allowed based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension. If the clinic is solely run by mid-level practitioners, then the FTP equivalent of those mid-level personnel will be applied against the 1200 maximum caseload.
- The RHC must specify what arrangements have been made for hospital admissions. If physicians within the RHC do not have admitting privileges, then the designee must be specified. If the RHC/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.

32.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

32.2.1 Covered Services

Rural health clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

The following services are covered in the provider-based rural health clinic:

- Medically necessary diagnostic and therapeutic services and supplies that are an incident to such services or as an incident to a physician's service and that are commonly furnished in a physician's office or a physician's home visit.
- Basic laboratory services essential to the immediate diagnosis and treatment of the patient that must include but are not limited to the following six tests that must be provided directly by the rural health clinic:
  - Chemical examinations of urine by stick or tablet methods or both (including urine ketones)
  - Hemoglobin or hematocrit
  - Blood glucose
  - Examination of stool specimens for occult blood
  - Pregnancy tests
  - Primary culturing for transmittal to a certified laboratory
- Medical emergency procedures as a first response to life threatening injuries and acute illness.
- Provider based rural health services may be provided by any of the following individuals:
- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, or registered nurse

The physician, physician assistant, nurse practitioner, certified nurse midwife, or registered nurse must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP can not make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

A nurse practitioner, physician assistant, or certified nurse midwife must furnish patient care services at least fifty (50%) percent of the time the clinic operates.

32.2.2 Reimbursement

PBRHC services are reimbursed by an all-inclusive encounter rate. All services provided for that date of service will be included in the encounter rate. If a recipient only has lab or x-rays, this will also constitute an encounter.

Reimbursement for an enrolled out-of-state PBRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state PBRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

NOTE:

The dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring will obtain these supplies from the county health department while maintaining a medical home with their chosen Plan First service provider. **Prescriptions for these supplies will not be honored at a pharmacy for Plan First patients.**

Plan First Providers are to submit an order per patient for the contraceptive method utilizing the **Plan First Patient Contraceptive Order Form.** This order will be in effect for one year from the time of the initial/annual family planning visit as dated on the order form. If changes in the contraceptive method are indicated due to patient need or preference, the patient will be required to obtain a new Plan First Patient Contraceptive Order Form from her provider.

The health department will provide oral contraceptives, the contraceptive patch and the vaginal ring as follows:

- First time users will initially receive a 3-month supply. If no problems exist upon return, the remainder of the year's supply will be issued.
- Current/Previous users will receive a 1-year supply.
- All contraceptive patch and vaginal ring users will receive a 3-month supply on a quarterly basis.

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

32.3 Prior Authorization and Referral Requirements

Procedure codes billed by rural health providers generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

32.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

NOTE:

Medicaid copayment is NOT a third party resource. Do not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For provider-based rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate established by Medicaid.

32.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Provider-based rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

32.5.1 Time Limit for Filing Claims

Medicaid requires all claims for provider-based rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

32.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

32.5.3 Procedure Codes and Modifiers

NOTE:

Provider based rural health provider should refer to Chapter 28, Physician, for procedure code information.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, or ear stick) and Q0091-90 for collection of Pap smear specimen.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities. Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
S9445	Prenatal Education (limited to 12 classes per recipient within 2-year period)
99412	Adolescent Pregnancy Prevention Education

32.5.4 Place of Service Codes

The following place of service codes apply when filing claims for provider-based rural health clinics:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

32.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

32.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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33 Psychiatric Treatment Facilities

The policy provisions for psychiatric hospitals and residential treatment facilities (RTFs) may be found in Chapter 41 of the Medicaid Administrative Code. The complete administrative code is found on the Medicaid website: www.medicaid.alabama.gov.

Psychiatric services for recipients under age 21 are covered services when provided under the following conditions:

- Under the direction of a physician
- By a psychiatric hospital enrolled as a Medicaid provider **OR**

  By a psychiatric residential treatment facility (RTF) which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (COA), or by another accrediting organization with comparable standards that is recognized by the State;
- Before the recipient reaches age 21
- If the recipient was receiving services immediately before he/she reached age 21, before the earlier of the following dates:
  - The date the recipient no longer requires the services
  - The date the recipient reaches age 22
  - The expiration of covered days
    - To a recipient admitted to and remaining in the facility for the course of the hospitalization
    - As certified in writing to be necessary in the setting in which it will be provided in accordance with 42 CFR 441.152.

Psychiatric hospitals and RTFs shall comply with all applicable regulations regarding the use of restraint and seclusion as cited in 42 CFR, Part 441, Subpart D, and 42 CFR, Part 483, Subpart G.

Inpatient and residential psychiatric services are unlimited if they are medically necessary and the admission and the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care provided in an acute care hospital.

Referrals from a recipient's Patient 1st Primary Medical Provider (PMP) are not required for admissions to psychiatric hospitals or RTFs.

However, hospitals and RTFs should notify the recipient's PMP of the admission within 72 hours by faxing a copy of the recipient's face sheet to the PMP. Fax numbers for all PMPs may be found in the "About Medicaid" section on the Medicaid website: www.medicaid.alabama.gov .

Ancillary services provided during the RTF stay may be billed fee-for-service if the recipient has been granted an exemption from the Patient 1st Program.

Written requests for Patient 1st exemptions should be submitted to Medicaid by the recipient's case worker or the RTF at the time of admission to the residential facility.

Requests must be submitted on the Patient 1st Medical Exemption Request found on the Medicaid website: www.medicaid.alabama.gov under the Patient 1st tab.

Written notification shall be provided to Medicaid by the caseworker or the RTF at the time of the recipient's discharge or transfer to another facility.

All correspondence regarding Patient 1st should be mailed to:

Alabama Medicaid Agency
Attention: Patient 1st Program
P.O. Box 5624
Montgomery, AL 36103-5624

33.1 Enrollment

EDS enrolls psychiatric hospital providers and issues provider contracts to applicants meeting the licensure and certification requirements of the State of Alabama, the Code of Federal Regulations, the *Medicaid Administrative Code*, and the *Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a psychiatric hospital or RTF is issued an eight-character Medicaid provider number that enables the provider to submit claims and receive reimbursements for psychiatric hospital-related services All eight characters are required when filing a claim.

Psychiatric hospitals and RTFs are assigned a provider type of 05 (Hospital). The valid specialty for psychiatric hospitals is (W3) and (WF) for RTFs.

Enrollment Policy for Psychiatric Hospital Providers

To participate in the Alabama Medicaid Program, psychiatric hospital providers must meet the following conditions:

- Receive certification for participation in the Medicare program
- Possess a license as an Alabama psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code. State hospitals that do not require licensing as per state law are exempt from this provision.
- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Have a distinct unit for children and adolescents
- Have a separate treatment program for children and adolescents

- Submit a written description of an acceptable utilization review plan currently in effect
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new provider

Psychiatric hospitals are required to submit a monthly inpatient census report to Medicaid. The census report must list the names of all Medicaid children and adolescents who are admitted to and discharged from the hospital during the calendar month. This report should also list the names of the children and adolescents who remain in the hospital during the calendar month. The census report must be received on or before the tenth of each month for the preceding month. Mail all reports to the following address: APS Healthcare, 1640 Phoenix Boulevard, Suite 200, Atlanta, Georgia 30349. Failure to send the required report within the specified time period will result in the hospital's reimbursement checks being withheld, until the report is received.

Deleted: ~~Medicaid must receive…the following month.~~

Added: The census report…Atlanta, GA 30349.

Deleted: ~~by Medicaid.~~

Psychiatric hospitals and RTFs may only bill for days when a recipient is on their census. If a recipient has been discharged to a general hospital, the psychiatric hospital/RTF must not bill Medicaid for those non covered days.

Enrollment Policy for Residential Treatment Facilities (RTFs)

To participate in the Alabama Medicaid program, RTFs must meet the following conditions:

- Be accredited by JCAHO, CARF, COA, or be certified as an Alabama RTF in accordance with standards promulgated by the Alabama Department of Human Resources (DHR), the Department of Mental Health/Mental Retardation (DMH/MR), or the Department of Youth Services (DYS), or the Department of Children's Services (DCA). Upon enrollment and each time the RTF is recertified a copy of the certification letter must be sent to Medicaid within forty-five business days.

Added: Upon enrollment and…forty-five business days.

- Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Execute a contract or placement agreement with DHR, DMH/MR, DYS, or DCA to provide residential psychiatric treatment services in the State of Alabama
- Execute a provider agreement with Alabama Medicaid to participate in the Medicaid program;
- Submit a written description of an acceptable UR plan currently in effect
- Submit a written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion upon enrollment and yearly on or before July 21;

Added: upon enrollment and yearly on or before July 21;

- Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21

All correspondence regarding application by Alabama RTFs for participation in the Medicaid program should be mailed to:

Alabama Medicaid Agency
Attention: Institutional Services
Box 5624
Montgomery, AL 36103.

33.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

For purposes of this chapter, an inpatient is a person admitted to a psychiatric facility for bed occupancy for purposes of receiving inpatient or residential psychiatric services.

The number of days of care charged to a recipient for inpatient psychiatric services is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used to report days of care for the recipients, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid covers the day of admission, but not the day of discharge.

33.2.1 Therapeutic Visits

Therapeutic visits away from the psychiatric hospital to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. An admission to a general hospital does not count as a therapeutic visit. Therapeutic visits are subject to the following limitations:

- No more than three days in duration
- No more than two visits per 60 calendar days per admission, per recipient

Therapeutic visit records will be reviewed retrospectively by Medicaid. Medicaid will recoup payments from providers who receive payments for therapeutic visits in excess of the amount as described above. This policy applies only to visits away from the psychiatric hospital. Visits away from the RTF are not limited by this policy.

33.3 Certification of Need for Inpatient and Residential Services

Providers should refer to Chapter 41 of the Medicaid Administrative Code for complete instructions on documenting the certification of need for inpatient or residential treatment services. Providers will find instructions for requesting prior authorization for inpatient hospital admissions and continued stays. Instructions for documenting emergency and non-emergency admissions to RTFs will also be found in Chapter 41.

All entries in the medical record must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate

his or her entry. Authentication may include signatures, written initials, or computer entry.

Reimbursement

Medicaid pays for inpatient services provided by psychiatric hospitals according to the per diem rate established for the hospital. The per diem rate is based on the Medicaid cost report and the provisions documented in the *Medicaid Administrative Code,* Chapter 23.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive one copy of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

If a uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100.00 per day for each calendar day after the due date.

Medicaid pays for residential treatment services provided by RTFs according to the per diem rate established in the placement agreement between the RTF and the contracting state agency (DHR, DYS, DMH, DCA).

33.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by inpatient psychiatric hospitals or RTFs.

33.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Psychiatric hospitals and RTFs billing Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

33.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

33.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

33.5.3 Revenue Codes

Refer to the Alabama UB-92 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

33.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

33.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with Third Party Denials.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

33.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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34 Psychologists

Licensed psychologists are enrolled only for services provided to QMB recipients or to recipients under the age of 21 referred as a result of an EPSDT screening.

The policy provisions for psychologists can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

34.1 Enrollment

EDS enrolls Psychology providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Psychology provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for psychology-related claims.

NOTE:

All nine digits are required when filing a claim.

Psychology providers are assigned a provider type of 19 (Psychologist). Valid specialties for psychology providers include the following:

- Psychology (62)
- QMB/EPSDT (EQ)

Enrollment Policy for Psychology Providers

Psychologists must meet the following requirements for participation in Medicaid:

- Possess a doctoral degree in psychology from an accredited school or department of psychology
- Have a current license issued by the Alabama Board of Psychology to practice as a psychologist
- Operate within the scope of practice as established by the Alabama Board of Psychology

34.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for psychology providers.

Psychology services are only covered for QMB recipients or for recipients referred directly as a result of an EPSDT screening.

NOTE:

Psychology providers can bill only those procedures listed in Section 34.5.3, Procedure Codes and Modifiers. Only the diagnosis codes within the range of 290-316 are covered for treatment services under this program. Mental retardation diagnosis codes (317-319) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120), and interpretation of results (90887) even if the resulting diagnosis is mental retardation.

Client Intake

An intake evaluation must be performed for each client considered for initial entry into any course of covered services.

The intake evaluation process shall result in a determination of the client's need for psychological services based upon an assessment that must include relevant information from among the following areas:

- Family history
- Educational history
- Medical history
- Educational/vocational history
- Psychiatric treatment history
- Legal history
- Substance abuse history
- Mental status exam
- Summary of the significant problems the client is experiencing

Treatment Planning

The intake evaluation process shall result in the development of a written treatment plan completed by the fifth client visit.

The treatment plan shall:

- Identify the clinical issues that will be the focus of treatment
- Specify those services necessary to meet the client's needs

- Include referrals as appropriate for needed services
- Identify expected outcomes toward which the client and therapist will work to have an effect on the specific clinical issues
- Be approved in writing by a psychologist licensed in the state of Alabama

Services must be specified in the treatment plan in order to be paid by Medicaid. Changes to the treatment plan must be approved by the psychologist licensed in the state of Alabama.

The psychologist must review the treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. This review shall be documented in the client's clinical record by notation on or near the treatment plan. This review shall note the treatment plan has been reviewed and updated or continued without change.

Service Documentation

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested shall include, at a minimum, the following:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

The list of required documentation described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed.

34.3 Prior Authorization and Referral Requirements

Psychology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

34.4 Cost Sharing (Copayment)

Copayment does not apply to services provided to recipients under the age of 18. A copayment of $1.00 applies to psychology services provided to recipients over the age of 18.

34.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Psychology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

34.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Psychology to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

34.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

34.5.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for psychologist services. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes listed in this section are covered under this program. Some codes are covered for QMB recipients only. Check the guidelines following this grid.

CPT Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90801	Psychiatric diagnostic interview examination		1	1
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication		1	1
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90805	With medical evaluation and management services	3	2	52
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90807	With medical evaluation and management services	3	1	26
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90809	With medical evaluation and management services	2, 3	1	12
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90811	With medical evaluation and management services	3	2	52
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90813	With medical evaluation and management services	3	1	26
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12

CPT Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90815	With medical evaluation and management services	2, 3	1	12
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90817	With medical evaluation and management services	3	2	52
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90819	With medical evaluation and management services	3	1	26
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90822	With medical evaluation and management services	2, 3	1	12
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90824	With medical evaluation and management services	3	2	52
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90827	With medical evaluation and management services	3	1	26
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90829	With medical evaluation and management services	2, 3	1	12
90847	Family medical psychotherapy (conjoint psychotherapy) with patient present	4	1	12
90849	Multiple-family group psychotherapy	4	1	12

CPT Code	Description	See Note	Daily Max	Annual Max
90853	Group psychotherapy (other than of a multiple-family group)	5	1	12
90887	Interpretation of explanation of results of psychiatric data, other medical examinations and procedures, or other accumulated data to family or other responsible persons; or advising them how to assist patient	7	1	12
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	6,7	5	5
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAID), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	6,7	5	5
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report	6,7	1	5
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	7,8	5	5
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Bettery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report	7	5	5

CPT Code	*Description*	*See Note*	*Daily Max*	*Annual Max*
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Bettery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	7	5	5
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	7	1	5

Guidelines for Covered Procedure Codes:

1. Individual psychotherapy codes should be used only when the focus of the treatment encounter involves psychotherapy. Psychotherapy codes should not be used as generic psychiatric service codes when another code, such as an E&M or pharmacologic management code, would be more appropriate.
2. Procedure codes 90808, 90809, 90814, 90815, 90821, 90822, 90828, and 90829 (75-80 minutes) are covered for QMB recipients only. These codes are reserved for exceptional circumstances and should not be routinely used. The provider must document in the client's clinical record the medical necessity of these services **and** define the exceptional circumstances
3. Medicaid will not accept psychiatric therapy procedure codes 90804-90829 being billed on the same date of service as an E&M service by the same physician or mental health professional group.
4. Procedure codes 90847 and 90849 are used to describe family participation in the treatment process of the client. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems in the family members in treatment.
5. Procedure code 90853 is used when psychotherapy is administered in a group setting with a trained group leader in charge of several clients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. Group therapy must be led by a clinical psychologist licensed in the state of Alabama.
6. Procedure code 96101-96103 includes the administration, interpretation, and scoring of the tests mentioned in the CPT description and other medically accepted tests for evaluation of intellectual strengths, psychopathology, mental health risks, and other factors influencing treatment and prognosis. The clinical record must indicate the presence of mental illness or signs of mental illness for which psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved.

7. Mental retardation diagnosis codes (317-319) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120), and interpretation of results (90887) even if the resulting diagnosis is mental retardation.
8. Procedure Code 96116 is intended to describe the performance of gathering information to provide an important first analysis of brain dysfunction and progression and changes in the symptoms over time. This exam must include screening for impairments in acquired knowledge, attention, language, learning, memory, problem solving, and visual-spatial abilities.

Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary.

NOTE:

Procedure codes 90862, pharmacologic management, and 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes, **are covered for physicians only** and may not be billed by psychologists.

34.5.4 Place of Service Codes

The following place of service codes apply when filing claims for psychology services:

POS Code	*Description*
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
72	Rural Health Clinic
99	Other Unlisted Facility

34.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

34.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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35 Renal Dialysis Facility

End Stage Renal Disease (ESRD) services are outpatient maintenance services provided by a freestanding ESRD facility or hospital-based renal dialysis center.

The policy provisions for Renal Dialysis Facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 24.

35.1 Enrollment

EDS enrolls Renal Dialysis Facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Renal Dialysis Facility provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for dialysis-related claims.

NOTE:
All eight characters are required when filing a claim.

Renal Dialysis Facility providers are assigned a provider type of 34 (Renal Dialysis Facility). The valid specialty for Renal Dialysis Facility providers is Hemodialysis (H5).

Enrollment Policy for Renal Dialysis Facility Providers

To participate in Medicaid, End Stage Renal Disease (ESRD) facilities/centers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authority

Satellites and sub-units of facilities or centers must be separately approved and contracted with Medicaid.

35.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid covers maintenance dialysis treatments when they are provided by a Medicaid-enrolled hospital-based renal dialysis center or a freestanding ESRD facility. The maintenance dialysis treatments do not count against the routine outpatient visit limit.

Hemodialysis is limited to 156 sessions per year, which provides three sessions per week.

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuing Cycling Peritoneal Dialysis (CCPD) are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis. Providers are to report the number of days in the units field on the claim.

The daily IPD or CAPD/CCPD payment does not depend upon the number of exchanges of dialysate fluid per day (typically 3-5) or the actual number of days per week that the patient undergoes dialysis. The daily rate is based on the equivalency of one week of IPD or CAPD/CCPD to one week of hemodialysis, regardless of the actual number of dialysis days or exchanges in that week.

Reimbursement will be based on a composite rate consisting of the following elements of dialysis treatment:

- Overhead costs
- Personnel services, such as administrative services, registered nurse, licensed practical nurse, technician, social worker, and dietician
- Equipment and supplies
- Use of a dialysis machine
- Maintenance of the dialysis machine
- ESRD-related laboratory tests
- Biologicals and certain injectable drugs, such as heparin and its antidote

NOTE:

Dialysis facilities that have a physician who performs EKGs on-site can apply for a physician provider number that will pay to the facility. The CPT-4 procedure codes for EKG tracing and interpretation may be billed using the physician provider number on the CMS-1500 claim form.

Laboratory Services

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. All other medically necessary lab tests are considered nonroutine and must be billed directly by the actual provider of service.

Hemodialysis

The following table lists Hemodialysis tests and frequency of coverage:

Frequency	*Covered Tests*
Per treatment	All hematocrit and clotting time tests furnished incidentally to dialysis treatments.
Weekly	Prothrombin time for patients on anticoagulant therapy; serum creatinine, BUN.
Monthly	Alkaline Phosphates LDH Serum Biocarbonate Serum Calcium Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein

Continuous Ambulatory Peritoneal Dialysis (CAPD)

The following table lists CAPD tests and frequency of coverage.

Frequency	*Covered Tests*	
Monthly	BUN	Total Protein
	Creatinine	Albumin
	Sodium	Alkaline Phosphatose
	Potassium	LDH
	CO2	SGOT
	Calcium	HCT
	Magnesium	Hgb
	Phosphate	Dialysis Protein

All laboratory testing sites providing services to Medicaid recipients, either directly by provider or through contract, must be certified by Clinical Laboratory Improvement Amendments (CLIA) that they provide the required level of complexity for testing. Providers are responsible for assuring Medicaid that they strictly adhere to all CLIA regulations and for providing Medicaid waiver certification numbers as applicable.

Laboratories that do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from Medicaid.

Ancillary Services

The actual provider of services must bill take home drugs that are medically necessary under the pharmacy program.

Routine parenteral items are included in the facility composite rate and may not be billed separately.

Non-routine injectables administered by the facility may be billed by the facility actually providing this service. Non-routine injectables are defined as those given to improve an acute condition such as arrhythmia or infection.

Routine drugs or injectables administered in conjunction with dialysis procedures are included in the facility's composite rate and shall not be billed separately. These include but are not limited to the following:

- Heparin
- Glucose
- Protamine
- Dextrose
- Mannitol
- Antiarrythmics
- Saline
- Antihistamines
- Pressor drugs
- Antihypertensives
- Trace elements
- Multivitamins

The administration fee for injectables is included in the facility's composite rate and must not be billed separately under a physician provider number.

The following procedures are non-routine and must be billed by the actual provider of service:

Procedure Code	***Description/Limits***
76061	Bone Survey - annually (roentgenographic method or photon absorptrometric procedure for bone mineral analysis)
71020	Chest X-ray - every six months
95900	Nerve Conductor Velocity Test (Peroneal NCV) - every three months
93000	EKG - every three months

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

Requirements must be met and clearly documented in the medical record for coverage of IDPN and/or IPN. All services rendered are subject to post payment review.

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyper-alimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient’s medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of the initial order and updated yearly in accordance with Medicaid billing practice.

IDPN and IPN involves infusing hyper-alimentation fluids as part of dialysis through the vascular shunt or intra-peritoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN
- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication
- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.
- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include, but is not limited to; creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist. These are glucose, dextrose, trace elements and multivitamins.

EPO and Aranasp Monitoring

The following are key points to remember when billing for EPO and Aranasp:

- This reduction will apply to both home dialysis patients and those receiving dialysis in the facility.
- The revised definition of the GS modifier is, “Dosage of EPO or Darbeopetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level.”
- Providers should include the GS modifier on the claim when the reported hematocrit level is above 39.0% (hemoglobin 13.0g/dL) and a corresponding dose reduction was made and maintained.
- When modifier GS is not present, EPO and Aranasp payments will be reduced by 25%.

Physician Services

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician’s services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient’s diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these service, For example, an attending physician who provides evaluation and management (E&M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E&M services for inpatient visits.
- Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day, may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

35.3 Prior Authorization and Referral Requirements

Dialysis procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

35.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Renal Dialysis Facility providers.

35.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Renal Dialysis Facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-92 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

35.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Renal Dialysis Facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

35.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

35.5.3 Procedure Codes, Revenue Codes, and Modifiers

The (837) Professional and Institutional electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Renal Dialysis Facility providers are limited to the following codes:

Revenue Code	*Procedure Code*	*Description*
821	90935	Hemodialysis procedure with single physician evaluation. Limited to 156 units per year.
821	90937	Hemodialysis procedure requiring repeated evaluations with or without substantial revision of dialysis prescription. Limited to 156 units per year.
831 841	90945	Dialysis procedure other than hemodialysis (e.g. peritoneal, hemofiltration) with single physician evaluation.
831 851	90947	Dialysis procedure other than hemodialysis (e. g. peritoneal, hemofiltration) requiring repeated evaluations with or without substantial revision of dialysis prescription.-
831	90989	Dialysis training, patient, including helper. Limited to 12 units per lifetime.
250	Q4081	Injection, epogen
250	J0882	Injection, darbepoetin alfa
250	Injectable Codes	See Alabama Medicaid Injectable Drug Listing in Appendix H for covered injectable drugs.

35.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

35.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

35.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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36 Rural Health Clinics/Independent

Rural health clinics are defined as clinics located in a rural area designated by the Bureau of Census as non-urbanized and medically under-served. Rural health clinics are designed to meet the needs of those recipients who might otherwise be unable to access medical attention.

Independent rural health clinics are physician-owned. These clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by Medicaid.

Reimbursement for an enrolled out-of-state IRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state IRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 8, for policy provisions for independent rural health clinic providers

36.1 Enrollment

EDS enrolls rural health clinic providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is issued nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for claims.

NOTE:
All nine digits are required when filing a claim.

Rural health clinics are assigned a provider type of 29 (rural health clinics). The valid specialty for an independent rural health clinic is Independent Rural Health Clinic (R8).

NOTE:

Physicians affiliated with rural health clinics are assigned their own Alabama Medicaid provider number, which links them to the clinic. The provider type for the physician is 29 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic's provider number, and are not assigned individual provider numbers.

Enrollment Policy for Independent Rural Health Clinics

To participate in the Alabama Medicaid Program, independent rural health clinic (IRHC) providers must meet the following requirements:

- Submit a copy of the following documentation of Medicare certification: the Centers for Medicare and Medicaid Services (CMS) letter assigning the Medicare Provider number.
- Submit a copy of the clinics budgeted cost report to Medicaid Alternative Services program to establish the reimbursement rate.
- Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.
- Operate in accordance with applicable federal, state, and local laws.

The effective date of the enrollment of an independent rural health clinic will be date of Medicare certification.

Change of Ownership

Medicaid must be notified within 30 calendar days of the date of an IRHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within the 30 day timeframe.

Patient 1st Requirements for Independent Rural Health Clinics

- The clinic must be a licensed federally recognized RHC enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, but not limited to, patient management, 24-hour coverage, and other program requirements.
- The RHC and or site must be opened a minimum of 40 hours per week and the physician must practice at the location of 40 hours per week to be considered a Full Time Equivalent (FTE)

- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of a total patient caseload will be allowed based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension. If the clinic is run solely by mid-level practitioners, then the FTP equivalent of those mid-level personnel will be applied against the 1200 maximum caseload.
- The RHC must specify what arrangements have been made for hospital admissions. If physicians within the RHC do not have admitting privileges, then the designee must be specified. If the RHC/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.

36.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

36.2.1 Covered Services

Rural health clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

Independent rural health clinic services are reimbursable if they are provided by any of the following individuals:

- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, registered nurse, or clinical social worker as an incident to a physician's service

The physician, physician assistant, nurse practitioner, certified nurse midwife, registered nurse or clinical social worker must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP can not make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department for Medicaid reimbursement.

A nurse practitioner, physician assistant, or certified nurse midwife must be available to furnish patient care at least fifty (50%) percent of the time the clinic operates

Services covered under the independent rural health clinic program are any medical service typically furnished by a physician in an office or in a physician home visit. Limits are the same as for the Physician Program.

NOTE:

The dispensing fee for birth control pills is a non covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring will obtain these supplies from the county health department while maintaining a medical home with their chosen Plan First service provider. **Prescriptions for these supplies will not be honored at a pharmacy for Plan First patients.**

Plan First Providers are to submit an order per patient for the contraceptive method utilizing the **Plan First Patient Contraceptive Order Form.** This order will be in effect for one year from the time of the initial/annual family planning visit as dated on the order form. If changes in the contraceptive method are indicated due to patient need or preference, the patient will be required to obtain a new Plan First Patient Contraceptive Order Form from her provider.

The health department will provide oral contraceptives, the contraceptive patch and the vaginal ring as follows:

- First time users will initially receive a 3-month supply. If no problems exist upon return, the remainder of the year's supply will be issued.
- Current/Previous users will receive a 1-year supply.
- All contraceptive patch and vaginal ring users will receive a 3-month supply on a quarterly basis.

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

36.3 Prior Authorization and Referral Requirements

Procedure codes billed by rural health providers generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

36.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

NOTE:

Medicaid copayment is NOT a third party resource. Do not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For independent rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate, established by Medicaid. Please refer to Chapter 5, Filing Claims, for additional information.

36.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

36.5.1 Time Limit for Filing Claims

Medicaid requires all claims for independent rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

36.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

36.5.3 Procedure Codes and Modifiers

Services of the independent rural health clinics are limited to the procedures listed below. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Encounters are all-inclusive. All services provided for the encounter are included in the reimbursement rate for the encounter.

The only exception to all-inclusive encounters is claims for laboratory services and for the technical component for EKG's and radiology services. Rural Health Clinic providers should use their regular Medicaid provider number, not their 541XXXXXXX Rural Health Clinic number.

Clinic Visit

Procedure Code	*Description*
99211-SE	Medical Encounter

Inpatient Hospital

Procedure Code	*Description*
99231-SE	Inpatient Hospital Encounter

EPSDT Codes

Procedure Code	*Description*
99381-EP	Initial EPSDT, Normal, under 1 year of age
99382-EP	Initial EPSDT, Normal, 1-4 years of age
99383-EP	Initial EPSDT, Normal, 5-11 years of age
99384-EP	Initial EPSDT, Normal, 12-17 years of age
99385-EP	Initial EPSDT, Normal, 18-20 years of age
99381-EP	Initial EPSDT, abnormal, under 1 year of age

Procedure Code	*Description*
99382-EP	Initial EPSDT, abnormal, 1-4 years of age
99383-EP	Initial EPSDT, abnormal, 5-11 years of age
99384-EP	Initial EPSDT, abnormal, 12-17 years of age
99385-EP	Initial EPSDT, abnormal, 18-20 years of age
99391-EP	Periodic EPSDT, normal, under 1 year of age
99392-EP	Periodic EPSDT, normal, 1-4 years of age
99393-EP	Periodic EPSDT, normal, 5-11 years of age
99394-EP	Periodic EPSDT, normal, 12-17 years of age
99395-EP	Periodic EPSDT, normal, 18-20 years of age
99391-EP	Periodic EPSDT, abnormal, under 1 year of age
99392-EP	Periodic EPSDT, abnormal, 1-4 years of age
99393-EP	Periodic EPSDT, abnormal, 5-11 years of age
99394-EP	Periodic EPSDT, abnormal, 12-17 years of age
99395-EP	Periodic EPSDT, abnormal, 18-20 years of age
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen
99391	Interperiodic EPSDT, infant (age under one year) Deleted 12/31/2006
99392	Interperiodic EPSDT, early childhood (age 1-4) Deleted 12/31/2006
99393	Interperiodic EPSDT, late childhood (age 5-11)) Deleted 12/31/2006
99394	Interperiodic EPSDT, adolescent (age 12-17) Deleted 12/31/2006
99395	Interperiodic EPSDT, adult (age 18-20) Deleted 12/31/2006

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

The new interperiodic screening codes will count against office visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child's primary insurance must be billed first, and then Medicaid as the payor of last resort.

See Appendix A for additional information regarding EPSDT Screening.

NOTE:

EPSDT vision and hearing screenings are performed in conjunction with a complete comprehensive screen and are limited to one per year for children 5-20 years of age.

Family Planning Codes

Procedure Code	*Description*
11975	Implant Insertion (limited to one per 365 days) Deleted as of 6-1-03
11976	Implant Removal (limited to one per 365 days)
11977	Implant Removal with Reinsertion (limited to one every five years) Deleted as of 6-1-03
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
57170	Diaphragm
58300	IUD Insertion
58301	IUD Removal
99401	HIV Pre-Test Counseling (Must be billed in conjunction with a family planning visit) - Limited to two per recipient per calendar year.
99402	HIV Post-Test Counseling (Must be billed in conjunction with a family planning visit) - Limited to two per recipient per calendar year.
J1055	Depo-Provera Shots 150 mg/ml, limited to one injection every 70 days
J1056	Medroxyprogesterone Acetate/Estradiol Cypionate
J7302	Levonorgestrel-releasing Intrauterine Contraceptive System
99205-FP	Initial Visit (limited to one per recipient per family planning provider)
99214-FP-	Annual Visit (limited to one per recipient per calendar year)
99213-FP	Periodic Visit (limited to four services per calendar year)
99347-FP	Home Visit
99212-FP	Extended Family Planning Counseling (limited to one service during 60-day post-partum period)
Z5270	Norplant Capsules Kit Deleted as of 6-1-03
Z5272	Implant Physical with Counseling Visit Deleted as of 6-1-03
S4989	Hormonal IUD (Progestesert)
J7300	Mechanical IUD (Paragard)

Prenatal Description

Procedure Code	*Description*
99212-HD	Prenatal Clinic Visit deleted 1-1-06
59430	Postpartum Clinic Visit deleted 1-1-06

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
S9445	Prenatal Education (limited to 12 classes per recipient within 2-year period)
99412	Adolescent Pregnancy Prevention Education

NOTE:

Medical encounter (99211-SE) counts against the physician yearly benefit limitations. More than one encounter may not be billed on the same date of service.

36.5.4 Place of Service Codes

The following place of service codes apply when filing claims for independent rural health clinics:

POS Code	Description
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

36.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

36.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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37 Therapy (Occupational, Physical, and Speech)

This chapter regarding therapy services is specifically designed for therapy providers who meet **either** of the following criteria:

- Provider receives a referral as a result of an EPSDT screening exam and possesses a Patient 1st/EPSDT Referral form (Form 362) as a result of an abnormality discovered during the EPSDT exam
- Provider treats QMB recipients

Physical therapy is also covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients. For more information regarding this, refer to Chapter 19, Hospital.

The policy provisions for therapy providers can be found in the *Alabama* Medicaid Agency Administrative Code, Chapter 11.

37.1 Enrollment

EDS enrolls therapy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative C*ode, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a therapy provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for therapy-related claims.

NOTE:
All nine digits are required when filing a claim.

Therapy providers are assigned a provider type of 21 (Therapy). Valid specialties for therapy providers include the following:

- Occupational Therapy (T6)
- Physical Therapy (T1)
- QMB/EPSDT (EQ)
- Speech Therapy (T2)

Therapists that enroll independently and have their own provider number bill on a CMS-1500 claim form as an EPSDT/QMB-only provider. Refer to Chapter 19, Hospital, for billing information for therapists enrolled by a hospital.

Enrollment Policy for Therapy Providers

Services provided must be ordered by a physician for an identified condition(s) noted during the EPSDT screening and provided by or under:

- For physical therapy services, a qualified physical therapist
- For occupational therapy (OT) services, the direct supervision of a qualified occupational therapist
- The supervision of a qualified speech therapist

A qualified Speech Therapist must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology.

A qualified occupational therapist must be licensed by the Alabama State Board of Occupational Therapy.

A qualified physical therapist must be licensed by the Alabama Board of Physical Therapy.

37.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Services provided to Medicaid-eligible children by those working under the direction of licensed, enrolled speech therapists, occupational therapists or physical therapists are subject to the following conditions:

- The person providing the service must meet the minimum qualifications established by state laws and Medicaid regulations.
- A supervising provider must employ the person providing the service.
- The case record must identify the person providing the service.
- The supervising therapist must assume full professional responsibility for services provided and bill for such services.
- The supervising provider must assure that services are medically necessary and are rendered in a medically appropriate manner.

For more information about the Plan of Treatment required for therapy services, refer to Appendix A, EPSDT.

Only procedures identified in Section 37.5.3, Procedure Codes and Modifiers, are reimbursable.

Speech Therapists (ST-Speech Language Pathologist)

Speech therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified speech therapist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Speech therapy assistants must be employed by a speech therapist, have a bachelor's degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. Assistants are only allowed to provide services commensurate with their education, training, and experience. They may not evaluate speech, language, or hearing; interpret measurements of speech language or hearing; make recommendations regarding programming and hearing aid selection; counsel patients; or sign test reports or other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist.

Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all time when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

NOTE:

Speech therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified speech therapist.

Occupational Therapists (OT)

Occupational therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified occupational therapist.

Services are limited to those procedures identified in Section 37.5.3, Procedure Codes and Modifiers. Some codes may require prior authorization before services are rendered. Medicaid does not cover recreational activities, such as movies, bowling, or skating.

Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth visit. Each supervisory visit must be documented and signed by the OT making the visit. Supervision for non-certified limited permit holders shall consist of one-to-one, on-site supervision a minimum of 50% of direct patient time by an OT who holds a current license. The OT must document supervising visits. The supervising OT ensures that the assistant is assigned only duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Occupational therapy aides employed by the OT may perform only routine duties under the direct, on-site supervision of the OT. Care rendered by an OT aide may not be charged as occupational therapy.

Physical Therapists (PT)

Services provided must be ordered by a physician and must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants may provide service only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy, and must be an employee of the supervising PT. The PT assistant must only be assigned duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Licensed certified physical therapist assistants (PTA) are covered providers when working under the direction of a Preferred Physical Therapist with the following provisions:

- The Physical Therapist must interpret the physician's referral.
- The Physical Therapist must perform the initial evaluation.
- The Physical Therapist must develop the treatment plan and program, including long and short-term goals.
- The Physical Therapist must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The Physical Therapist must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The Physical Therapist must implement (perform the first treatment) and supervise the treatment program
- The Physical Therapist must co-sign each treatment note written by the PTA.
- The Physical Therapist must indicate he/she has directed the care of the patient and agrees with the documentation as written by the PTA for each treatment note.

The Physical Therapist must render the hands-on treatment, write and sign the treatment note every sixth visit.

Only procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers, are valid procedure codes and reimbursable for physical therapy services.

NOTE:

To determine if a procedure code requires prior authorization, use the Automated Voice Response System (AVRS).

37.3 Prior Authorization and Referral Requirements

Therapy procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

If the EPSDT screening provider wants to render treatment services himself, the provider completes a self-referral.

After receiving a screening referral form, Medicaid providers may seek reimbursement for medically necessary services to treat or improve the defects, illnesses, or conditions identified on the referral form. The consulting provider completes the corresponding portion of this form and returns a copy to the screening provider. If services or treatment from additional providers is indicated, a copy of the referral form must be sent to those providers for their medical records. A completed Referral for Services Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped.

37.4 Cost Sharing (Copayment)

Copayment does not apply to therapy services.

37.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Therapy providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Therapy services are billed using the CMS-1500 claim form. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

37.5.1 Time Limit for Filing Claims

Medicaid requires all claims for therapy services to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

37.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

37.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Speech Therapy

Speech therapy providers are limited to the procedure codes listed below:

Procedure Code	*Description*
92506	Evaluation of speech, language, voice, communications, and/or auditory processing
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Group, two or more individuals
92607***	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour ***
92608***	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes ***
92609***	Therapeutic services for the use of speech-generating device, including programming and modification ***

******* Requires prior authorization. For procedure code 92609, documentation must support that Augmentative Communication Device (ACD) has been

purchased by Medicaid. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Physical Therapy

Physical therapy providers are limited to the procedure codes and limits listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report		1
95832	Muscle Testing Manual		1
95833	Total evaluation of body, excluding hands		1
95834	Total evaluation of body, including hands		1
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10
95852	ROM measurements and report (separate procedure);hand, with or without comparison with normal side		2
97001	Physical therapy evaluation		1
97002	Physical therapy reevaluation		1
97010	Application of a modality to one or more areas; hot or cold packs	1, 3	1
97012*	Traction, mechanical	1	1
97014*	Electrical stimulation, unattended	1, 2	4
97016*	Vasopnuematic device	1	1
97018*	Paraffin bath	1, 3	1
97022	Whirlpool	3	1
97024*	Diathermy	1	1
97026*	Infrared	1	1
97028	Ultraviolet		1
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4
97033	Lontophoresis, each 15 minutes	3	4
97034	Contrast baths, each 15 minutes	3	4
97035	Ultrasound, each 15 minutes	3	4
97036	Hubbard tank, each 15 minutes	3	4
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1
97113*	Aquatic therapy with therapeutic * exercises		1
97116	Gait training (includes stair climbing)		1

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).	3	1
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1
97150	Therapeutic procedure(s), group (2 or more individuals)		1
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3	4
97532	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training) direct (one on one) patient contact by the provider, each 15 minutes	3	4
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	3	4
97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider each 15 minutes.	3,4	4
97542	Wheelchair management/propulsion training, each 15 minutes	3	4
97597	Removal of devitalized tissue From wounds		1
97598	Removal of devitalized tissue From wounds		1
97750	Physical performance test or measurement, (e.g., muscoloskeletal, functional capacity) with written report, each 15 minutes	3	4
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3,5	4
97761-	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4

NOTE:

1. Restricted to one procedure or date of service (cannot bill two together for the same date of service.)

2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.

3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient for the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for procedure, not the maximum units allowed for both providers.

4. Requires PA

5. 97760 should not be reported with 97116 for the same extremity.

Occupational Therapy

Occupational therapy providers are limited to the procedure codes and limits listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Medicaid **does not** cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Individual occupational therapy services are limited to the following codes:

Code	***Description***	***See Note Above***	***Max Units Per Day***
97003	Occupational therapy evaluation		1
97004	Occupational therapy re-evaluation		1
97010	Application of a modality to one or more areas; hot or cold packs	1, 3	1
97018	Paraffin bath	1, 3	1
97022	Whirlpool	3	1
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4
97033	Lontophoresis, each 15 minutes (Deleted 1-1-99)	3	4
97034	Contrast baths, each 15 minutes	3	4
97035	Ultrasound, each 15 minutes	3	4
97036	Hubbard tank, each 15 minutes	3	4
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to	3	4

Code	Description	See Note Above	Max Units Per Day
	develop strength and endurance, range of motion and flexibility		
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense posture, and proprioception	3	1
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	3	1
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3	4
97535	Self care / home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.	4, 3	4
97542	Wheelchair management /propulsion training, each 15 minutes	3	4
97597	Removal of devitalized tissue from wounds		1
97598	Removal of devitalized tissue from wounds		1
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	4
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3	4
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4

NOTE:

Refer to Chapter 14, Durable Medical Equipment, for L codes.

37.5.4 Place of Service Codes

The following place of service codes apply when filing claims for therapy services:

POS Code	Description
11	Office

37.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

37.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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38 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid.

The policy provisions for anesthesia can be found in the Alabama Medicaid Agency Administrative Code, Chapter 6.

38.1 Enrollment

EDS enrolls anesthesiologists, Certified Registered Nurse Anesthetists (CRNA) and Anesthesiology Assistants (AA) and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

EDS also enrolls Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician.

A CRNA or AA may not enroll with Medicaid if he or she is employed and reimbursed by a facility, such as a rural health clinic that receives reimbursement from the Alabama Medicaid Program for services provided. In this case, the CRNA or AA services are already being paid through that facility's cost report.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Anesthesiologist, CRNA, or AA is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for anesthesia-related claims.

NOTE:

All nine digits are required when filing a claim.

Anesthesiologists are assigned a provider type of 01 (Physician). CRNAs and AAs are assigned a provider type of 92 (Anesthesiology). Valid specialties for the above include the following:

- Anesthesiology (05)
- Anesthesiology Assistant (N7)
- CRNA (C3)

Enrollment Policy for Anesthesiology Providers

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program.

In addition to the completed application, the following information for Anesthesiologist Assistants must be submitted and approved before the enrollment process can be initiated:

- Copy of current state license
- Copy of current certifications (CRNA or AA)

38.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth in Rule No. 540-X-7-.51 of the Alabama Board of Medical Examiners. The AA must enroll and receive a provider number to bill the Alabama Medicaid Program. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist

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

For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. The definition of medical direction is an anesthesiologist medically directing four concurrent cases (CRNA/AA) or less. In order to bill for medical direction, the anesthesiologist must be immediately physically available at all times. Addressing an emergency of short duration, or rendering the requisite CRNA or AA direction activities (listed below in a. through g.), within the immediate

operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist's personal continuing involvement in a particular case, medical direction ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical direction activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities:

- Performs a pre-anesthesia examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual
- Monitors the course of anesthesia administration at frequent intervals
- Remains immediately physically available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

A necessary task or medical procedure may be executed while concurrently medically directing CRNAs or AAs only if the task or procedure is one which may be: (1) immediately interruptible without compromising the wellbeing, quality of care, or health of the recipient and (2) is executed in an area close enough to the operating rooms where the CRNAs and AAs are being medically directed and that will permit the physician to remain in compliance with the requirements of being immediately physically available. Examples of an “area close enough to the operating rooms” are the Post-Anesthesia Care Unit (PACU) or receiving room. A task or procedure that may be stopped instantly is defined as one of limited difficulty and brief duration so that if it is stopped instantly, it would not interfere with the quality of care, wellbeing, or health of the recipient. There are two exceptions to the above:

1. acting in response to urgencies of short duration or medical emergencies (e.g., ACLS provision, intubation, starting difficult intravenous (IV) lines that without them would reduce the recipient’s quality of care, etc.)
2. labor epidural placement and management

The execution of a trigger point injection or an epidural steroid injection while medically directing is permissible when requested by another physician. The 1:4 ratio should be maintained while the trigger point injection or the epidural steroid injection is being executed. The consult for the execution of the aforementioned may serve as the second, third, or fourth simultaneous case. Therefore the execution of these limited pain services is disallowed while medically directing four simultaneous anesthetics. The ability to respond to urgent or emergent needs in the hospital (operating room, labor and delivery room, or anywhere in the hospital where his/her responsibility lies) may not be decreased at any time and is the responsibility of the anesthesiologist who is medically directing. The intent of this exception is to allow for provision of commonly requested procedures and to improve effectiveness. However, this exception does not include consults to diagnose. Diagnosis of chronic pain and treatment of complex problems is not allowed while simultaneously medically directing CRNAs and AAs.

Global Anesthesia Definition

The Agency has identified certain procedures to be included in the global payment for the anesthesia services. These procedures include but are not limited to the following: general anesthesia, regional anesthesia, local anesthesia, supplementation of local anesthesia, and other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure.

Anesthesia services include:

- All customary preoperative and postoperative visits,
- Local anesthesia during surgery,
- The anesthesia care during the procedure,
- The administration of any fluids deemed necessary by the attending physician, and any usual monitory procedures

Interpretation of non-invasive monitoring to include EKG, temperature, blood pressure, pulse, breathing, electroencephalogram and other neurological monitoring,

Monitoring of left ventricular or valve function via transesophageal echocardiogram,

Maintenance of open airway and ventilatory measurements and monitoring,

Oximetry, capnography and mass spectrometry.

Monitoring all fluids used during cold cardioplegia through non-invasive means. Additional claims for such services should not be submitted.

Placement of lines such as arterial catheterizations and insertion and placement of pulmonary artery catheters (e.g., Swan-Ganz) for monitoring will no longer be included in the global anesthesia reimbursement when billed with other procedures but will be allowed to be billed using the same guidelines outlined in this chapter under “Special Situations for Anesthesia”. The time of placement of invasive monitors and who placed them should be documented in the medical record. Verification of anesthesia time units may be subject to post-payment audits. Billing for anesthesia time while placing invasive monitors is not allowed unless the patient required general anesthesia for placement.

The time anesthesia starts is at the beginning of induction via the injection or inhalation of an anesthetic drug or gas and ends at the time the recipient is transferred to the recovery room or post anesthesia care unit (PACU). Induction is defined as the time interval between the initial injection or inhalation of an anesthetic drug or gas until the optimum level of anesthesia is reached. The recipient must be prepared by the anesthesiologist prior to induction and must be assessed by the anesthesiologist immediately after the surgical procedure. Up to 15 minutes are allowed for the preparation of anesthesia, and up to 15 minutes are allowed after the operation (for transfer of the recipient to the receiving room, recovery room, or PACU). It is inappropriate to bill for anesthesia time while the patient is receiving blood

products or antibiotics in the holding area or waiting in a holding area, or waiting in the operating room more than 15 minutes prior to induction.

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

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

When a medical procedure is a non-covered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a non-covered service.

A primary anesthesia procedure is included in the procedure code range of 00100-01997 as noted in the Relative Value Guide.

NOTE:

Medical record documentation should clearly support and reflect physician services. Post-payment reviews may be performed.

Special Situations for Anesthesia

If two procedures of equal unit value are billed, the first procedure will be paid and the second one will deny because the subsequent procedure is included in the primary anesthesia charge.

If two procedures are billed with different unit values, the procedure with the greatest unit value will pay and the other procedure will deny because the subsequent procedure is included in primary anesthesia charge.

The anesthetic agent for nerve blocks (CPT codes 64400-64530) is included in the reimbursement fee for the performance or administration of the nerve block. No additional procedures should be filed for the nerve block medication.

Anesthesia for CAT Scans or MRI/MRA Procedures is not covered for anesthesiologists. The attending/admitting physician is responsible for ordering the necessary measure(s) to ensure the patient is prepared for these tests.

Monitored Anesthesia Care is a covered service.

Medicaid does not cover physical status modifiers.

Qualifying factors may be billed in addition to anesthesia codes if applicable. See Section 38.5.3 for more information.

Standby anesthesia is not payable under Medicaid.

Consultations

A consultation for anesthesia performed on the day of or days before a procedure is considered part of the global procedure and is not a separately reimbursable item.

There are two exceptions to the above as outlined below.

- A recipient with chronic intractable pain receives a consult from an anesthesiologist for the chronic intractable pain, or
- A recipient receives a consult from an anesthesiologist to have an anesthesia procedure performed but ends up not receiving the anesthesia, e.g., the surgery is canceled due to complications.

Post-Operative Pain Management and Epidural Catheters

Surgeons routinely provide necessary post-operative pain management services and are reimbursed for these services through the global surgery fee. The surgeon should manage post-operative pain except under extraordinary circumstances. Procedures involving major intra-abdominal, vascular and orthopedic, and intrathoracic procedures will be covered for post-operative pain management by an anesthesiologist when medically indicated. Postoperative pain management services is not covered by non-physicians.

The definition for post-operative pain management is the management of a recipient's pain beyond, or separate from, the recovery room or operating room. The separately identifiable physician-recipient encounter and management should occur outside the intraoperative area. A separately identifiable physician-recipient encounter reflecting the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications should be clearly reflected in the medical record documentation.

No additional payment is allowed for an injection of Duramorph or other analgesic agents as a boost at the end of an anesthesia procedure (using the same catheter used for the epidural or spinal anesthesia) without a separately identifiable physician-recipient encounter including the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications. However, if there is a separately identifiable physician-recipient encounter on subsequent post-op days, where the physician provides post-operative analgesic orders and manages post-operative analgesic complications, daily management of epidural or subarachnoid drug administration may be billed.

If a recipient receives general anesthesia and consequently requires additional pain control such as an epidural injection or an epidural catheter placement on the same day as the general anesthesia, the single injection or catheter placement will be reimbursed at one-half of the allowable. However, catheter placement and daily management of an epidural catheter is not allowed on the same date of service. When the physician provides a separately identifiable physician-recipient encounter to manage and evaluate the catheter and it is reflected in the medical record, this coverage is satisfactory for a reasonable period of time over the consecutive post-operative days.

Patient Controlled Analgesia

Patient controlled analgesia (PCA) services are reimbursable when they are administered by an anesthesiologist and are performed for the control of post-operative pain. A separately identifiable physician-recipient encounter should be reflected in the medical record documentation. PCA pumps are usually administered through an intravenous (IV) line or the PCA pump is connected to an epidural catheter line.

Daily management of a PCA pump through an IV line is disallowed. When an anesthesiologist provides the management of the PCA pump through an IV line, the anesthesiologist will be allowed a total of four units and will be considered a global payment for the management regardless of the number of days the recipient remains on the pump. Use procedure code 90784 for daily hospital management of intravenous patient-controlled analgesia.

The anesthesiologist should use the appropriate procedure code(s) when filing claims for a single injection or for an injection including catheter placement (epidural, subarachnoid, cervical, thoracic, lumbar, or sacral) when the PCA pump is connected to an epidural line. Placement of the epidural catheter and daily management of a subarachnoid or epidural catheter is not reimbursable on the same date of service. Daily management of a subarachnoid or epidural catheter is reimbursable on subsequent days. Delivery of pain medication through intermittent injections, a regular infusion, or by a PCA pump is included in the management of an epidural line whether a registered nurse or a physician administers it. Additional units for a PCA pump that is connected to an epidural line is not separately reimbursable.

The global surgical reimbursement fee to the surgeon includes the management of a PCA pump for post-operative pain control and is not a separately reimbursable item. Similarly, a physician's global medical service reimbursement includes the management of a PCA pump for recipients with chronic pain control or terminal cancer and is not separately reimbursable.

Intractable Pain and Epidural Catheters

Some forms of conventional therapy such as oral medication, physical therapy, or a TENS unit may not relieve recipients with intractable pain. Placement of an epidural catheter may be allowed when medically necessary for recipients with intractable pain. Reimbursement for daily management is allowed when it is medically necessary and is a separately identifiable physician-recipient encounter is clearly documented in the medical record by the anesthesiologist. Placement of an epidural catheter and daily management of an epidural catheter is not reimbursable on the same date of service.

38.3 Prior Authorization and Referral Requirements

Anesthesiology procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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

NOTE:

Consults performed in the inpatient hospital setting do not require a Patient 1st referral. Consults performed in a setting other than inpatient hospital require a Patient 1st referral.

38.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Anesthesiologists, Certified Registered Nurse Anesthetists or Anesthesiology Assistants.

38.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

38.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Anesthesiologists, CRNAs and AAs to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

38.5.2 Diagnosis Codes

The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

38.5.3 Procedure Codes and Modifiers

Anesthesia providers are required to utilize the appropriate anesthesia code identified in the current Relative Value Guide published by the American Society of Anesthesiologists. Time in attendance should be billed by listing total minutes of anesthesia time in block 24G of the CMS-1500 claim form. Type of service "7" should be used for billing anesthesia codes (00100-01997). The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers. Effective October 1, 2004 to bill for code 90784, bill the first line item with the code and one unit. Bill the second line item with code 90784 with modifier 76 (repeat procedure) and 3 units.

EDS will calculate total units by dividing the total minutes (reported in block 24G) by 15, rounding up to the next whole number, and adding the time units to the auto-loaded base unit values. The base unit values are derived from the ASARVG for CPT-4 anesthesia codes.

The number of qualifying factor units is multiplied by the price allowed for anesthesia services. For more information regarding qualifying factors, see the next section of this manual.

Qualifying Factors

Beginning June 14, 2002, qualifying factors will be reimbursable. Qualifying factors allow for anesthesia services provided under complicated situations depending on irregular factors (ex: abnormal risk factors, significant operative conditions). The qualifying procedures would be reported in conjunction with the anesthesia procedure code on a separate line item using 1 unit of service.

The qualifying procedure codes are indicated below.

Procedure Code	Description	Units
99100	Anesthesia for recipient with farthest ages, over seventy and under one year	1
99116	Complication of anesthesia by utilization of total body hypothermia	1
99135	Complication of anesthesia by utilization of controlled hypotension	1
99140	Complication of anesthesia by emergency conditions	1

Medical Supervision - CRNA or AA

Two modifiers are used to indicate whether the service was medically directed or not medically directed in regards to anesthesia. The modifiers listed below should be used:

- QX - MEDICALLY DIRECTED
- QZ - NOT MEDICALLY DIRECTED

Medical direction should only be billed when the CRNA or AA supervision is rendered by an anesthesiologist. If a procedure is medically supervised by the surgeon, the claim should be billed as if the service were not medically directed.

Medical Supervision - Anesthesiologists

Medically directed services are defined as anesthesia services that are medically directed by an anesthesiologist for 1, 2, 3, or 4 CRNAs or AAs.

When billing for medically directed services, anesthesiologists should utilize the modifiers listed below:

- QY for medically directed services of 1 CRNA or AA (effective for 01/01/99)
- QK for medically directed services of 2, 3, or 4 CRNAs or AAs

The payment amount for the physician's service and the CRNA or AA is 50% of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

Other Anesthesia Modifiers

Other appropriate anesthesia modifiers for anesthesiologists include the following:

Modifier	***Description***
AA	Anesthesia services performed personally by an Anesthesiologist
AB	Medical direction of own employee performed by an Anesthesiologist
AC	Medical direction of other than own employee performed by an Anesthesiologist

NOTE:

All procedures for anesthesiology services must include appropriate modifiers. CRNAs and AAs are limited to QX and QZ. Anesthesiologists are limited to QY, QK, AA, AB, and AC. Medical directing five or more concurrent cases is not allowed.

38.5.4 Referring Provider Information

Effective July 1, 2004, anesthesia providers must submit the UPIN number of the referring surgeon/physician on the claim. If you file hard copy, the UPIN number should be populated in block 17a of the CMS 1500 claim form. For those who file electronically, you should submit the referring surgeon/physician's UPIN number in REF02 of the 837P. This is necessary for proper claims processing.

Anesthesiologists should use "OTH000" as the referring or attending UPIN number for providers who are not assigned a UPIN number by Medicare. For example, when providing anesthesia services for recipients who are being treated by dental providers, please use "OTH000" as the UPIN number in block 17a of the CMS 1500 form. Use "OTH000" in REF02 and the ID qualifier 1G in REF 01 when filing claims electronically on the 837P. If you use PES software or a vendor, please make sure your software has been updated to accommodate this change. As a reminder, claims for anesthesia providers not containing this information will deny.

38.5.5 Place of Service Codes

The following place of service codes apply when filing claims for CRNP services:

POS Code	***Description***
11	Office
12	Home
22	Outpatient Hospital
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic

38.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

38.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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39 Patient 1st

The **Patient 1st** Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the Patient 1st program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the EDS Provider Insider as well as any letters, transmittals or ALERTS regarding any updates or changes within this program.

If you have any questions about this program please contact the Provider Assistance Center at 1(800) 688-7989.

39.1 Overview

Patient 1st is Medicaid's primary care case management (PCCM) program, linking Medicaid recipients with a primary medical provider (PMP). The PMP acts as a gatekeeper to provide and arrange for most of the recipient's health care needs. PMPs bill fee-for-service and are reimbursed based on the Medicaid fee schedule. PMPs also receive a monthly case management fee per member, per month for coordinating the care of Medicaid recipients enrolled with their practice. The goal of this managed care program is to improve health care for Medicaid recipients by providing a "medical home" while containing the escalating cost of quality healthcare.

Patient 1st operates pursuant to an approved 1915(b) (1) waiver granted in accordance with Title XIX of the Social Security Act. The program was operational from 1997 through February 29, 2004. The Program was re-instated effective December 1, 2004. **Patient 1st** was active in all counties effective February 1, 2005. Providers can access Medicaid's website for details on the implementation schedule at www.medicaid.alabama.gov.

Patient 1st can be successful only with the commitment of the provider community. To ensure an adequate provider base, the Alabama Medicaid Agency (Medicaid) executes provider agreements with physicians on a continuous basis who wish to participate in the **Patient 1st** Program. The physician acting as a PMP agrees to abide by all existing laws, regulations and procedures pursuant to the **Patient 1st** Program and Medicaid participation.

39.2 Eligible Providers

39.2.1 Enrollment

Alabama Medicaid providers who are interested in participating as a Patient 1st provider must complete and submit a **Patient 1st Application Package** (application and agreement) to the EDS Provider Enrollment Unit.

A copy of the application package is available on Medicaid's website at www.medicaid.alabama.gov or by calling the Provider Assistance Center at 1(800) 688-7989.

The following provider types are eligible to participate as a PMP for the Patient 1st Program:

Family Practitioners

General Practitioners

Pediatricians

Internists

OB/GYN

Federally Qualified Health Centers

Rural Health Clinics

NOTE:

When in the best interest of a patient, a nontraditional PMP may be chosen (e.g., children with special health care needs). Other physicians may be considered for PMP participation if willing to meet all contractual requirements.

A participating physician in a clinic or health center can not work at more than three sites and must provide Medicaid with information regarding percentages of time spent at each site and the number of Patient 1st enrollees per site.

The Patient 1st enrollee must be given information regarding the usual days and hours the physician is available for scheduled appointments. If a certified nurse practitioner or physician assistant cares for an enrollee, the enrollee must know the Patient 1st physician responsible for supervision. These obligations can be fulfilled through office signs, verbal instructions or written information.

The PMP has the option of being placed on the published or non-published PMP list. The PMP must indicate their preference when completing the Patient 1st Enrollment Form. The PMP list includes the PMP's county (ies) of participation, the PMP's name, specialty, physician extenders, physical address, and phone numbers (regular and 24 hour). This PMP list is sent to all Medicaid recipients to assist them in selecting physicians/clinics serving their county. The PMP list may also be accessed via the Medicaid web site at www.medicaid.alabama.gov.

Regardless of publication, the PMP is included in the assignment process if caseload is available and criteria can be met.

39.2.2 Caseload

The following standards apply to PMP caseloads:

PMPs may serve multiple counties and/or sites; however, the maximum panel a PMP can serve collectively is 1200, with the minimum of 25. PMPs may specify the number of **Patient 1st** enrollees they will accept per county and/or site.

Physician Extenders (Nurse Practitioners and Physician Assistants) will allow the caseload to be extended by 400 additional patients per extender. Only two Physician Extenders per physician will be allowed and may only be counted once in a caseload extension.

The PMPs practice must be opened a minimum of 32 hours per week and the PMP must practice at that location a minimum of 32 hours per week to be considered a Full Time Equivalent (FTE).

If less than an FTE, a percentage of a total patient caseload will be allowed, based on availability.

Examples:

Maximum Hours Worked in Office/Clinic	Maximum Recipients Assigned
32 to 40 Hours	1.0 FTE = 1200 recipients
16 Hours	.5 FTE = 600 recipients
12.8 to 15.9 Hours	.4 FTE = 500 recipients
9.6 to 12 Hours	.3 FTE = 375 recipients
6.4 to 8 Hours	.2 FTE = 250 recipients
3.2 to 4 Hours	.1 FTE = 125 recipients

All caseloads will be coordinated with Medicaid through EDS.

Caseloads for group/clinic enrolled providers will be determined by the number of FTEs and physician extenders associated with the group.

NOTE:

If a nontraditional PMP has been assigned based on a case need, the minimum enrollee or full time requirement will not apply.

If the PMP wishes to extend the caseload above 1200 or 2000 (with extenders), a written request from the PMP for an extension of the PMP enrollee cap should be submitted in writing and must address the following:

The PMP's name and Medicaid number;

The total number of enrollees over the cap that the PMP is requesting;

The reason for the request to extend the PMP enrollee cap;

The total number of patients the PMP is seeing who are not Medicaid (PMP may provide the actual total of patients broken down by payer source, and/or PMP's percentage of Medicaid enrollees to total patients and/or the percentage of Medicaid income to total income);

The length of time the PMP has been in practice in the area;

Description of PMP's practice, such as, is the PMP in private or group practice;

Other extenuating documentation and explanations that would justify the request for an extension of the cap.

- The request can be submitted at the time the Provider Agreement is signed or at a later date by contacting EDS Provider Enrollment.

** A PMP's caseload may be exceeded to accommodate sibling assignment, newborn assignment, or assignments for previously established patients (last PMP on file).

If the PMP wishes to decrease the number of enrollees, he/she must notify EDS Provider Enrollment in writing, at least thirty (30) days in advance of the planned decrease in enrollees to allow for enrollee reassignment. If the PMP wishes to increase the maximum number of enrollees within the caseload specifications, he/she must notify EDS Provider Enrollment in writing. Such changes should be faxed to (334) 215-4298.

Individual or specific recipient additions must be submitted in writing on the requesting provider's letterhead and include the following information; the provider's name and provider number as enrolled in the Patient 1st Program, the recipient's name, Medicaid number and the county in which the recipient lives. These changes can be faxed to EDS at (334) 215-4140.

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. 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.

39.2.3 Disenrollment

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.

NOTE:

Failure to provide a 30-day notice may preclude future participation opportunities and/or recoupment of case management fees.

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.

39.3 PMP Responsibilities

39.3.1 Functions and Duties

The PMP and its group practice/clinic shall comply with all applicable federal and state statues and regulations, and all amendments thereto, that are in effect when the provider agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to the approved waiver document and Title 42 of the Code of Federal Regulations.

The Patient 1st PMP agrees to do the following:

Be a licensed physician, enrolled in the Alabama Medicaid Program, who has not been sanctioned.

Accept enrollees and be listed as a PMP in the Patient 1st Directory for the purpose of providing care to enrollees and managing their health care needs through the Medical Home concept.

Provide primary care and patient care coordination services to each enrollee in accordance with the policies set forth in Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st policy.

Provide or arrange for primary care coordination and coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement. PMPs must have at least one telephone line that is answered by the office staff during regular office hours.

Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PMPs serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PMPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.

Maintain a unified patient medical record for each enrollee following the medical record documentation guideline as defined by Patient 1st policy.

Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the authorization number (Medicaid provider number) to the referred provider.

Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Note: Patients must request their records be transferred to the new PMP and must not be charged a fee for this service.

Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st policy.

Refer for a second opinion as defined by Patient 1st policy.

Review and use all enrollee utilization and cost reports provided by the Patient 1st program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st policy.

Participate with Agency utilization management, quality assessment, and administrative programs.

Provide the Agency or its duly authorized representative or the Federal government unlimited access (including on site inspections and review) to all records relating to the provision of services under the provider agreement as required by Medicaid policy and 42 C.F.R. 431.107.

Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

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.

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

Refrain from discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

Refrain from discrimination against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discrimination on the basis or race, color, or national origin.

Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

NOTE:

Recipients can obtain assistance with language interpretation by calling the Recipient Call Center at 1(800) 362-1504.

1. Receive prior approval from the Agency of any marketing materials, Patient 1st specific, or education materials prior to distribution. Materials shall not make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.

2. Refrain from door-to-door, telephonic or any form of marketing

3. Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends).

4. Refrain from knowingly engaging in a relationship with the following:

    1. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or

    2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation. Note: The relationship is described as follows:

        a. As a doctor, officer, partner of the PMP,

        b. A person with beneficial ownership of more than five percent (5%) or more of the PMP's equity; or,

        c. A person with an employment, consulting or other arrangement with the PMP for the provision of items and services which are significant and material to the PMP's contractual obligation with the Agency.

39.3.2 Hospital Admitting Privileges Requirement

Patient 1st Primary Medical Provider (PMPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addressed the needs of all enrollees or potential enrollees. If a PMP does not admit patients, then the *Patient 1st Hospital Admitting Agreement* form must be submitted to the Agency to address this requirement for participation.

A formal arrangement is defined as a voluntary agreement between the Patient 1st PMP and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Patient 1st enrollee throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five minutes drive time from the Patient 1st PMP's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the Patient 1st PMP's practice will be accepted.

To qualify for the additional case management fee component a PMP must admit patients or have a formal arrangement with a hospitalist group.

If the PMP has a formal arrangement with another physician group, no additional monies will be paid. The providers must be enrolled as Alabama Medicaid providers, but it is not necessary that they be enrolled as Patient 1st providers. Admissions through unassigned hospital-based call groups do <u>not</u> meet this requirement.

Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

39.3.3 24/7 Coverage Requirement

PMPs must provide enrollees with after-hours coverage. It is important that patients be able to contact their PMP to receive instruction or care at all times so that care will be provided in the most appropriate manner to the patient's condition. PMP's can meet this requirement through a variety of methods. However, only those arrangements that put the patient into contact with voice-to-voice assistance from someone associated with the physician's practice or call center will receive the additional monies through the case management fee.

- To qualify for this case management fee component, the PMP or someone on his staff, or a nurse call center must provide voice-to-voice assistance.

- The after hours telephone number must connect the enrollee to; a call center system that automatically transfers the recipient to another telephone line answered by a person who will promptly contact the PMP; an answering service that promptly contacts the PMP or PMP authorized medical practitioner; or a recording directing the caller to another number to reach the PMP or PMP authorized medical practitioner.

- A PMP may have an arrangement with another physician group or the local emergency room to provide 24/7 coverage, but will not qualify for the additional case management fee component.

- A hospital may be used for the 24 hour telephone coverage requirements under the following conditions; the 24 hour access line is not answered by the Emergency Department staff; the PMP establishes a communication and reporting system with the hospital and the PMP reviews the results of all hospital authorized services.

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer enrollees to the PMP's home telephone if there is not a system in place as outlined above to respond to calls. PMPs are encouraged to refer patients with urgent medical problems to an urgent care center.

39.3.4 Standards of Appointment Availability and Office Wait Times

The PMP must conform to the following standards for appointment

availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if pregnant)

The PMP must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
- Scheduled appointment – within one hour
- Life-threatening emergency – must be managed immediately

If these standards can not be met due to extenuating circumstances, then the patient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

39.3.5 Patient 1st Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the Patient 1st program. All Patient 1st PMPs must implement the following guidelines as the standards for medical record keeping.

1. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.

2. All entries are dated.

3. All entries are identified as to the author.

4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization administration.
9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

39.3.6 Recipient Education

Recipient education will be an integral part of the program to help the recipients understand the Patient 1st Program system and their responsibilities under such a system. The Agency has recently outlined in the Patient Handbook the recipient's rights and duties as being part of the Patient 1st Program. All educational materials have stressed the importance of contacting the PMP before receiving services, which services do not require a PMP referral, and most importantly, the 1-800 number to call anytime there is a question.

In addition, as the coordinator of care, it is important for PMPs to be actively involved in patient education. Patient 1st PMPs are strongly encouraged to contact all new enrollees by telephone or in writing. New enrollees are identified in the monthly Patient 1st Provider Enrollment Report.

Providers should address the following subjects with each new enrollee:

The PMPs requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PMP.

- The requirement that the enrollee contact the PMP for a referral before going to any other doctor.
- The requirement that the enrollee must contact the PMP before going to the emergency department unless the enrollee feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits such as Well Child Check-ups (EPSDT) screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings.
- The availability of additional information for enrollees from the Agency.

39.3.7 Non-Performance (Sanctions)

Failure to meet the terms outlined in the Patient 1st provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly case management fee may be withheld
- The PMP may be referred to Program Integrity (PI) or Quality Assurance (QA) Unit for investigation of potential fraud or for quality of care issues.
- The PMP may be referred to the Board of Medical Examiners.
- The PMP may be terminated from the Patient 1st program.

Medicaid makes the determination to initiate sanctions against the PMP and may impose one or more sanctions simultaneously based on the severity of the contract violation. Medicaid Legal Division may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered or Medicaid may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit Medicaid from exercising its right to do so for subsequent contract violations.

39.3.8 Non-Performance (Sanction) Appeals

The PMP is notified by certified mail of the sanction(s) and the right to appeal the sanction. Medicaid must receive the PMP's request for a formal evidentiary hearing by the Medicaid Legal Division no later than 15 calendar days from the receipt of the sanction notice. The hearing provides an opportunity for all side to be heard in an effort to resolve the issue. The sanctioned party may represent himself/herself or may enlist the services of an attorney or designate a representative. The findings are documented by the Legal Division and presented to the Commissioner who makes the final determination to uphold or rescind the sanction. The PMP is notified by certified mail of the Commissioner's decision.

PMPs that are terminated from the Patient 1st program – or voluntarily withdraw to avoid a sanction – are not eligible to reapply for a minimum of one year with a maximum time period to be determined by the Agency. The decision is predicated on the extent or severity of the contract violation, necessitating the termination.

39.4 Monthly Case Management Fee

The PMP is paid a medical case management fee per month for each recipient the PMP has enrolled, as of the first day of each month. However, Federally Qualified Health Centers, Independent Rural Health Clinics and Provider Based Rural Health Clinics do not qualify for the case management fee.

The monthly fee amount that may be paid each PMP is determined by fee components taken from the enrollment application. There is no limit on the accumulation of case management fees; however, the fees paid are contingent upon the fee components the PMP agrees to and the number of enrollees on a PMP's panel with a cap set at 2,000(with extenders) enrollees. The case management fee will generally be paid on the first checkwrite of the month. The medical case management fee will be automatically generated based on Medicaid enrollment reports. Therefore, the PMP is not required to file a claim for the medical case management fee. All other services provided are reimbursed by the current fee-for-service method.

The case management fee will appear on the 1st checkwrite as a "rolled-up" claim on the PMP's EOB. A "rolled-up" claim is one in which all case management fees are paid as a lump sum under a pseudo Medicaid number. The provider's EOB should contain procedure code G9008.

39.4.1 Case Management Fee Components

PMP's will receive a case management fee that reflects the contractual requirements to which the PMP has agreed. The components of the fee are delineated below. Details on the components are provided so that the PMP can determine whether the component can be met. This information will be entered based on the providers Medicaid enrollment and the Patient 1st application submitted.

- **EPSDT**

  If the PMP does his own screenings, then **.45** will be built into the monthly case management fee. The PMP must have a signed EPSDT agreement on file with EDS. If the PMP authorizes another provider to do his screenings on a routine basis, then he is not eligible for this component of the case management fee. This component will be auto plugged based on information on the PMP's regular Medicaid enrollment.

- **VFC (Vaccine for Children)**

  If the PMP is an enrolled VFC provider, then **.10** will be built into the monthly case management fee. The PMP must have a signed VFC agreement with the Health Department. This component will be auto plugged based on information on the PMP's regular Medicaid enrollment.

- **24/7 Coverage**

  If the PMP or someone on his staff, or a nurse call center provides voice-to-voice assistance, then **.85** will be built into the monthly case management fee.

- **Medical Home Project**

  If the PMP completes the Medical Home Training Project then **.10** will be built into the monthly case management fee. The Medical Home Project is a training module that helps train PMPs on the components of establishing and maintaining a medical home for patients. As CMEs are received, a copy should be sent to Medicaid for inclusion in the monthly case management fee.

- **Hospital Admitting Privileges**

  If the PMP admits his own patients or has arrangements with a hospitalist group to admit his patients, then **.30** will be built into the monthly case management fee. If patients have to be admitted through another provider then the PMP is not eligible for this component of the case management fee. This information will be plugged from the Patient 1st application.

- **Electronic Notices**

  If the PMP agrees to receive notices from Medicaid and EDS via electronic means (not paper copies), then **.05** will be built into the monthly case management fee. This information will be auto plugged based on information on the PMP's regular Medicaid enrollment.

- **Electronic Education Materials**

  If the PMP agrees to receive educational materials via electronic means and reproduce those materials for his Patient 1st patients, then **.15** will be built into the case management fee. This information will be plugged from the Patient 1st application.

- **In-Home Monitoring (Disease Management)**

  If the PMP agrees to work with the Agency and its partners to place in-home monitoring equipment on select patients, then **.10** will be built into the case management fee. The PMP will be responsible for identifying patients and reviewing monitoring reports provided on the patient's condition(s). This information will be obtained from the Patient 1st application.

- **InfoSolutions**

  If the PMP agrees to work with BC/BS and utilize their InfoSolutions Pharmacy Program, then **.50** will be built into the case management fee. This information will be plugged from the Patient 1st application.

- **Performance**

  Additional monies may be paid to the PMPs meeting performance measurements as defined by the Agency. The additional monies will be based on the total amount of savings and the percentage of measures met by the PMP.

39.5 Monthly Reports of Enrollees

The following reports are provided to PMPs to help identify and manage patients on their panel.

39.5.1 Initial Assignment Listing

This report will list new patients that the Agency has assigned for a future date (approximately 45 days) and consists of the following recipient information:

- Name
- Address
- Medicaid Number
- Date of Birth
- Aid Category
- County of Residence

The PMP should use this list to gauge caseloads, ensure service can be provided to all enrollees, and to determine if any patients have previously been dismissed. This list is not final, as the patient will have until the 15th of the month preceding the enrollment date to change.

39.5.2 Monthly Enrollee Listing

The first of each month, the PMP will receive a listing of all enrollees that are the responsibility of the PMP for the month, as well as those that have been added or deleted. This listing will include the recipient's demographic information, Medicaid number, aid category, reason assigned to PMP, county code and review date. The enrollee status will be noted as new, continuing, or deleted.

- New Enrollees –enrollees that are new to your panel. A reason code will be listed on the report indicating new enrollee
- Continuing Enrollees – enrollees that have been previously assigned and continue to be assigned to the PMP
- Deleted Enrollees – enrollees that have been deleted from the PMP's panel. A reason code will be listed on this report to explain why the enrollee was deleted from the panel. The explanation of the reason code will be listed on the last sheet of the enrollment report.

In addition a cover sheet will be included that provides information about the PMPs panel and will list the following:

- Counties – current counties in which the PMP has agreed to see Patient 1st eligibles
- Current Caseload – the number of patients currently assigned to the PMP
- Maximum Caseload – the maximum caseload that can be assigned
- Age Criteria – the age range of enrollees the PMP specified he/she wanted on their panel

- PMP List – indicates if the PMP wants to be included on the Patient 1st Providers Listing (county specific)
- Case Management Fee – the case management fee amount paid to the provider based on the case management components he/she agreed to participate in.

It is the PMP's responsibility to review this report every month and report any errors to Medicaid. PMP's must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported until the change or error has been resolved and reported correctly.

If the report is not received by the first of the month, a replacement list can be requested by calling the Provider Assistance Center at 1(800) 688-7989.

NOTE:

This list is not a substitute for eligibility verification. All providers should always verify Medicaid eligibility prior to rendering services.

39.6 Eligible Recipients

The Agency is responsible for recipient enrollment in Managed Care programs. Patient 1st is mandatory for most Medicaid recipients. Medicaid eligibles that must participate in **Patient 1st** are those for whom eligibility has been determined as listed below. Eligibility categories include:

SOBRA eligible children

MLIF and MLIF related

Refugees

Blind

Disabled

Aged

Infants of SSI mothers

Medicaid recipients in the above categories of Medicaid eligibility are ***excluded from participation in Patient 1st in the following circumstances***. NOTE: Those categories with an asterisk are not automatically removed from the Program. These individuals must be reported to Patient 1st for removal from the program. Removal from Patient 1st does not affect their normal Medicaid benefits.

Medicaid eligibility is retroactive only;

Recipient is enrolled in another managed care program in which access to primary care physician is limited (i.e., HMO);*

Recipient is a lock-in;

Recipient resides in a residential or institutional facility such as a nursing home or ICF/MR or a group or foster home or DYS (Department of Youth Services);*

Recipients with dual eligibility (Medicare and Medicaid); and

Recipients who have been determined to be Medically Exempt for the Patient 1st Program, including:*

Terminal illness – the enrollee has a life expectancy of six months or less or is currently a hospice patient,

Developmental delay or Impaired Mental Condition – the enrollee does not possess the ability to understand and participate in Patient 1st (*Note:* This statement is not a determination of the patient's legal mental competence),

Chemotherapy or Radiation treatment – the enrollee is currently undergoing treatment (*Note:* This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than six months, the exemption must be requested after the initial six-month time period during reapplication for Medicaid coverage,

Continuity of Care issues (*Note:* A temporary exemption may be granted to allow a Patient 1st enrollee to continue to see a non-participating physician while the physician is in the process of applying for participation in Patient 1st), and Diagnosis/Other – an enrollee may be granted an exemption if there is a specific diagnosis or other reason why the enrollee would not benefit from coordinated care through a PMP.

The **Patient 1st Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the Patient 1st Program, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103. A copy of the form is included in Appendix E and on the Agency's website at www.medicaid.alabama.gov.

Recipients are removed from **Patient 1st** participation if they are changed to an excluded aid category, or if they lose eligibility or change county of residence. Dependent upon when a person becomes Medicaid eligible, they may not yet be enrolled in **Patient 1st .**

If you have a patient who is enrolled in **Patient 1st** who should not be enrolled, please contact the Recipient Call Center at 1(800) 362-1504.

Eligibility verification indicates enrollment status and assigned PMP name and telephone number.

39.7 Recipient Enrollment/Assignment

39.7.1 Enrollment

To facilitate enrollment into the Patient 1st Program, recipients required to participate are assigned a PMP. Recipients have the ability to change PMP providers on a monthly basis. Dependent upon when a person became Medicaid eligible, they may not yet be enrolled in Patient 1st. **Always verify eligibility**.

Recipients who are added to the eligibility file (refer to 39.7.2 below for information regarding newborns) are notified of their Patient 1st assignment approximately 45 days prior to the effective date of the assignment. The purpose of the 45-day lead time is to allow recipients to change providers prior to actual PMP assignment. A second notification will be mailed to recipients approximately 5 days prior to assignment, which will confirm the original assignment if no change is made, or confirming the requested change. Providers will be notified at the same time as recipients of assignments. The assignment process takes into account group practices and/or clinic affiliation.

The computer assignment algorithm is as follows:

Newborn Will check for the person to be on the newborn list sent from the state.

Sibling Will check to see if a sibling is in the program based on payee number. If there is no payee number, then this step cannot be considered. Siblings already enrolled or those in the same batch will be considered. If two siblings are enrolled and assigned to different PMPs, then the new sibling will be assigned to the PMP of the youngest sibling.

Last PMP on file will be checked. If caseload and age criteria can be met, then assignment will be made to that PMP.

Historical Claims history will be considered for 18 months.

Random assignment based on PMPs serving the recipient's county as long as caseload is available and age criteria can be met.

Random assignment is predicated on lowest available caseload on a rotating basis.

39.7.2 Newborns

Mothers of infants who will be required to participate in the program have the opportunity to select the provider they want for their child's PMP prior to assignment by the Agency. This is accomplished through the completion and submission of a Newborn Assignment Form. These forms are available through a variety of sources including, but not limited to, the physician's office, the Maternity Care Program Care Coordinator, and the hospital. The form must be completed and submitted prior to the Agency's assignment of the infant. Newborn assignments may be faxed to EDS at (334) 215-4140. In order for the request to be granted, the PMP must have available caseload for the recipient's county.

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Deleted: ~~mailed to the Patient 1st Program or~~

Added: EDS at

Deleted: ~~353-3856~~

Added: 215-4140

39.7.3 Eligibility Verification

It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are three sources available for obtaining recipient information:

The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.

The Automated Voice Response System may be accessed by dialing 1(800) 727-7848 using a true touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.

The Provider Assistance Center at EDS can be reached at 1(800) 688-7989 from 8:00 am – 5:00 pm, Monday through Friday.

The verification will give contact information for the recipient's assigned PMP.

39.7.4 Recipient Changes of Primary Medical Providers

Enrollees may request to change their PMP at any time. EDS is responsible for processing an enrollee's change request. Enrollees can change PMPs by calling the 1-800 line, or by mailing or faxing a written request to the Agency. The Agency monitors the reasons for change as part of the program compliance protocol.

Recipients must initiate changes to their PMP assignment

Enrollments and disenrollments to effect a change in PMP are effective the first of the month, following the date of the change if the request for change is received by the Agency by the 15th of the month. If requests for changes are received after the 15th, the change is effective the 1st of the following full calendar month.

NOTE:

If changes are not received by the 15th of the month, assurances for an effective date for the first of the following month can not be given. This will allow a 5 day processing timeframe.

Please see Appendix E of the Medicaid Provider Manual for a copy of the PMP change form that can be utilized by the recipient. Patient requested changes are confirmed by a mailing prior to the 1st of the month in which the change is effective.

39.7.5 PMP Request Change/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. The request should contain documentation as to why the PMP does not wish to serve as the patient's PMP.

*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.

Additionally, a Patient 1st enrollee may be disenrolled 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 enrollee.

However, a recipient may not be charged or billed a cancelled or missed appointment ("no-show") fee. Refer to Chapter 6 of the Administrative Code for further information.

The PMP is responsible for sending a letter of dismissal to the enrollee and include a copy as an attachment to documentation provided to Medicaid. The dismissal letter should be addressed to the patient and signed by the PMP. Another PMP, not one in the same group as the original PMP, will be selected for the recipient.

Recipients 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 faxed to Medicaid at (334) 353-3856.

39.7.6 PMP Disenrollment

Patient 1st enrollees are assigned to a different PMP if a PMP dies, moves out of the service area, or loses Medicaid and/or **Patient 1st** provider status. Such reassignment is usually accomplished by automated means. Medicaid sends a notice to the affected recipients, telling them of the reassignment, and the reason for the reassignment. They may then select another PMP if the reassignment is not satisfactory.

PMP Leaves Group Practice

If it is a situation of a PMP leaving the area, then patients will be reassigned to the remaining practitioner or group.

PMP Site Change

If it is a situation of a PMP leaving one site to open another site, the patients will be reassigned to the remaining practitioner.

PMP Closing a Site

If it is a situation of a PMP maintaining two locations within the same geographical area, then the patients from the closed site will be reassigned to the site remaining open. This will apply if the PMP is maintaining a group or clinic site or private practice site.

39.8 Referral Process

Coordination of care is an important component of Patient 1st. PMPs are contractually required to either provide services or authorize another provider to treat the enrollee while adhering to the referral process. This applies even when an enrollee has failed to establish a medical record with the PMP. The patient does not have to be seen by the PMP prior to a referral being given.

PMPs may make referrals to any practitioner that can best meet the patient's needs. However, every effort should be made to refer patients to Medicaid enrolled physicians that are geographically accessible to help facilitate the reimbursement process.

In some cases, the PMP may choose to authorize a service retroactively. All referrals, including services authorized retroactively, are at the discretion of the PMP. Some services do not require referral; refer to Section 39.10 of this Chapter for more information.

In addition to Patient 1st PMP referral, prior approval (PA)- may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. Refer to Chapter 4, **Prior Approval** of the Medicaid Provider Manual for additional information about services requiring PA.

39.8.1 Referral Form

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362)* or the referral form on www.Efileshare.com. Medicaid requires that the one of these two referral forms be used **for each referral authorization given**.

NOTE:

For information on the Efileshare system, please contact Laura Gilmour, Regional Sales Director at (205) 427-2262 or lgilmour@scisolutions.com. A crosswalk for the Efileshare referral form is available at www.medicaid.alabama.gov under Programs/Patient 1st/Billing Resources for Providers.

Referral authorization from the PMP must be given prior to patient treatment. If given verbally, ** a written referral form, from the PMP to the consultant, must follow within 72-hours of the verbal authorization.

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The form can be obtained by accessing Medicaid's website.

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39.8.2 Comprehensiveness / Duration of Referral

The comprehensiveness and duration of the referral is determined by the PMP and the other provider. The referral may cover one visit or it may cover multiple visits as long as those visits are part of a plan of care and are medically necessary. A new approval must be provided if the diagnosis, plan of care or treatment changes.

If the consulting physician decides that the recipient must be treated by another consulting physician (or another provider who is not the PMP), the first consulting physician must contact the PMP for approval and authorization to further refer the patient, unless such approval has already been **indicated on the referral form.** The second provider should then use the PMP's approval code when billing. This same procedure should be followed for **any** successive referrals.

Referrals can be for duration of up to 12 months for EPSDT referred services. Referrals from a previous PMP may be honored for a 6 month time frame. The referral number is the PMP's provider number. If the PMP is with a Clinic/ Group, the referral number is the Clinic's/Group's provider number.

39.8.3 EPSDT Screening Referrals

It is not necessary to redo EPSDT screening referrals on the Patient 1st/EPSDT Referral form. If the original screener is not the PMP, then the PMP must either sign on the original Patient 1st EPSDT referral form (anywhere is acceptable) or issue a written **Patient 1st** referral. Please refer to the Appendix A of the Medicaid Provider Manual. In addition, screenings performed prior to enrollment as Patient 1st are acceptable as long the PMP concurs with the findings and treatment plan.

39.8.4 Group/Clinic Practices

Physicians within the same group/clinic and enrolled at Medicaid with a group/clinic number are not required to have referrals among the group/clinic physicians. If a group/clinic physician is covering for another PMP, and a patient requires a referral to a provider outside the group/clinic, then the authorization number of the assigned PMP must be provided to the referred provider and noted in the chart.

39.8.5 Referral for Coverage of Non-Group/Clinic Physicians

When a physician is providing coverage for a PMP (outside of a formal group practice) and services are rendered to an enrollee, the covering physician must provide the PMP with documentation as to the nature of the services rendered and any follow-up required for placement in the patient's medical record. The PMP must provide the covering physician with a referral authorizing such coverage in order to facilitate reimbursement.

39.8.6 Referral for a Second Opinion

Patient 1st PMPs are required to refer an enrollee for a second opinion at the request of the enrollee.

39.8.7 Referrals for Non-Established Patients

The Agency understands that it may be the policy of a PMP not to issue a referral unless the patient is established. We can appreciate the need to know a patient in order to appropriately manage his or her care. However through **Patient 1st** , new patients are continually added—patients which the PMP may not have an established relationship. If a patient who is a new patient or one who has not consulted with the PMP requests a legitimate urgent referral, we suggest that you issue the referral and use this opportunity to schedule a follow-up visit. If the patient refuses to follow-up with a visit to your office at that time, it would be appropriate to refuse further referrals or pursue the option of dismissing the patient if behavior is deemed to be of a non-compliant nature. See “PMP Request Change/Dismissal of Recipient”.

Keep in mind that many of these patients have changed their PMP assignment to the physician to whom they are currently seeing or have been seeing in the past. For one month, the patient may be assigned to you as a PMP. If a referral is necessary during this one month, then it can be documented as a billing referral only.

NOTE:

PMP referral grants access only to service, it does not supersede benefit limits and/or other authorization processes. Please refer to the Appendix E for Patient 1st services that require a referral and services that **do not** require a referral.

39.8.8 Special Authorizations

There are situations in which a PMP may be requested to authorize Medicaid services for a recipient who no longer lives in the service area, who changes eligibility categories and is no longer in a category covered by **Patient 1st** , or who has changed PMPs. Examples for the most common of these situations are given below:

Example 1

The recipient moves to another **Patient 1st** county and selects another PMP. If the recipient needs medical care and his/her county has not been changed (perhaps in the middle of the month), the provider must contact the PMP for authorization of services.

Example 2

A child is removed from an MLIF case because he/she is now in foster care and eligible for Medicaid under the foster care program. If the child needs medical care during the period that his/her **Patient 1st** still is in effect (usually in the middle of the month), the provider must contact the PMP for authorization of services in the same manner as described above.

39.8.9 Referral for Billing Purposes Only

A PMP may approve a referral for billing purposes only. Such a referral should be documented "for billing purposes only" on the standard billing referral form in the space provided under REFERRAL VALID FOR. The billing procedure for this type of referral is the same as all other referral types.

39.8.10 Billing for Referred Services

If a Patient 1st enrollee goes to any other Medicaid provider for non-emergency services without the referral of the PMP for Patient 1st services, the provider should refer the enrollee back to the PMP or contact the PMP. If the PMP authorizes the services at that time he/she will give the provider his/her provider number for entry on the claim form and Medicaid will pay the claim if the enrollee is eligible and has benefits available. If the Medicaid recipient insists upon receiving the unauthorized service, he/she should be informed that Medicaid will not pay the claim and that the recipient will be responsible for payment of services rendered.

A pharmacist does not have to contact the PMP prior to filling a prescription written by another Medicaid provider, but must enter on the claim form the license number of the prescribing physician.

For complete billing instructions, refer to Chapter 5 of the Medicaid Provider Billing Manual.

39.8.11 Authorization Number

Access to services is authorized through use of the PMP's nine digit Medicaid Provider Number. To facilitate the process, and lessen the administrative burden for the physician, the following procedures are used when processing claims:

Step One (Billing Provider)

The **PMP** provider number on the claim is compared against the **PMP** provider number to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.

The group number of the provider on the claim is compared against the group number on the PMP file. Groups are assigned a group number. If they match, the claim continues through Medicaid edits. 'Informal' groups are not considered to be a group as they cannot be identified systematically.

Step Two (Referring Provider)

The referring **PMP** provider number indicated on the claim is compared against the provider number to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.

The referring **PMP** group number on the claim is matched against the group number on the PMP file. If they match, the claim continues through Medicaid edits.

If the claim is for **Patient 1st** coordinated services and steps one and two do not apply, the claim will be denied with an **EOB** Code of **107**. A **107** denial code means 'Recipient enrolled in the **Patient 1st** Program, services require referral from PMP'.

When making referrals, the PMP must provide the nine digit Medicaid provider number to be used by the consulting provider. All PMP referrals must be in writing. The PMP may make the referral verbally, but must follow with a written referral to the requesting physician within a 72-hour period of the verbal authorization.

39.8.12 Override Requests

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In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that a referral override may be prudent in some situations. Providers must request an override using the **Patient 1st Override Request form** to obtain payment. A copy of the **Patient 1st Override Request form** is in Appendix E of the Medicaid Provider Manual. Override requests must be submitted to the Patient 1st Program by mail within 90 days of the date of service. Requests will be evaluated within 60 days of receipt. Overrides will not be approved for well visits.

NOTE:

All efforts to obtain a referral from the PMP should be exhausted before an Override Request is submitted.

39.9 Complaint / Grievance Process

39.9.1 Filing a Complaint or Grievance

Enrollees can file complaints or grievances through the 1(800) 362-1504 Recipient Call Center or in writing by submitting a Patient 1st Complaint form to the address indicated on the form (a copy of the form is available in Appendix E or from the Agency). Providers can file complaints or grievances through the Recipient Call Center at 1(800) 362-1504 or in writing. Enrollees or Providers may file complaints or grievances about their assigned provider or other aspects of the **Patient 1st** Program system. Medicaid's Managed Care QA Program will thoroughly investigate each complaint or grievance and report the results of its findings back to the enrollee or provider. When appropriate, the enrollee's assigned provider will be notified to document the complaint and obtain necessary correction of problems noted. In especially acute situations, Medicaid may use the special authorization system or various procedure exception systems to resolve the grievance. The enrollee may appeal the action or may request a formal Medicaid hearing. Complaints by other providers or reports by informants are investigated similarly to grievances.

39.9.2 Grievance Log

Medicaid will maintain a log of the grievances received and their disposition. Complaints/Grievances will be "categorized" as a tool by which to assess program impact. Complaints/Grievances usually fall into one of the following five categories:

1. Contract violations/program policy
2. Professional conduct – general
3. Professional conduct – physical, sexual or substance abuse
4. Quality of care
5. Program fraud/abuse

39.10 Detail on Select Services

39.10.1 Benefits

Patient 1st enrollees have the same range scope, amount of services and co-payments as other Medicaid recipients. There are some services that are excluded from the **Patient 1st** program and do not require authorization by the PMP. These are obtained through the same procedure as used by other Medicaid recipients outside the Patient 1st program. It is anticipated; however, that the enrollee will look to the PMP for advice and/or coordination of these services. **Patient 1st** enrollees should be offered the same level of service coordination for non-authorized services as would other patient populations.

The **Patient 1st** Program does not extend or supersede any existing program benefit or program requirement. A matrix of what services **do** and **do not** require referral follows.

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Allergen/Immunotherapy	M	Procedure Codes 95115-95199 (Administration of allergy injections)
Ambulance	M	Ambulance-Ground and Air
CRNA	M	Certified Registered Nurse Anesthetist
Certified Emergency	M OP	Any service rendered by a provider resulting from a documented certified emergency (utilize claim block 24-I with an "E" indicator on the CMS -1500 Claim Form; utilize claim block 78 with an "E" indicator on the UB-92 Claim Form.)
Dental	M DE OP	Dentists & Federally Qualified Health Centers (Claim Type DE only), Clinics- Children's Dental/Orthodontia and Orthodontists, Oral, Maxillofacial Surgeons Procedure Codes: D8080 (Comprehensive orthodontia treatment of adolescent dentition), D8680 (Orthodontic retention-removal of appliances, construction/ placement of retainers), D9430 (Office visit for obs services during regular hours) Outpatient facility procedure codes D9420. Note: OP facilities do not require a referral for **DENTAL** procedures.
Dialysis	OP	Dialysis Centers
EEG/EKG Related Services	M OP	Procedure Codes: 93000-93278 (Routine ECG w/at least 12 leads w/interpretation & report), 95805-95827 (EEG related services)
Early Intervention Services	M	Provider type 44
End Stage Renal Disease	M	Nephrologists Diagnosis Code: 585.6 (End Stage Renal Disease)
EPSDT Developmental Diagnostic Assessment	M	Procedure Codes: 96110 & 96111 (EPSDT Developmental Assessment) **NOTE: Other EPSDT requires referral**
Eye Exams, non-medical	M	Optometrists Procedure Codes: 92002-92015, 92313 (Corneoscleral lens) **NOTE: Opthalmological services require referral**
Eyeglass & Other Lens Fittings	M	Procedure Codes: 92340-92355 (Fitting of spectacles), 92310-92312 (Prescription/fitting for contact lens-medical supervision of adaptation)
Eyeglasses/Lens	M	Procedure Codes: V0100-V2799 (CMS Assignment of Vision Services), V2020 (Standard Eyeglasses, Frames), V2025 (Eyeglasses, Special Order Frames, 92315-92317 (Corneal Lens/Corneosclera Lens) 92326 (Replacement of Lens), 92370 (Repair of spectacles)
Factor 8	ANY	Procedure Codes: J7197, J7198, J7199(Anti-Inhibitor Coagulant Complex), J7193, J7194, J7195(Factor IX Complex-Per IU)

M=Medical (CMS 1500) IP=Inpatient OP=Outpatient DE=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Family Planning • Medical • Outpatient	M OP	**Medical Outpatient:** Family Planning Indicator (Y) – Procedure Codes: 58300-58301 (Insert intrauterine device), 58600 (Ligat/Trans of fallopian tubes), 58605 (Ligat/Trans of fallopian tubes), 58611 (Ligat/Trans of fallopian tubes), 58615 (Ligat/Trans of fallopian tubes), 50610 (Initial visit), Birth control pills, Adolescent pregnancy prevention education, Hormonal IUD, 11975-11977 (Insertion/Removal of contraceptive capsule), 55250 (Vasectomy), 55450 (Ligation: vas deferens), 58670-58671 (Laproscopy), 57170 (Diaphragm fitting), Depo Provera; Diagnosis Codes: V25-V2590 (Contraceptive Management)
Glucose Test Strips/Lancet	M	Procedure Codes: A4253 (Blood Glucose Test/Reagent Strips for Home Blood Glucose per box of 50 - limited to 3 boxes per month), A4259 (Lancets, per box of 100 - limited to 2 boxes per month), A4233, A4234, A4235 and A4236 (Replacement batteries for use with medically necessary Home Blood Glucose Monitor owned by patient.) **NOTE: Requires prior authorization if additional strips and/or lancets are needed.**
Gynecology/Obstetrics	M	OB/GYN-Any service performed by this specialty is exempt from referral requirement. Note: **OP facility** fees for OB/GYN services require a PMP referral unless for Family Planning or Maternity Services as defined herein.
HCBS Services	M	Providers of HCBS waivered services i.e. Elderly & Disabled Waiver-ED, Homebound Waiver-EC, and MR/DD Waiver-EE)
Hearing Aids	M	Hearing Aid Dealers (EPSDT only)
Hospice	OP	Hospice
Immunizations	M OP	Administrative Fees for Procedure Codes: 90700-90748 (Immunization, Active DTAP for intramuscular use), 90633 (Hepatitis A Vaccine), 90636 (Hepatitis A&B, 3 Dose, Adult), 90645 (HIB Vaccine), 90647-90648 (HIB Vaccine), 90649 (Human Papilloma Virus Vaccine), 90655 (Influenza, Preservative-Free), 90656 (Hemophilus Influenza Split Virus), 90657-90658 (HIB Vaccine), 90660 (Influenza Virus Vaccine, Live, Intranasal), 90669 (Pneumococcal Conjugate Vaccine 7 Valent), 90680 (Rotavirus Vaccine), Factor IX Complex, per IU, Rhogham Serum, Pneumovax 23, Pnu-Imune 23, Fluzone, DT Toxoid, Fluzone-Subviron, Recombivax-Hep B, Haemoph B Prohibit, Hepatitis B-Energix B, Antihemophilic Factor
Infant Birth Diagnosis	ANY	Diagnosis Codes: V30-V3911 (Single Liveborn)
Inpatient Consults	M	Procedure Codes: 99251-99263 (Initial inpatient consult), 99360 (Physician Standby), 99436 (Attendance at delivery)
Inpatient Hospital • General • Psychiatric • Physician Hospital Visit	IP	Hospital

M=Medical (CMS 1500) IP=Inpatient OP=Outpatient DE=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Laboratory	M	Independent Labs & Hospitals-(Claim Type OP) - Outpatient Hospital Lab Services-Procedure codes: 36415 (Routine Venipuncture), 36416 (capillary blood specimen), 80048-89399 (Pathology & Lab Organ or Disease Panels); Outpatient Hospital Chemotherapy-procedure codes: 96400-96549 (Chemotherapy Administration)
Long Term Care (LTC) • Intermediate Care Facility-Mentally Retarded (ICF-MR) • Nursing Home	IP	Nursing Homes & ICF-MR Facilities
Maternity Care Program	M	Maternity Care Program-Primary Caregiver
Maternity Services	M OP	Diagnosis Codes: 640-67699 (Pregnancy-related)
Mental Health Services	M	Mental Health Services **NOTE:** Includes Community Mental Health Centers and other providers with same provider type. PMP notification is required for services rendered.
Newborn Care	M	Procedure Codes: 54150 (Circumcision/clamp), 54160 (Circumcision/surgical), 99440 (Newborn resuscitation), 99431-99436 (History/exam of newborn), 99360 (Physician Standby)
Optometrist/Optician	M	Optometrist/Optician
Physicians	M	Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians ****All other physicians require referral in any office or outpatient setting.**
Pregnancy-Related Services	M IP OP	Diagnosis Codes: 640-67699 (Pregnancy-related), V22-V242 (Normal pregnancy-routine postpartum f/u), V27-V289 (Outcome of delivery)
Preventive Education	M	County Health Department, Preventive Ed
Professional Component	M	Modifier 26; Procedure Codes: 93010 (Interpretation/Report of Cardiography), 93237 (Physician review/report), 93300-93399 (Echo)
Radiology	M	Independent Radiologists & Hospitals (Claim Type OP) Outpatient Hospital Radiology-procedure codes: 70010-79999 (Diagnostic Radiology)

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PATIENT 1ST SERVICES REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Ambulatory Surgical Center	OP	Lithotripsy other than physicians and centers **NOTE:** Includes Ambulatory Surgical Centers and Lithotripsy
Anesthesia	M	Physicians **EXCEPTION:** Anesthesiologists
Audiologists' Services	M	Audiologists (EPSDT ONLY)
Chiropractor Services	M	Chiropractors. (EPSDT or QMB recipients only)
Clinics	M DE	Clinics **EXCEPTION:** Children's Dental & Children's Orthodontia (Orthodontist) Procedure Codes: 08080 (Comprehensive orthodontia treatment of adolescent dentition), 08680 (Orthontic retention-removal of appliances, construction/placement of retainers), 09430 (Office visit for obs services during regular hours)
County Health Department	M	**EXCEPTION:** County Health Department/Preventive Education
Durable Medical Equipment	M	Durable Medical Equipment-DME **EXCEPTION:** L8000, L8010, L8020 and L8030.
EPSDT Screenings	M	Procedure Codes: 99381-EP – 99385-EP Initial, 99381-EP – 99395-EP (Periodic; 99391-99395 w/o EP modifier (Interperiodic); 99173-EP (EPSDT Vision Screening), 92551-EP (Hearing Screening).
FQHC Services (Federally Qualified Health Center)	M	FQHCs **EXCEPTION:** Family Planning Indicator (Y)
Home Health	OP	Home Health Providers **NOTE:** Inpatient services do not require a referral, however, discharge planning of outpatient services (i.e. home health, DME, specialist visits) **do require** a PMP referral.
Independent Nurse	M	Independent Nurses
Nephrology	M	**EXCEPTION:** Nephrologists-Diagnosis Code: 585 (End Stage Renal Disease (ESRD))
Optometrist/Optician Svcs	M	Optometrists/Opticians), for medical diagnosis.
Outpatient Hospital Services	M OP	Hospitals-Procedure Codes: 99281-99285, outpatient surgical procedures and therapies (PT, ST and OT), observation beds and non-certified emergencies. **EXCEPTION:** Outpatient Hospital Radiology (procedure codes: 70010-79999); Outpatient Hospital Lab Services (procedure codes: 36415, 80048-89399); Outpatient Hospital Chemotherapy (procedure codes: 96400-96549) Outpatient facility procedure code D9420. Outpatient facilities do not require a referral for DENTAL procedures.
Physicians	M	Physicians-any billing by physicians unless the particular provider type or service is excluded **EXCEPTION:** Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians
Podiatrists' Services	M	Podiatrists (EPSDT and QMB only)
Private Duty Nurse	OP	Private Duty Nurses (EPSDT only)
Psychologists' Services	M	Psychologists (EPSDT only)
Rural Health Clinics	M	Rural Health Clinics
Therapists' Services	M	Physical Therapists, Occupational Therapists and Speech Therapists. Outpatient therapy services must be a result of an EPSDT or for QMB recipients.

M=Medical (CMS 1500) IP=Inpatient OP=Outpatient DE=Dental

39.10.2 Emergency Services

Access to certified emergency services will not be restricted by the **Patient 1st** Program. Certified emergencies in outpatient emergency room settings do not require referral or prior authorization by the PMP. However, documentation should be maintained by the provider of service to support emergency certification.

39.10.3 Certified Emergency Services

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 an average knowledge of health and medicine, could reasonably expect the absence of immediate medial 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 person presenting, their medical background, extenuating circumstances, presenting symptoms, time of day, and availability of primary care (e.g., weekend, night or holiday.)

Determine whether the presenting symptoms as reported would be reasonably expected to cause the patient to expect a lack of medical attention could 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 not an emergency, **do not certify** the visit. Note that follow-up care should not be certified as an emergency (i.e. physical therapy, suture removal, rechecks, etc.)

Ancillary or billing staff is not permitted to certify. Certification must be done by the attending physician.

Children or adults brought to the ER for exam due to suspected abuse or neglect may be certified by virtue of the extenuating circumstances.

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PMP. Please note that follow-up care should not be certified as an emergency and in some cases may require PMP referral (i.e. physical therapy, suture removal, rechecks, etc.).

In order for the claim not to require a Patient 1st referral, there must be an "E" indicator in the appropriate claim block. Refer to the Chapter Five of the Billing Manual for further instructions.

Providers should bill certified emergency services separately from those of non-certified emergency services, which require PMP referral.

The Agency stresses the importance of coordinating with the PMPs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept of the Patient 1st program.

39.10.4 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 requested to either perform or make arrangements for EPSDT screenings. The PMP is responsible for ensuring that age appropriate EPSDT screenings are provided. 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 in the birth to 21 year age group.

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 the 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 noncompliance 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 this agreement.

Immunizations

Immunizations do not require PMP referral; however, the PMP must maintain documentation of immunizations received. Documentation must include: the date the immunization was given, the type of immunization, and who provided the immunization. PMPs are required to ensure that immunizations are up-to-date for children in their panel.

Providers should be aware that through **Patient 1st** new patients will be assigned, many of which, will be children. These children will be looking to the PMP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PMPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush**. ALL PMPs SHOULD MAKE EVERY EFFORT TO WORK WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED**.

EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal of these services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

Care coordination services are available for eligible children from birth through 20 years of age at no cost to any provider who wishes to utilize them. The Agency, along with the Department of Public Health, identifies children at greatest risk who have potential for effective intervention. These Medicaid eligible recipients are targeted for outreach.

The scope of services is designed to support the physician's office personnel in identifying, contacting, coordinating services and providing office visit follow-up for children. Areas targeted include:

- Under utilization of EPSDT and immunization services,
- Vision/Hearing Screenings, including Newborn hearing screening follow-up,
- Dental Screenings,
- High utilization of Emergency Room visits,
- Elevated Blood Lead levels,
- Abnormal Sickle Cell and Metabolic Screening results,
- Referral follow-up,
- Missed appointment follow-up
- Outreach for At Risk children, and
- Teen Pregnancy Prevention Services coordination.

In addition, care coordinators are available to assist with transportation services. Care coordinators may receive referrals from physicians and dentists regarding Medically-at-Risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, care coordinators will encourage and assist in recruiting private physicians to improve services to this population.

EPSDT care coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "Programs", then select "EPSDT". A list of EPSDT care coordinators by county and telephone numbers is available to support your office personnel.

39.11 Program Enhancements

The following enhancements are designed to help the PMP achieve the overall program goal of establishing a medical home for our recipients that is accountable and cost-effective.

39.11.1 Disease Management

Patients with a diagnosis of Diabetes, COPD and/or CHF are eligible to be enrolled in an in-home monitoring program. This program is a joint effort between the Agency, the University of South Alabama (USA) and the Alabama Department of Public Health (ADPH). Upon enrollment by the physician, a biomonitoring box will be placed in the home of patients identified for intervention. This box will be supplied by the University of South Alabama (USA) for a reasonable monthly fee. Peripherals to the box which are not covered through the DME program will also be supplied by USA. USA will bill Medicaid monthly for the "rental" fee on a medical claim form for each recipient utilizing a procedure code. This will allow for necessary tracking and monitoring of the program. An ADPH nurse will place the equipment in a patient's home and provide the necessary training to the patients as well as provide necessary follow-up. USA will maintain the database which daily monitors the patient data transmitted via standard

telephone lines from the patient's home. Alerts will be generated either to the PMP or the ADPH nurse when a patient reports outside their specified parameters. The system is very flexible with regard to the structure of an alert protocol. The PMP or the ADPH nurse will follow-up with the patient and determine what services are needed.

In addition to the alert feature the USA system will generate valuable patient data reports monthly for each PMP participating in the biomonitoring program. Summary data will also be provided to Medicaid for monitoring of the program.

PMPs are encouraged to contact the Agency for further information about patient enrollment.

39.11.2 Patient Intervention (Case Management)

In addition to the technology that will be available through the biomonitoring box, the Agency will be partnering with the Alabama Department of Public Health to provide patient intervention services. These services will be provided through social workers and will target patients who are identified as non-discriminate users of the emergency room, identified by PMPs as needing educational reinforcement and/or may have a disease state that requires extra monitoring. It is the intention that referrals will be made by the Agency as well as the PMP. These type services will be available statewide and reimbursed fee for service.

39.11.3 InfoSolutions

InfoSolutions is a product offered by Blue Cross/Blue Shield (BC/BS) that will provide the PMP with pharmacy information about patients on their panel. Medicaid and BC/BS claims information can be downloaded on a regular basis to 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.

This information will then be available to the provider to determine what prescriptions have been prescribed, filled and being taken on a regular basis. Prescribing suggestions will also be available based on Medicaid's Preferred Drug List. This enhancement will help the PMP achieve the Patient 1st goal of reducing pharmacy expenditures. Medicaid is partnering with BC/BS to make this service available to PMPs (and other Medicaid providers) at no cost.

Medicaid monitors the use of this product by participating 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:

Quarter	Review Month	Suspend/Reinstate Month
JAN/FEB/MAR	APRIL	MAY
APR/MAY/JUN	JULY	AUGUST
JUL/AUG/SEP	OCTOBER	NOVEMBER
OCT/NOV/DEC	JANUARY	FEBRUARY

For more information on InfoSolutions you can contact the Patient 1st program or visit the InfoSolutions website at www.infosolutions.net.

39.12 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Medicaid Managed Care Quality Assurance Program and the Patient 1st Program. Monitoring efforts will look at all facets of the program including measuring the PMP against established program goals, determining contract compliance and focusing in on program outcomes all of which involve both administrative and performance measures.

The Profile Report (Profiler) will be the central source of data for program reporting and measurement. This report is based on claims information and one is produced for each PMP. The data in the report is collected from paid claims and is processed to produce characterizations of providers, their enrollee panel and provides comparisons of providers within a peer group.

The Profiler will have three primary components:

- Individual report cards sent to each PMP to provide activity information and program measurements
- A summary report on all providers for use by the Agency. The summary information will be used to monitor the program and identify program outliers.
- Detail reports will identify program areas that need follow-up.

Program over-site activities involve monitoring both administrative measures and performance measures.

Administrative measures are collected using focused reviews and are not primarily dependent on paid claims data. These measurements focus on:

- **24/7 Medical Coverage**
  Ensures PMPs are meeting the requirement for providing after hours coverage to enrollees.
- **Referral Report**
  Monitors PMP's referral numbers to ensure appropriate usage by other providers.
- **PMP Patient Disenrollments**
  Ensures PMPs are not selectively dismissing patients so that performance measures can be met.
- **EDS Enrollment Process**
  Ensures patients are linked to the most appropriate caregiver based on patient choice, family linkage and/or historical patterns of care. This will be aimed at internal processes.

- **Complaints and Grievances**
  Ensures patients and providers have a consistent mechanism to express concerns and dissatisfaction with the Patient 1st Program or services provided through the program.

- **Recipient Targeted Survey (REOMBS)**
  Monitors the enrollee's health care experience in order to improve the Patient 1st Program and identify potential problems.

- **Cost Monitoring**
  Costs will be reviewed quarterly to ensure budget neutrality requirements are being met, to track overall costs per recipient and to track costs/savings.

Performance measures are primarily claims driven and focus on:

- **Generic Dispensing Rate**
  The percentage of generic prescriptions ordered for the Primary Medical Provider's (PMP) panel. This percentage will be compared to the performance of their peer group and risk adjusted.

- **Visits Per Unique Recipient**
  Average number of visits per recipient seen by the PMP. The PMP's expected visit rate will be computed by weighting the performance of the PMP's peer group. The measure will compare the PMP's actual visit rate with their expected visit rate.

- **The Average Number of Non-Certified Office Visits**
  Will identify PMP's that are not providing care to members for which they are receiving a case management fee. This information may be used by the Agency to reassess the PMP's continued participation in the Patient 1st Program.

Deleted:
~~Community Outreach Unit section~~

The Agency must ensure all requirements of the Centers for Medicare and Medicaid Services (CMS) are met; therefore the above list of measures is not inclusive and may be modified.

39.13 Obtaining Forms / Educational Materials

Patient 1st forms may be obtained by accessing the Medicaid website.

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~~or by completing… Montgomery, AL 36103-5624~~

Note: Educational materials are also available for use by providers and may be obtained using the online ordering form on the Agency's website at www.medicaid.alabama.gov. A catalog listing these materials is also on the website.

Some materials available for download from the website include:

"Your Guide to Alabama Medicaid". This 36 page booklet describes the services covered, co-payments, the different types of eligibility, patient responsibilities, as well as other useful information.

"Alabama Medicaid Covered Services and Co-Payments" (English or Spanish). Describes services covered by Medicaid and associated co-payments.

"EPSDT Brochure". This is a colorful pamphlet that encourages Well-Child checkups and outlines the periodicity schedule.

"Are you expecting a baby?" This full colored brochure lets pregnant women enrolled in Medicaid know who to contact for prenatal care in their county of residence.

39.13.1 Medicaid Forms

The following forms can be found in Appendix E and/or on the Medicaid website www.medicaid.alabama.gov under Programs/Patient 1st:

Immunization Record
Alabama Medicaid Agency Referral Forms
EPSDT Documentation
Complaint/Grievance Form
PMP Change Form
Newborn PMP Request Form
Request For Educational Material
Patient 1st Override Form
Patient 1st Medical Exemption Form

39.14 Patient 1st Billing Instructions

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing.

If you have program or policy questions about Patient 1st, contact Medicaid's Medical Services Division at 1(800) 362-1504.

39.15 Contact Information Summary

For general Patient 1st billing questions or to request an application package call the Provider Assistance Center: 1(800) 688-7989

To increase the maximum number of enrollees within a caseload the request may be faxed to EDS Provider Enrollment: (334) 215-4298 or mailed to EDS Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To add counties or disenroll from the program the request may be faxed to EDS Provider Enrollment: (334) 215-4298 or mailed to EDS Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To obtain recipient information on eligibility, benefit limits, or coverage call the Provider Assistance Center: 1(800) 688-7989

Automated Voice Response System: 1(800) 727-7848

To address program and policy questions, for individual or specific recipient additions or deletions, for recipient language interpretation services or to report patients enrolled in Patient 1st who should not be enrolled call the Recipient Call Center: 1(800) 362-1504

Deleted: ~~requests, faxed to the Community Outreach Unit: (334) 353-4193~~

Patient 1st forms may be requested on Medicaid's website.

Added: requested on Medicaid's website.

Newborn assignment forms may be faxed to EDS at (334) 215-4140.

Deleted: ~~the Patient 1st Program at (334) 353-3856~~

Patient dismissal requests may be faxed to Medicaid at (334) 353-3856.

Added: EDS at (334) 215-4140.

For written correspondence to the Agency: Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624

100

100 Children’s Specialty Clinics

Children's Specialty Clinic Services are specialty-oriented services provided by an interdisciplinary team to children who are eligible for EPSDT services and who experience developmental problems. Children's Specialty Clinic Services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided in a clinic setting that is not part of a hospital, but is operated to provide medical care on an outpatient basis to children with special health care needs.

Clinic services include the following outpatient services:

- Services furnished at the clinic by or under the direction of a physician or dentist
- Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address

Clinics include:

Amputee
Arthritis
Augmentative Communication
Cerebral Palsy
Child Development
Cleft Palate
Club Foot and Hand
Craniofacial
Cystic Fibrosis
Dentistry
Eye
Feeding (OT)
Genetics
Hearing
Hearing Aid
Hemophilia
Inborn Errors of Metabolism
Infant and Toddler Evaluation
Multiple Disabilities
Neurology
Neuromotor
Neurosurgery
Orthopedic
Pediatric Evaluation
Pediatric Surgery
Plastic
Psycho-education
Scoliosis
Seating, Positioning & Mobility
Seizure
Spina Bifida
Spinal Deformity
Teen Transition
Therapeutic Positioning
Urology

Eligible persons may receive Children's Specialty Clinic Services through providers who contract with Medicaid to provide services to children eligible for EPSDT services.

The policy provisions for clinic providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 61.

100.1 Enrollment

EDS enrolls children's specialty clinics and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code,* and the *Alabama Medicaid Provider Manual.*

In order to meet federal enrollment criteria, all Children's Rehabilitation Services providers must have an individual Medicaid provider number with ADRS/CRS identified as payee. Sparks Rehab Center shall submit claims for clinic services to Medicaid under the physician's clinic provider number or (if no physician is present) under the clinic provider number.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a clinic is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for clinic-related claims.

NOTE:
All nine digits are required when filing a claim.

Clinics are assigned a provider type of 24 (Clinics). Valid specialties for clinics include the following:

- Children's Rehabilitation Service (SC)
- EPSDT (E3)
- Hemophilia (SH)
- Orthodontia (V6)
- Radiology Clinics (SR)
- Sparks Rehab Center (SD)

NOTE:

Physicians affiliated with children's specialty clinics are assigned their own Alabama Medicaid provider number, which links them to the clinic. The provider type for the physician is 24 (Clinics). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the children's specialty clinic, such as physician assistants or nurse practitioners, bill using the clinic's provider number, and are not assigned individual provider numbers.

Enrollment Policy for Children's Specialty Clinics

Providers are clinics organized apart from any hospital that operate to provide specialty care through an interdisciplinary team approach.

Clinics must meet recognized standards of care for children with special health care needs and provide services in their clinics for the following disciplines, at a minimum:

- Specialty physicians
- Nurses
- Social workers/service coordinators
- Physical therapists
- Audiologists
- Nutritionists
- Speech/language pathologists

All providers serving children must meet state and federal criteria for participation in the Medicaid program.

100.2 Benefits and Limitations

All Children's Specialty Clinic Services must be furnished by or under the direction of a physician directly affiliated with the clinic. "Under the direction of" means the physician must see the patient at least once, prescribe the type of care, and periodically (at least annually, unless the scope of services requires more frequent review) review the need for continued care.

Providers must develop a patient care plan that provides medical and rehabilitative services as well as coordination and support services to children with special health care needs.

Case management/service coordination is an integral part of ADRS/CRS clinic activities. Case managers/service coordinators provide services such as assessment, care plan development, linking/coordination of services, and parent counseling, parent and child education, and follow-up. Types of services provided include assisting the family with surgery/hospital arrangements, scheduling and coordinating appointments for evaluation and treatment, referral to appropriate resources as needed, home visits, school visits, patient and parent counseling/anticipatory guidance, and patient support. Individual case managers must meet the following criteria at a minimum: a four-year college degree or a registered nurse, and all case managers/service coordinators must receive training appropriate to the need of the target population.

Children's Specialty Clinic Teams

The clinic teams are usually comprised of physicians, registered nurses, social workers, therapists, audiologists, and clinic aides, clerical and/or support personnel. Clinic composition may vary depending on the type of clinic; however, clinic team protocol must be furnished to and approved by Medicaid. Clinic team protocol will be updated on an as-needed basis, but annually at a minimum. The team will establish a written patient care plan. The case management team then implements this plan.

100.2.1 Covered Services

Children's Specialty Clinic Services do not include services rendered under other Medicaid programs.

Children's Specialty Clinic Services are covered when provided by a Medicaid-enrolled children's specialty clinic provider.

Types of covered services provided in clinics include:

- Diagnosis of medical condition
- Completion of durable medical equipment assessments
- Development of a patient care plan
- Therapy (physical, speech/language, occupational)
- Patient/parent education
- Audiology services
- Physician services
- Psychological services
- Multidisciplinary evaluations
- Orthotic services
- Prosthetic services
- Optometrical services
- Dental services
- Nutrition services
- Prescriptions for services or medications

- Nursing and social work services
- Case management
- Hearing aid services
- Vision services

For details of dental services covered in children's specialty clinics see Rule No. 560-X-15.06 (3) of the *Alabama Medicaid Administrative Code.*

A patient care plan is required for each child and a service coordinator is responsible for arranging specialty and needed social services for the family.

100.2.2 Reimbursement

Children's Specialty Clinics will be reimbursed by an encounter rate. For more information regarding reimbursement for governmental providers, please refer to the "Children's Specialty Clinic Services Reimbursement Manual."

Governmental providers of Children's Specialty Clinic Services will be reimbursed by an encounter rate based on reasonable allowable cost, as defined by OMB Circular A-87, established by the Medicaid Agency based on completion of the required cost report documentation.

Non-governmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.

Claims may be submitted for reimbursement for only one clinic visit per date of service per recipient, except in the case of dental visits. A dental encounter may be billed in conjunction with only one other clinic visit for the same date of service for the same recipient.

NOTE:

Procedure code D8080 is limited to once per year with prior authorization.

Procedure code D8680 is limited to once every two years with prior authorization.

Procedure code D9310 is limited to once per recipient per lifetime with prior authorization.

100.2.3 Encounters

Covered encounters are face-to-face clinic contacts during which a health professional team provides medical services to a patient. They are identified based on the data from clinic sign-in sheets and the individual medical records.

The definition of a health professional depends upon the type of clinic. To be counted as a physician encounter, the highest level health professional must be a physician.

Examples of physician encounters include the following types of visits, all of which are attended by a physician:

Added: Newborn Cystic Fibrosis

- Amputee
- Arthritis
- Cerebral palsy
- Cleft palate
- Clubfoot
- Craniofacial
- Cystic fibrosis
- Eye
- Genetics
- Hearing
- Hemophilia
- Multi-specialty
- Neurology
- Neuromotor
- Neurosurgical
- Newborn Cystic Fibrosis
- Orthopedic
- Pediatric Evaluation
- Pediatric surgery
- Plastic
- Scoliosis
- Seizure
- Spina bifida
- Spinal deformity
- Teen Transition
- Urology clinics

To be counted as a non-physician encounter, the health professional(s) must be qualified to perform the service, and although a physician is not present, the service must be provided under the direction of a physician. Examples of non-physician clinics include augmentative communication, feeding (OT), hearing aid orientation/maintenance, infant/toddler functional evaluation, and seating.

Multiple contacts with the same health professional(s) that take place on the same day at a single location constitute a single encounter. Services incident to an encounter, or subsequent to the clinic encounter, such as social services, case management, nursing, writing of prescriptions, clerical, therapy, and pre-certification evaluations are inclusive in the encounter and should not be billed separately.

For example, if a client comes to the amputee clinic, the minimum staffing standards must be met in order for the contact to be counted as an encounter. In this case, the orthopedist, physical therapist, and social worker must be present. Their face-to-face contact with the client constitutes an encounter. Subsequent visits for purposes of physical therapy only by the therapist do not constitute an encounter since these costs are included in the encounter rate that is billed only when the minimum staffing standards for a clinic are met.

100.2.4 Maintenance of Records

The provider must make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider will permit access to all records and facilities for the

purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. The provider maintains complete and accurate fiscal records that fully disclose the extent and cost of services.

The provider maintains documentation of Medicaid clients' signatures. These signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the clients' signatures and dates of service.

The provider maintains all records for a period of at least three years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three-year period, the provider retains the records until the legal action is resolved. The provider must keep records in a format that facilitates the establishment of a complete audit trail in the event the items are audited.

100.3 Prior Authorization and Referral Requirements

Clinic procedure codes generally do not require prior authorization; however, **orthodontia services always require prior authorization**. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

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).

100.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Children's Specialty Clinics.

100.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Children's specialty clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Online adjustment functions
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

100.5.1 Time Limit for Filing Claims

Medicaid requires all claims for clinics to be filed within one year from the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

100.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

100.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes have been approved for billing by children's specialty clinics.

Clinic Services

Procedure Code	*Who Can Bill*	*Description*
99213-HT	CRS	Regular Clinic, which includes Craniofacial Clinic, Eye Clinic, Neurosurgery Clinic, Orthopedic Clinic, Pediatric Surgery, and Plastic Clinic
99214-HT	CRS, Sparks	Specialty Clinic, which includes Amputee Clinic, Arthritis Clinic, Clubfoot and Hand Clinic, Craniofacial Clinic, Pediatric Surgery Clinic, Scoliosis Clinic, Urology Clinic, Cerebral Palsy Clinic, Cleft Palate Clinic, , Multi-specialty Clinic, Neuromotor Clinic, Spina Bifida Clinic, Spinal Deformity Clinic
99205-HT	CRS, Sparks	Interdisciplinary Team Clinic (new patient) – limited to only once per physician per recipient lifetime
99215-HT	CRS, Sparks	Interdisciplinary Team Clinic (established patient) – repeat clinic visits Interdisciplinary Team Clinics include Augmentative Communication Technology Evaluation, Cystic Fibrosis Clinic, Feeding Clinic, Genetics Clinic, Hemophilia Clinic, Infant/Toddler Functional Evaluation, Neurology Clinic, Seating Clinic, Seizure Clinic, and Teen Transition Clinic.
99212-HT	CRS	Hearing Clinic, Hearing Aid Clinic and Maintenance Evaluation Clinic
D9430	Sparks, CRS	Dentistry Clinic

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
AMPUTEE CLINIC 99212-HT	*ORTHOPEDIST or PHYSICAL MEDICINE	*PHYSICAL THERAPIST Occupational Therapist	*LICENSED SOCIAL WORKER Secretary
ARTHRITIS CLINIC 99212-HT	*RHEUMATOLOGIST or IMMUNOLOGIST Ophthalmologist Orthopedist	*NURSE (BSN) *PHYSICAL THERAPIST Occupational Therapist Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
AUGMENTATIVE COMMUNICATION/ TECHNOLOGY CLINIC Evaluation 99215-HT	Under the direction of a physician	*SPEECH/LANGUAGE PATHOLOGIST (CCC/SLP) *PHYSICAL THERAPIST *OCCUPATIONAL THERAPIST *REHABILIATION TECHNOLOGY SPECIALIST	*LICENSED SOCIAL WORKER Vocational Rehabilitation Counselor Secretary

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
CEREBRAL PALSY CLINIC 99212-HT Also known as NEURO-ORTHO CLINIC	*ORTHOPEDIST or PEDIATRIC NEUROLOGIST or NEUROLOGIST or PEDIATRICIAN or PHYSICAL MEDICINE	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist Speech/Language Pathologist (CCC/SLP)	*LICENSED SOCIAL WORKER Secretary
CLEFT PALATE CLINIC 99212-HT	*PLASTIC SURGEON *ORTHODONTIST or DENTIST Pediatrician Geneticist Prosthodontist Otolaryngologist Oral Surgeon	*NURSE (BSN) *AUDIOLOGIST *SPEECH/ LANGUAGE PATHOLOGIST (CCC/SLP) *REGISTERED DIETITIAN Genetics Counselor/RN	*LICENSED SOCIAL WORKER Mental Health Counselor Secretary
CRANIOFACIAL CLINIC 99212-HT	*PLASTIC SURGEON *NEUROSURGEON *ORAL SURGEON *ORTHODONTIST	*NURSE (BSN) *REGISTERED DIETITIAN Speech/language Pathologist (CCC/SLP)	*LICENSED SOCIAL WORKER Mental Health Counselor Secretary
CYSTIC FIBROSIS CLINIC 99214-HT 99205-HT or 99215-HT	*PULMONOLOGIST Allergist/Immunologist Gastroenterologist	*NURSE (BSN) *REGISTERED DIETITIAN Respiratory Therapist Pharmacist Audiologist	*LICENSED SOCIAL WORKER Secretary
EYE CLINIC 99212-HT	*OPHTHALOMOLOGIST or OPTOMETRIST	*NURSE (BSN) Optician Ophthalmic Technician	*LICENSED SOCIAL WORKER Secretary
FEEDING CLINIC 99215-HT	Under the direction of a physician	*REGISTERED DIETITIAN *OCCUPATIONAL THERAPIST *SPEECH/ LANGUAGE PATHOLOGIST (CCC/SLP) *NURSE (BSN)	*LICENSED SOCIAL WORKER Secretary
GENETICS CLINIC 99204-HT or 99214-HT	*GENETICIST	*NURSE (BSN) *GENETICS NURSE/ COUNSELOR Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
HEARING CLINIC	*OTOLARYNGOLOGIST	*AUDIOLOGIST *NURSE (BSN)	*LICENSED SOCIAL WORKER

*Denotes minimum staffing standards

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
99212-HT		Speech/language Pathologist (CCC/SLP) Registered Dietitian	Secretary
HEARING AID CLINIC and Maintenance Evaluation 99215-HT	Under the direction of a physician	*AUDIOLOGIST Nurse (BSN)	Licensed Social Worker Secretary Hearing Aid Dealer
HEARING ASSESSMENT CLINIC 99215-HT	Under the direction of a physician	*AUDIOLOGIST Nurse (BSN)	Licensed Social Worker Secretary
HEMOPHILIA CLINIC 99203-HT or 99213-HT	*HEMATOLOGIST Orthopedist Dentist	*NURSE (BSN) *PHYSICAL THERAPIST Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
INFANT/TODDLER FUNCTIONAL EVALUATION CLINIC 99215-HT	Under the direction of a physician	*TWO OF THE FOLLOWING: Nurse (BSN) Physical or Occupational Therapist Speech/language Pathologist (CCC/SLP) Audiologist Licensed Social Worker	Secretary
NEUROLOGY CLINIC Also known as PEDIATRIC ASSESSMENT PEDIATRIC NEUROLOGY 99203-HT or 99213-HT	*NEUROLOGIST	*NURSE (BSN) *REGISTERED DIETITIAN Physical Therapist Occupational Therapist Speech/language Pathologist (CCC/SLP)	*LICENSED SOCIAL WORKER Secretary
NEUROMOTOR CLINIC 99212-HT	*PHYSICAL MEDICINE Neurosurgeon Orthopedist Urologist	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist Neuro-psychologist Speech/language Pathologist	*LICENSED SOCIAL WORKER Recreational Therapist Secretary

*Denotes minimum staffing standards

CRS CLINIC TEAMS

Added:
NEWBORN CYSTIC FIBROSIS CLINIC
99205-HT or 99215-HT or 99203-HT or 99213-HT

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
		(CCC/SLP)	
NEUROSURGERY CLINIC 99212-HT	*NEUROSURGEON	*NURSE (BSN) Physical Therapist (on call) Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
NEWBORN CYSTIC FIBROSIS CLINIC 99205-HT or 99215-HT or 99203-HT or 99213-HT	*PULMONOLOGIST Allergist/Immunologist Gastroenterologist	*NURSE (BSN) *REGISTERED DIETICIAN Respiratory Therapist Audiologist Pharmacist	*LICENSED SOCIAL WORKER Secretary
ORTHOPEDIC CLINIC 99212-HT	*ORTHOPEDIST	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist Speech/language Pathologist	*LICENSED SOCIAL WORKER Secretary
PEDIATRIC EVALUATION CLINIC 99205-HT or 99215-HT	*DEVELOPMENTAL PEDIATRICIAN	*NURSE (BSN) *PHYSICAL THERAPIST Registered Dietician Occupational Therapist Speech/Language Pathologist	*LICENSED SOCIAL WORKER Secretary
PEDIATRIC SURGERY CLINIC 99212-HT	*SURGEON	*NURSE (BSN) *REGISTERED DIETITIAN	*LICENSED SOCIAL WORKER Secretary
SCOLIOSIS CLINIC 99212-HT	*ORTHOPEDIST	*NURSE (BSN) *PHYSICAL THERAPIST Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
SEATING, POSITIONING & MOBILITY CLINIC 99215-HT	Under the direction of a physician	*PHYSICAL OR OCCUPATIONAL THERAPIST	*DME SPECIALIST Licensed Social Worker Secretary
SEIZURE CLINIC 99203-HT or 99213-HT	*NEUROLOGIST	*NURSE (BSN) *REGISTERED DIETITIAN Pharmacist	*LICENSED SOCIAL WORKER Secretary

*Denotes minimum staffing standards

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
SPEECH PATHOLOGY CLINIC 99203-HT or 99213-HT	Under the direction of a physician	*SPEECH/LANGUAGE PATHOLOGIST Audiologist	Licensed Social Worker Administrative Support Assistant
SPINA BIFIDA CLINIC 99212-HT Also known as: MULTI-SPECIALTY CLINIC	*ORTHOPEDIST or NEUROSURGEON or UROLOGIST	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist	*LICENSED SOCIAL WORKER Secretary
SPINAL DEFORMITY CLINIC 99212-HT	*ORTHOPEDIST	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist	*LICENSED SOCIAL WORKER Secretary
TEEN TRANSITION CLINIC 99215-HT	*PHYSICAL MEDICINE or ADOLESCENT MEDICINE SPECIALIST or PEDIATRICIAN		*TWO OF THE FOLLOWING: REHABILITATION TECHNOLOGY SPECIALIST or VOCATIONAL ASSESSMENT SPECIALIST or INDEPENDENT LIVING SPECIALIST *LICENSED SOCIAL WORKER Vocational Rehabilitation Counselor Recreational Therapist Secretary
UROLOGY CLINIC 99212-HT	*UROLOGIST	*NURSE (BSN) Registered Dietitian	*LICENSED SOCIAL WORKER Secretary

Added: SPEECH PATHOLOGY CLINIC 99203-HT or 99213-HT

*Denotes minimum staffing standards

NOTE:
Claims for Radiology codes 70010 – 79999 must be filed separately from claims for all other services.

Non-Clinic Services

Children's Specialty Clinics also provide, or arrange provision of, non-clinic services. The following procedure codes shall be utilized and will be reimbursed on a fee-for-service basis.

Procedure Code	***Who Can Bill***	***Description***
70010-79999	CRS	Radiology
J7188 J7189 J7190 J7191 J7192	CRS	Injection, Von Willebrand factor complex, per i.u. Factor ViiA, per 1mcg. Factor viii (antihemophilic factor, human), per i.u. Factor viii (antihemophilic factor, porcine), per i.u. Factor viii (antihemophilic factor, recombinant), per i.u.
J7197 J7198 J7199	CRS	Antithrombin iii (human), per i.u. Anti-inhibitor, per i.u. Hemophilia clotting factor, not otherwise classified
J7193 J7194 J7195	CRS	Factor ix (antihemophilic factor, purified, non-recombinant) Factor ix, complex, per i.u. Factor ix (antihemophilic factor, recombinant), per i.u.
D8080	CRS	Comprehensive Orthodontic Treatment of the Adolescent Dentition (requires prior authorization)
D8680	CRS	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s)) (requires prior authorization)
D9310	CRS	Consultation
L3650	CRS	Shoulder orthosis (SO), figure of "8" design abduction restrainer
L3660	CRS	SO, figure of "8" design abduction restrainer, canvas and webbing
L3670	CRS	SO, acromio/clavicular (canvas and webbing type)
L3700	CRS	Elbow orthoses (EO), elastic with stays
L3710	CRS	EO, elastic with metal joints
L3720	CRS	EO, double upright with forearm/arm cuffs, free motion
L3730	CRS	EO, double upright with forearm/arm/cuffs, extension/flexion assist
L3740	CRS	EO, double upright with forearm/arm cuffs, adjustable position lock with active control
L3800	CRS	Wrist-hand-finger-orthoses (WHFO), short opponens, no attachments
L3805	CRS	WHFO, long opponens, no attachment
L3810	CRS	WHFO, addition to short and long opponens, thumb abduction ("C") bar
L3815	CRS	WHFO, addition to short and long opponens, second M.P. abduction assist
L3820	CRS	WHFO, addition to short and long opponens, IP extension assist, with M.P. extension stop
L3825	CRS	WHFO, addition to short and long opponens, M.P. extension stop
L3830	CRS	WHFO, addition to short and long opponens, M.P. extension assist
L3835	CRS	WHFO, addition to short and long opponens, M.P. spring extension assist
L3840	CRS	WHFO, addition to short and long opponens, spring swivel thumb
L3845	CRS	WHFO, addition to short and long opponens, thumb IP extension assist with M.P. stop

Procedure Code	*Who Can Bill*	*Description*
L3850	CRS	WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855	CRS	WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860	CRS	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.
L3900	CRS	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven
L3901	CRS	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven
L3906	CRS	WHO, wrist gauntlet, molded to patient model
L3907	CRS	WHFO, wrist gauntlet with thumb spica, molded to patient model
L3908	CRS	WHO, wrist extension control cock-up, non-molded
L3910	CRS	WHFO, Swanson design
L3912	CRS	HFO, flexion glove with elastic finger control
L3914	CRS	WHO, wrist extension cock-up
L3916	CRS	WHFO, wrist extension cock-up with outrigger
L3918	CRS	HFO, knuckle bender
L3920	CRS	HFO, knuckle bender, with outrigger
L3922	CRS	HFO, knuckle bender, two segments to flex joints
L3924	CRS	WHFO, Oppenheimer
L3926	CRS	WHFO, Thomas suspension
L3928	CRS	HFO, finger extension, with clock spring
L3930	CRS	WHFO, finger extension, with wrist support
L3932	CRS	FO, safety pin, spring wire
L3934	CRS	FO, safety pin, modified
L3936	CRS	WHFO, Palmer
L3938	CRS	WHFO, dorsal wrist
L3940	CRS	WHFO, dorsal wrist, with outrigger attachment
L3942	CRS	HFO, reverse knuckle bender
L3944	CRS	HFO, reverse knuckle bender, with outrigger
L3946	CRS	HFO, composite elastic
L3948	CRS	HFO, finger knuckle bender
L3950	CRS	WHFO, combination Oppenheimer, with knuckle bender and two attachments
L3952	CRS	WHFO, combination Oppenheimer, with reverse knuckler and two attachments
L3954	CRS	HFO, spreading hand
L3960	CRS	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design
L3962	CRS	SEWHO, abduction positioning, erbs palsy design
L3964*	CRS	SEO, mobile arm support attached to wheelchair, balanced, adjustable – **Requires Prior Authorization**
L3965*	CRS	SEO-mobile arm support. Attached to wheelchair, balanced, adjustable rancho type – **Requires Prior Authorization**
L3966*	CRS	SEO, mobile arm support attached to wheel chair, balanced, reclining – **Requires Prior Authorization**
L3968*	CRS	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) – **Requires Prior Authorization**

Deleted: ~~L3963~~

Procedure Code	*Who Can Bill*	*Description*
L3969*	CRS	SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support – **Requires Prior Authorization**
L3970*	CRS	SEO, addition to mobile arm support, elevating proximal arm – **Requires Prior Authorization**
L3972*	CRS	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control – **Requires Prior Authorization**
L3974*	CRS	SEO, addition to mobile arm support, supinator – **Requires Prior Authorization**
L3980	CRS	Upper extremity fracture orthosis, humeral
L3982	CRS	Upper extremity fracture orthosis, radius/ulnar
L3984	CRS	Upper extremity fracture orthosis, wrist
L3985	CRS	Upper extremity fracture orthosis, forearm, hand with wrist hinge
L3986	CRS	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist, (example-colles fracture)
L3995	CRS	Addition to upper extremity orthosis, sock, fracture or equal, each
L3999*	CRS	Upper limb orthosis, not otherwise specified – **Requires Prior Authorization**
L4000	CRS	Replace girdle for Milwaukee orthosis
L4010	CRS	Replace trilateral socket brim
L4020	CRS	Replace quadrilateral socket brim, molded to patient model
L4030	CRS	Replace quadrilateral socket brim, custom fitted
L4040	CRS	Replace molded thigh lacer
L4045	CRS	Replace non-molded thigh lacer
L4050	CRS	Replace molded calf lacer
L4055	CRS	Replace non-molded calf lacer
L4060	CRS	Replace high roll cuff
L4070	CRS	Replace proximal and distal upright for KAFO
L4080	CRS	Replace metal bands KAFO proximal thigh
L4090	CRS	Replace metal band KAFO-AFO, calf or distal thigh
L4110	CRS	Replace leather cuff, KAFO, calf or distal thigh
L4130	CRS	Replace pretibial shell
L4205	CRS	Repair pretibial shell
L4210	CRS	Repair of orthotic device, repair or replace minor parts

Deleted: ~~L4200~~

NOTE:

Refer to Chapter 37, Therapy (Occupational, Physical, and Speech) for the therapy codes.

100.5.4 Place of Service Codes

The place of service code 99 (Other Unlisted Facility) applies when filing claims for clinic services, except for dental and orthodontia services. For dental and orthodontia services, use place of service 11.

100.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

100.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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101

101 County Health Departments

Medicaid contracts with the State of Alabama Department of Public Health to reimburse services provided by County Health Departments.

101.1 Enrollment

EDS enrolls county health departments and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

Medicaid issues county health departments a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for health department-related claims.

NOTE:

All nine digits are required when filing a claim.

County health departments are assigned a provider type of 30 (County Health). Valid specialties for county health departments that employ physicians include the following:

- Family Planning (F1)
- Environmental Lead Assessment (L4)
- EPSDT (E3)
- Immunizations (V8)
- Primary Care Clinic (PC)
- Prenatal Clinic (MI)
- Preventive Education (P9)

County health departments that are enrolled to provide hospice services are assigned a provider type of 47 (Hospice). The valid specialty is Hospice (H6).

County health departments that are enrolled to provide home health services are assigned a provider type of 14 (Home Health). The valid specialty is Home Health (H3).

NOTE:

Physicians affiliated with county health departments are assigned their own Alabama Medicaid provider number, which links them to the health department. The provider type for the physician is 30 (County Health Department). The valid specialties are any of those specialties valid for physicians. Refer to Section 28.1, Enrollment, for a listing of valid physician specialties.

All other personnel affiliated with the county health department, such as physician assistants or nurse practitioners, bill using the health department's provider number, and are not assigned individual provider numbers.

101.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Consent of a Minor

Any minor who is 14 years of age or older; has graduated from high school; or is married, divorced, or pregnant may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself. The consent of another person is not necessary.

101.2.1 EPSDT

County health departments providing EPSDT services should refer to Appendix A, EPSDT, for specifics regarding benefits and limitations.

EPSDT off-site screening providers must follow the protocols and procedures for EPSDT off-site services listed in the EPSDT appendix. Failure to comply may result in recoupment of the funds paid to the provider.

101.2.2 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

Scope of Services

The scope of services include and are designed to support physician's office personnel with identifying, contacting, coordinating, and providing follow up for visits with your office for children who are behind on their EPSDT screenings, immunizations, vision/hearing screenings, dental screenings, identify recipients who have high utilization of emergency room visits; follow up services for newborn hearing screenings, elevated blood lead levels, abnormal sickle cell and metabolic results; follow up on referrals, missed appointments, identify children at greatest risk for targeted outreach, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, EPSDT Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Reports

The following reports provided by the Alabama Medicaid Agency will be utilized by the Alabama Department of Public Health (ADPH) to assist with the following items.

- Monthly Eligibles Report – enables Care Coordinators the ability to track eligible recipients
- Monthly Selected Services Report – enables Care Coordinators to ascertain utilization of EPSDT services, immunizations, elevated blood lead levels, dental services, and high utilization of emergency room visits.

In addition, the Agency and ADPH has developed strategies to identify the children at greatest risk and with the potential for effective intervention utilizing diagnosis codes. Care Coordinators can track referrals, missed appointments, and follow up appointments utilizing the reports listed above.

The following information obtained from ADPH will be utilized as follows:

- Metabolic and Sickle Cell Screening – enables Care Coordinators the ability to track eligible recipients with abnormal results
- Newborn Hearing Screening - enables Care Coordinators the ability to track eligible recipients with abnormal results
- Immunizations - enables Care Coordinators the ability to track eligible recipients with inadequate or delayed immunizations

Measurement Criteria

- ADPH will provide a monthly Summary Report by county.
- EPSDT screenings, immunizations, dental screenings, follow up on elevated blood lead levels, referred visits, kept appointments will increase after the first two years of implementation.

Participation

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Procedure code G9008, type of service 1 with modifier "EP" (e.g., G9008-EP) will be utilized for billing purposes. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "General", then select "About". A list of EPSDT Care Coordinators by county and telephone numbers is available to support physician office personnel.

101.2.3 Family Planning

County health departments providing family planning services should refer to Appendix C, Family Planning, for specific benefits, limitations, covered services and family planning diagnosis codes.

101.2.4 Prenatal

Prenatal services listed below are the services provided to a pregnant woman not participating in a maternity care program during the period of gestation, including obstetrical, psycho-social, nutrition, health education, and related coordination directed toward protecting and ensuring the health of the woman and the fetus. For recipients enrolled in the maternity care program, refer to Chapter 24, Maternity Care Program.

Medicaid provides prenatal services to persons who are eligible for Medicaid benefits and are deemed pregnant through laboratory tests or physical examination, without regard to marital status.

Prenatal services provided by county health departments must conform to the Program Guidelines for prenatal services under the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act), Migrant Health Centers, or Community Health Centers.

County health departments providing prenatal services should contact the Medicaid Customer Service Unit at (334) 242-5524 for information on billing the following procedure codes:

Procedure	***Description***
99212-HD	Prenatal Clinic Visit – Includes diagnosis of pregnancy, comprehensive history, complete physical examination, preparation of medical record, risk assessment, diabetic and genetic screening, referral services, counseling services, collection of specimens for lab tests, hemoglobin or hematocrit and chemical urinalysis. Also includes reevaluation of the pregnancy during the prenatal period.
59430	Postpartum Clinic Visit – An in-depth evaluation of a patient in a stage of recovery from childbirth, requiring the development of or complete reevaluation of medical data, including history of labor and delivery, complications and/or pregnancy outcome, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures. Patient education to include formal conference with the patient to review findings and contraceptive services.

101.2.5 Preventive Health

Refer to Chapter 30, Preventive Health Education, for specifics regarding benefits and limitations. Services are **limited** to the billing of the following two procedure codes:

Procedure Code	*Description*
S9445	Prenatal Education – Limited to pregnant female recipients. Limited to diagnosis codes V220 and V222.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509.

101.2.6 Environmental Lead Investigators

A qualified investigator must have graduated from a four-year college or university with a minimum of 30 semester hours or 45 quarter hours of continued coursework in biology, chemistry, environmental science, mathematics, physical science, or a minimum of at least five years of permanent employment in an environmental health field. Any person employed must have successfully completed the training program for environmentalists conducted by the Alabama Department of Public Health before being certified by the Alabama Department of Public Health.

Environmental Lead Investigations are billable as a unit of service. A unit of service is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Testing of substances that must be sent off-site for analysis, or any non-medical activities such as removal or abatement of lead sources, or relocation efforts, are not billable as part of an Environmental Lead Investigation.

Please refer to Appendix A, EPSDT, for further information regarding lead levels and children.

101.2.7 Adult Immunizations

County health departments that provide immunizations to Medicaid-eligible recipients who are 19 years old and older must submit a claim for the appropriate HCPCS code. Vaccines are reimbursable on a fee-for-service basis. The administration fee is included in the price of the vaccine. Do not bill a separate procedure code for administration of the vaccine.

Refer to Appendix H, Alabama Medicaid Injectable Drug List, for procedure codes.

101.2.8 Home Health

County health departments providing home health care services should refer to Section 17.2, Benefits and Limitations, for specifics regarding home health benefits and limitations.

101.2.9 Hospice

County health departments providing hospice care services should refer to Section 18.2, Benefits and Limitations, for specifics regarding hospice benefits and limitations.

Refer to Section 18.5.3, Procedure Codes, Revenue Codes and Modifiers, for hospice procedure codes.

101.2.10 Physicians/Practitioners

Physicians and practitioners practicing within a county health department should refer to Section 28.2, Benefits and Limitations, for specifics regarding physician benefits and limitations.

Physicians have a provider number for each health department clinic/clinic type for which they provide services. Billable charges depend on the clinic, for example, Prenatal, EPSDT screening clinic, Family Planning, etc.

101.2.11 *Vaccines for Children (VFC)*

The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under-insured. The Alabama Department of Public Health (1(800) 469-4599) administers this program.

Refer to Appendix A, EPSDT, for information about the VFC program.

101.3 Prior Authorization and Referral Requirements

County health department procedure codes generally do not require prior authorization. Any service provided outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Claims for recipients enrolled in the Patient 1st Program **require a referral** from the recipient's assigned Primary Medical Provider (PMP). Refer to Chapter 39, Patient 1st for more information on obtaining a referral through the Patient 1st Program.

101.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

101.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

101.5.1 Time Limit for Filing Claims

Medicaid requires all claims for county health departments to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

101.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

101.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional, and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

101.5.4 Place of Service Codes

The following place of service codes apply when filing claims for health department services:

POS Code	*Description*
11	Office
12	Home
34	Hospice
71	State or Local Public Health Clinic
81	Independent Laboratory

101.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

101.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Family Planning	Appendix C
Medicaid Standard Injectable Drug List	Appendix H
Outpatient Hospital/ASC Procedure List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Patient 1st	Chapter 39

102 Intermediate Care Facility for the Mentally Retarded (ICF-MR)

An Intermediate Care Facility for the Mentally Retarded (ICF-MR) is an institution that primarily provides the diagnosis, treatment or rehabilitation of the mentally retarded or persons with related conditions. ICF-MRs provide a protected residential setting, ongoing evaluations, planning, 24-hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.

The policy provisions for ICF-MR facilities can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10.

102.1 Enrollment

EDS enrolls ICF-MR facilities and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a ICF-MR facility is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for ICF-related claims.

NOTE:
All eight characters are required when filing a claim.

ICF-MR facilities are assigned a provider type of 12 (Intermediate Care Facility). The valid specialty for ICF-MR facilities is Intermediate Care Facility (W4).

Enrollment Policy for ICF-MR Facilities

To participate in the Alabama Medicaid Program, ICF-MR facilities must meet the following requirements:

- Possess certification for Medicare Title XVIII
- Submit a letter to the Long Term Care Division requesting enrollment
- Submit a budget to the Provider Audit Division for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Patient Agreement with Medicaid

The Provider Agreement presents in detail the requirements imposed on each party to the agreement.

102.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

ICF-MRs must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

102.2.1 Therapeutic Visits

Payments to ICF-MR facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid will track the use of therapeutic leave through the claims processing system.

An ICF-MR must provide written notice to the resident and a family member or legal representative of the resident specifying the Medicaid policy upon a resident taking therapeutic leave and at the time of transfer of a resident to a hospital.

An ICF-MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility.

102.2.2 Review of Medicaid Residents

The Alabama Medicaid Agency or its designated agent will perform the following types of review of services provided to Medicaid residents in nursing facilities and in ICF-MR facilities:

- Pre-admission review on all Medicaid residents to assure the necessity and appropriateness of their admission and that a physician has certified the need
- The effectiveness of discharge planning
- Quality assessment and assurance

Annual physical examinations are required for ICF-MR residents.

102.2.3 Utilization Review

The Utilization Review function in the ICF-MR facilities is the responsibility of Medicaid or its designee.

The Utilization Review function in the ICF-MR facility is a facility-based review conducted by the Department of Mental Health/Mental Retardation (DMH/MR).

DMH/MR provides Medicaid with a written Utilization Review Plan. The Utilization Review Plan must include written description of who will perform the Utilization Review. At least one team member must be knowledgeable about the treatment of this type resident (Qualified Mental Retardation Professional).

The Utilization Review team **must not** include an individual who meets any of the following criteria:

- Is directly responsible for the care of the recipient whose case is being reviewed
- Is employed by the ICF-MR

The facility staff provides necessary administrative support to the review team.

The review team reviews each resident for the necessity of continued stay. Re-certifications are conducted 60 days from the date of the initial certification; 180 days from the date of the initial certification; 12 months from the date of the initial certification; 18 months from the date of the initial certification; 24 months from the date of the initial certification; and every 12 months thereafter.

DMH/MR provides Medicaid with a semi-annual report of utilization reviews carried out in the ICF-MR facilities.

102.2.4 Resident Medical Evaluation

The admitting and attending physician must certify the necessity for admission of a resident to an intermediate care facility and make a comprehensive medical evaluation. The facility maintains this evaluation as part of the resident's permanent record.

Each Medicaid resident in an intermediate care facility must have a written medical plan of care established by his physician. The plan of care must be periodically reviewed and evaluated by the physician and other personnel involved in the individual's care.

102.2.5 Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

102.2.6 Resident Records

Medicaid or its designated agent will perform a 10% random retrospective review of Medicaid nursing facility/ICF/MR facility residents' records to determine appropriateness of admission on a monthly basis.

102.3 Prior Authorization and Referral Requirements

ICF-MR residents are exempt from the Patient 1st program. No referrals are required for billing.

102.3.1 ICF-MR Applications

The medical determination for admission or continued care in an ICF-MR is made by the facility designated Qualified Mental Retardation Professional (QMRP).

The facility must maintain the following documents for the retrospective review:

- A fully completed written application form XIX-LTC-18
- The resident's physical history
- The resident's psychological history
- The resident's interim rehabilitation plan
- A social evaluation of the resident

Before the ICF-MR may admit an individual, it must determine that his or her needs can be met. The interdisciplinary professional team must do the following:

- Conduct a comprehensive evaluation of the individual, covering physical, emotional, social and cognitive factors.
- Define the individual's need for service without regard to the availability of these services.
- Review all available and applicable programs of care, treatment, and training and record its findings.

If the ICF-MR determines that admission is not the best plan but that the individual must be admitted, it must clearly acknowledge that admission is inappropriate and actively explore alternatives for the individual. An otherwise eligible recipient or the recipient's sponsor cannot be billed when the ICF-MR fails to submit all forms in a timely manner.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

102.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by ICF-MR facilities.

102.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims for general claims filing information and instructions.

102.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ICF-MR facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

102.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

102.5.3 Covered Revenue Codes

Claims for ICF-MR facilities are limited to the following revenue codes:

Code	*Description*
101	All inclusive room & board
184	Intermediate Care Facility charge

102.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

102.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

102.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Outpatient Hospital/ASC Procedure List	Appendix I
Patient 1st	Chapter 39
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

103 Local Education Agencies (LEAs)

Changes in federal law have made it possible for state education agencies to finance health-related education services through Medicaid and private insurance companies. Medicaid works with the State Department of Education, Special Education Services (SES), and the Local Education Agencies (LEAs) throughout the state to reimburse for these services.

Background Information

In 1975, the Individuals with Disabilities Education Act, formerly the Education for All Handicapped Children Act (P.L. 94-142) was signed into law, guaranteeing every child the right to a free, appropriate public education (FAPE) and related services in the least restrictive environment possible. Section 300.301 (a) (b) of the 34 Code of Federal Regulations states the following:

- Each State may use whatever state; local, federal, and private sources of support are available in the State to meet the requirements of this part. For example, when it is necessary to place a handicapped child in a residential facility, a State could use joint agreements between agencies involved for sharing the cost of that placement.
- Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a handicapped child.

In 1986, a General Accounting Office report recommended that Medicaid law be amended to allow Medicaid to pay for related services they typically would have covered if P.L. 94-142 were not in effect (GAO HRD 86-62BR). Congress acted on this recommendation through the Medicare Catastrophic Coverage Act (P.L. 100-360), which was signed into law on July 1, 1988.

A provision of P.L. 100-360 amended Section 1903 of the Social Security Act specifying that Medicaid was not restricted from covering services furnished to a child with disability simply because the services are included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Congress further clarified that federal Medicaid matching funds are available for the cost of health services that are furnished to a child with disabilities, even though the services are included in the child's IEP or IFSP.

Regulations implementing the Individuals with Disabilities Education Act of 2004 require that school districts secure parental permission prior to billing Medicaid for services provided by the school districts. The regulation can be found at 34CFR 300.154(d).

In summary, Congress has established that while State education agencies are financially responsible for educational services, in the case of a Medicaid-eligible child, State Medicaid agencies remain responsible for the "related services" identified in a child's IEP if the services are covered under the State's Medicaid plan.

In November 1989, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) was passed requiring Medicaid to cover all medically necessary services allowed under Section 1905(a) to "correct and ameliorate defects and physical and mental illnesses and conditions discovered by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening, regardless of whether these services are included in the Medicaid State Plan." This act provides a mechanism for the local education agencies, through their professional staff, to bill Medicaid for health-related services that meet Medicaid's criteria for reimbursement.

Participation

Effective 10/1/03, the scope of services that can be billed through the LEA will be expanded. Refer to Section 103.6 for details on covered services. The LEA will need to have qualified subcontractors or employees in place to perform direct services. The LEA will bill the appropriate code identifying the procedure performed. Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

The LEA must verify that no practitioner providing service has been terminated, suspended, or barred from the Medicaid or Medicare Program. The lists of terminated, suspended and barred practitioners are available on Medicaid's website at www.medicaid.alabama.gov.

LEA Provider Numbers

Each LEA will be issued nine-digit Alabama Medicaid provider numbers that reflect the provider/service being billed. Refer to Section 103.5.1 for further information on provider numbers.

NOTE:
All nine digits are required when filing a claim.

The qualifications for direct service providers are delineated in the scope of services. It is the responsibility of the LEA to ensure that direct service providers meet these qualifications. RNs, LPNs and School nurses must practice within the scope of the Standards of Nursing Practice as defined in Rule 610-X-6. Other practitioners must meet their own licensing requirements and practice within the scope of those licenses or credentials.

103.1 Records and Samples

Providers of service are required to keep the following records and, upon request, furnish these records to authorized State representatives of the Alabama Medicaid Agency, the Department of Health and Human Services, the State Examiners of Public Accounts, the State Attorney General, the Comptroller General, the General Accounting Office, and the State Department of Education:

- A copy of the original and all updates of the Individualized Education Program (IEP), including parental signature. The IEP should be updated yearly.
- Description of specific professional services and activities provided with the date, the duration of services and activities rendered, and the name and title of the professional providing services and activities
- Dated updates/progress notes describing the student's progress, or lack thereof, signed or initialed by the professional providing services and activities
- The School's Official Attendance Record
- Discharge notes from services completed/treatment summary

All records shall be completed promptly, filed, and retained for a minimum of five years from the date of services or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever is longer.

NOTE:

Failure to furnish records upon request may result in recoupment of funds paid.

103.1.1 Progress Notes

Medicaid highly recommends that therapists follow the SOAP method for recording appropriate documentation. The letters SOAP outline the four parts of documentation:

Subjective comment
Objective or goal
Assessment
Plan: Continue, Add, or Delete

An example of a progress note developed using the SOAP method would be:

Date	*Student progressing in all areas. Auditory discrimination tasks are improving (50 to 70%). Single word level production for new goals continues to be difficult. Continue present plan.* *Signature of Therapist*

After the initial date of treatment, it is recommended that the therapist also SOAP all additional visits.

Date	*Showed marked improvement aud-dis (l) and blends; otherwise about the same. Encouraged to continue notebook. Continue present plan.* *Signature of Therapist*

NOTE:

Progress notes must be written after each service. Each progress note must be dated and signed or initialed. Electronic signatures on electronic medical records are acceptable.

103.1.2 Recipient Signature Requirement

Medicaid recognizes that the parents do not take their children to school each day; therefore, it would be impossible to obtain a parental signature for each date of service. To meet Medicaid's recipient signature requirement, the LEA must have the following:

- An IEP signed by the parent or responsible guardian that indicates the services the student will receive (for example, speech therapy three times a week for nine months)
- An attendance record that reflects the student was in attendance for the date of service

103.2 Prior Authorization and Referral Requirements

Services provided through an LEA do not require EPSDT, prior authorization or Patient 1st referral.

103.3 Cost Sharing (Copayment)

Copayment does not apply to services provided through LEA providers.

103.4 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE: When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

103.4.1 Performing and Billing Provider Numbers

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BILLING: In block 33 of the CMS-1500 claim form, enter the billing provider number and the billing provider's name.

PERFORMING: In block 24K of the CMS-1500 claim form, enter the individual provider number of the LEA as assigned by Medicaid. Performing provider numbers will be assigned as follows:

- The first digit of the provider number will be zero.
- The second and third digits indicate the kind of provider:

  52 = Speech Pathologist

  64 = Audiologist

  65 = Physical Therapist

  68 = Occupational Therapist

  89 = Rehab

  22 = Vision

- The fourth, fifth and sixth digits indicate the LEA's system number as assigned by the Department of Education.
- The seventh, eighth and ninth digits are zeros.

103.4.2 Place of Service

Claims should be filed with Place of Service (POS) Code 11 – office.

103.4.3 Time Limit for Filing Claims

Medicaid requires all claims for local education agencies to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

103.4.4 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610. The diagnosis code must come from the direct provider of service unless a diagnosis code is listed.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

103.4.5 Required Claim Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

103.5 Covered Services

Covered services are face-to-face health related services provided to a student, group of students, or parent/guardian on behalf of the student. Covered services are listed in the Alabama State Plan of Medical Assistance and are medically necessary for the development of the IEP or fully documented in the IEP. An IEP must be completed in order for services to be billed. Covered services are:

- Intake/Evaluation
- Audiology Services
- Developmental Diagnostic Assessments
- Vision Screening
- Hearing Screening
- Occupational Therapy
- Physical Therapy
- Behavioral Health Services
- Health Aide Services
- Speech/Language Services

The CPT manual lists most required procedure codes. Certain CPT codes must be billed with the SE modifier as indicated. The services in this section may be covered by Medicaid when provided by an authorized provider according to an IEP. **Annual limitations are based on calendar year.**

The following paragraphs provide a detailed list of covered services, grouped by service.

103.5.1 Intake/Evaluation

Service Description: The intake evaluation presents psychological, social functioning and medical needs for development of an initial treatment plan for subsequent treatment and/or evaluation. The intake evaluation considers: family history, educational history, medical background, and a description of the significant problems of the child. Services must be specified in the treatment plan (IEP).

Professional Qualifications: Multidisciplinary team as identified by the needs of the child that may include the following professionals as licensed under Alabama law: psychologist, professional counselor, certified social worker, marriage and family therapist, or registered nurse.

Procedure Code:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
90801 SE	Intake/evaluation, utilize dx code V62.9	1	1

103.5.2 Audiology Services

Service Description: Audiology services necessary for the development or the student's IEP or documented in the IEP included, but are not limited to evaluations, tests, tasks and interviews to identify hearing loss in a student whose auditory sensitivity and acuity are so deficient as to interfere with normal functioning.

Professional Qualifications: Must meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
92551 SE	Screening test, pure tone, air only	1	12
92552 SE	Pure tone audiometry (threshold); air only	1	12
92553 SE	Pure tone audiometry (threshold); air and bone	1	12
92555 SE	Speech audiometry threshold	1	12
92556 SE	Speech audiometry threshold with speech recognition	1	12
92567 SE	Tympanometry (impedance testing)	1	12
92592 SE	Hearing aid check; monaural	1	12
92593 SE	Hearing aid check; binaural	1	12

103.5.3 Developmental Diagnostic Assessments

Service Description: Administration of a standardized objective and/or projective tests of an intellectual, personality or related nature in a face-to-face interaction between the client and the professional and interpretation of the test results to determine medical/mental needs.

Professional Qualifications: Testing may be performed by the following professionals who are licensed under Alabama law: psychologist, professional counselor, certified social worker, or registered nurse with a master's degree in psychiatric nursing.

AND

Have documentation of training at the pre-service or in-service level on administering developmental assessments and meet any additional requirements of the specific test publishers.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
96101 SE	Developmental Diagnostic – administered by a physician or psychologist, first hour; face-to-face	1	12
96102 SE	Developmental Diagnostic – administered by a technician, first hour; face-to-face	1	12
96103 SE	Developmental Diagnostic – administered by a computer	1	12

103.5.4 Vision Assessments

Service Description: Vision assessments may be performed on students 3 through 20 years of age once a year unless additional screenings are medically necessary.

Professional Qualifications: A person who has been trained on the device by observing a trained employee on a minimum of three patients, verbalization of understanding the procedure and successful completion of the procedure on at least three patients.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
99173 SE	Vision Screen, utilize diagnosis code V72.0	1	1

103.5.5 Hearing Assessment

Service Description: Hearing assessments may be performed beginning at 3 years of age. After the initial screening, all children may be assessed once a year unless additional screenings are medically necessary.

Professional Qualifications: A person that has been trained on the device by observing a trained employee on a minimum of three patients, verbalization of understanding the procedure and successful completion of the procedure on at least three patients.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
92551 SE	Hearing Screen, utilize diagnosis code V72.1	1	1
92567 SE	Tympanometry (impedance testing) *, utilize diagnosis code V72.1 *must be provided under the direction of an audiologist	1	12

103.5.6 Occupational Therapy

Service Description: Occupational Therapy services, necessary for the development of the students IEP or documented in the IEP include, but are not limited to:

1. Evaluation of problems which interfere with the student's functional performance

2. Implementation of a therapy program or purposeful activities which are rehabilitative, active or restorative as prescribed by a licensed physician,

These activities are designed to:

A. improve, develop or restore functions impaired or lost through illness, injury or deprivation,

B. improve ability to perform tasks for independent functioning when functioning is impaired or lost,

C. prevent, through early intervention, initial or further impairment or loss of function,

D. correct or compensate for a medical problem interfering with age appropriate functional performance.

Professional Qualifications: Must be licensed by the Alabama State Board of Occupational Therapy. Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the OT making the visit.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Medicaid **does not** cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Use the following procedure codes for services prescribed by a physician and provided by a qualified occupational therapist:

Procedure Code/ Modifier	***Description***	***Daily Limits***	***Annual Limit***
97003 SE	Occupational therapy evaluation	1	1
97004 SE	Occupational therapy re-evaluation	1	1
97110 SE	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*	4	96

*If additional services are needed, provider of service must use modifier 22. Medicaid monitors the use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which therapy is ordered.

103.5.7 Physical Therapy

Service Description: Physical Therapy services, necessary for the development of the student's IEP or documented in the IEP include, but are not limited to:

1. Evaluations and diagnostic services
2. Therapy services which are rehabilitative, active, restorative. These services are designed to correct or compensate for a medical problem and are directed toward the prevention or minimization of a disability, and may include:
    a. developing, improving or restoring motor function
    b. controlling postural deviations
    c. providing gait training and using assistive devices for physical mobility and dexterity
    d. maintaining maximal performance within a student's capabilities through the use of therapeutic exercises and procedures.

Professional Qualifications: Must be licensed by the Alabama Board of Physical Therapy. Physical therapy assistants may provide services only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy. Supervision of licensed PT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the PT.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Use the following procedure codes for services prescribed by a physician and provided by a qualified physical therapist. Physical therapy is not covered for groups. Physical therapy services may not be span billed.

Procedure Code/Modifier	***Description***	***Daily Limits***	***Annual Limit***
97001 SE	Physical therapy evaluation	1	1
97002 SE	Physical therapy re-evaluation	1	1
97110 SE	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*	4	96

*If additional services are needed, provider of service must use modifier 22. Medicaid monitors the use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which therapy is ordered.

103.5.8 Behavioral Health Counseling

Service Description: Behavioral health services based on a treatment plan with focused intervention and specific goals designed to maximize strengths and reduce behavioral problems or functional deficits.

These services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications:

A psychologist licensed under Alabama law OR a professional counselor licensed under Alabama law OR a certified social worker licensed under Alabama law OR a registered nurse who has completed a master's degree in psychiatric nursing OR school psychologist certified by the Alabama State Department of Education.

Procedure Codes:

CPT Code/ Modifier	*Description*	*Daily Max*	*Annual Max*
H0025 SE	Behavioral health counseling, billed in 15 minute increments, utilize dx code V62.9	4	1200

103.5.9 Health Aide Services

Service Description: Services provided to an individual to enable a student to independently function within the school setting with emphasis on training and assistance. Examples of these services include: transferring and ambulating, and assistance with food, nutrition and diet activities.

Professional Qualifications: School Health Aide services are provided by staff that have been trained and remain under the direction of skilled professional medical personnel. Aides shall possess a high school diploma or equivalent, completed a course and obtained certification as a nursing assistant and shall posses a current card in first aid and CPR.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
T1004 SE	School Health Aide, Billed in 15 minute increments, utilize diagnosis code V65.49	32	9600

103.5.10 Speech/Language Services

Service Description: Speech/language therapy services necessary for the development of the student's IEP or documented in the student's IEP include, but are not limited to:

1. Diagnostic services
2. Screening and assessment
3. Preventive services
4. Corrective services

Speech therapy services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications: Must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology. Speech Therapy Assistants must have a bachelor's degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Use the following procedure codes for services provided by a qualified speech pathologist for individuals with speech disorders. Speech therapy services may not be span-billed.

Procedure Code/ Modifier	***Description***	***Daily Limits***	***Annual Limits***
92506 SE	Evaluation of speech, language, voice, communication, and/or auditory processing	1	4
92507 SE	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	1	300
92508 SE	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group 2 or more individuals	1	300

103.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

104 Psychiatric Hospital (Recipients 65 & Over)

For purposes of this chapter, an inpatient is a person, age 65 or over, who has been admitted to a free-standing psychiatric facility specializing in the diagnosis, treatment, and care of geriatric patients, for the purpose of maintaining or restoring them to the greatest possible degree of health and independent functioning.

The policy provisions for psychiatric hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 5.

104.1 Enrollment

EDS enrolls psychiatric hospital providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a psychiatric hospital is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for psychiatric hospital-related claims.

NOTE:
All eight characters are required when filing a claim.

Psychiatric hospitals are assigned a provider type of 05 (Hospital). The valid specialty for psychiatric hospitals is Inpatient Psychiatric Hospital Over 65 (W2).

Enrollment Policy for Psychiatric Hospital Providers

To participate in the Alabama Medicaid Program, psychiatric hospital providers must meet the following requirements:

- Receive certification for participation in the Medicaid/Medicare program
- Possess a license as a free-standing acute geriatric psychiatric hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification,* Chapter 420-5-7. State hospitals that do not require licensing as per state law are exempt from this provision.
- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Specialize in the care and treatment of geriatric patients with serious mental illness
- Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician
- Employ only staff who meet training certification standards in the area of geriatric psychiatry as defined by the State's mental health authority
- Be recognized as a teaching hospital affiliated with at least one four-year institution of higher education that employs a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illness
- Provide outpatient and community liaison services throughout the state of Alabama directly or through contract with qualified providers
- Submit a written description of an acceptable utilization review plan currently in effect
- Submit a budget of cost for its inpatient services for its initial cost reporting period, if a new provider
- Exist under the jurisdiction of the State's mental health authority

After enrollment, psychiatric hospitals are required to submit a monthly inpatient census report using the PSY-4 form.

It is the facility's responsibility to ensure compliance with all federal and state regulations and to ensure that all required documentation is included in the recipient's record. Failure to comply will result in denial of payment and possible recoupment of reimbursements made previously.

104.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

The number of days of care charged to a recipient of inpatient psychiatric service is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used in reporting days of care for the recipient, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid reimbursement is available for the day of admission, but not the day of discharge.

Inpatient psychiatric services for recipients age 65 or over, are covered services when provided under the following circumstances:

- Psychiatric services are provided in a free-standing psychiatric hospital exclusively for the treatment of persons age 65 or over with serious mental illness.
- Psychiatric services are provided under the direction of a geriatric psychiatrist.
- The psychiatric facility providing services is enrolled as a Medicaid provider.
- The recipient is admitted to the psychiatric facility during the entire hospitalization.
- The recipient is age 65 years or older.

Inpatient psychiatric services for recipients age 65 and over are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care in an acute care hospital.

Therapeutic visits away from the psychiatric facility to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient.

- Therapeutic visits may be authorized up to 14 days per admission if certified by the attending physician as medically necessary in the treatment of the recipient. No part of the time spent on any therapeutic leave may be billed to Medicaid.
- Return to inpatient status from therapeutic visits exceeding 14 days per admission will be considered a readmission with the required certification of need for treatment documented in the patient's record.
- Therapeutic visit records will be reviewed retrospectively by the Quality Assurance Division at Medicaid. Providers who have received payments for therapeutic visits will have funds recouped.

Certification of Need for Service

Certification of need for services is a determination that is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility.

The physician must certify for each applicant or recipient that inpatient services in a mental hospital are needed.

The certification must be made at the time of admission. No retroactive certifications will be accepted.

For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment.

The physician must complete the PSY-5 form, which is the certification of need for care. This form must be kept in the patient's record.

The PSY-6 form, which is the recertification of need for continued inpatient services, or acceptable equivalent approved by Medicaid, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician. The PSY-6 form or equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record.

The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status.

Medical, Psychiatric, and Social Evaluation

Before admission to a psychiatric facility or before authorization for payment, the attending physician, psychiatrist, or staff physician must make a medical evaluation of each individual's need for care in the facility. Appropriate professional personnel must make a psychiatric and social evaluation.

Each medical evaluation must include:

- Diagnosis
- Summary of present medical findings
- Medical history
- Mental and physical functional capacity
- Prognosis
- A recommendation by the physician concerning admission to the psychiatric facility or continued care in the psychiatric facility, for individuals who apply for Medicaid while in the facility

Plan of Care

The attending physician or staff physician must establish a written plan of care for each individual before admission to a mental hospital and before authorization of payment.

The plan of care must include the following:

- Diagnosis, symptoms or complaints indicating a need for admission to inpatient care
- Description of the functional level of the patient
- Treatment objectives
- Orders for medications, treatments, therapies, activities, restorative/rehabilitative services, diet, social services, and special procedures needed for health and safety of the patient
- Continuing care plans that include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family and community service providers upon discharge

The attending or staff physician and other appropriate staff involved in the care of the recipient must review the plan of care at least every 90 days or when significant changes occur in patient functioning or acuity.

The plan of care is evaluated to ensure that the recipient receives treatment that maintains or will restore the patient to the greatest possible level of health and independent functioning.

A written report of the evaluations and the plan of care must be in the individual's record at the time of admission or immediately upon completion of the report if the individual is already in the facility.

Utilization Review (UR) Plan

As a condition of participation in the Alabama Medicaid program, each psychiatric facility must do the following:

- Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to the recipient.
- Maintain recipient information required for UR, which includes the certification of need for service and the plan of care.
- Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval.

Payment

Payment for inpatient services provided by psychiatric facilitates for individuals age 65 and older shall be the per diem rate established by Medicaid for the hospital. The per diem rate is based on the Medicaid cost report and all the requirements expressed in the *Alabama Medicaid Administrative Code,* Chapter 23*.* Ancillary charges (lab, x-ray, etc.) may not be billed in addition to the facility per diem rate.

Patient liabilities, if applicable, are deducted from the per diem. The hospital is responsible for collecting the liability amount from the patient and/or the patient's sponsor.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive two copies of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

NOTE:

If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100 per day for each calendar day after the due date.

104.3 Prior Authorization and Referral Requirements

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Claims for recipients enrolled in the Patient 1st Program **do not require a referral** from the recipient's assigned Primary Medical Provider (PMP).

Authorization for Admission

All admissions to psychiatric hospitals for recipients age 65 or older must be approved by Medicaid prior to payment authorization using the Alabama Prior Review and Authorization Request Form.

Medical records or other documentation may be requested when the medical necessity of the admission cannot be determined from the application form. Providers will receive notification when admissions are not found to be medically necessary.

Applications must be submitted within eight working days after admission. Applications that are not received within eight working days will be approved beginning the day the application is received, provided the criteria for admission are met.

Information required for admission review includes, but is not limited to the following:

- Recipient information that includes:
  - Admitting diagnosis
  - Events leading to hospitalization
  - History of psychiatric treatment
  - Current medications
  - Physician orders
  - Presenting signs and symptoms
- Verification that Certification of Need Form (PSY-5) has been completed
- Verification that medical, social, and psychiatric evaluations have been completed
- Verification that initial treatment plan (Plan of Care) is present on recipient's chart

Medicaid uses the Psychiatric Criteria for Age 65 or Over to approve or deny the admission.

- If the admission is approved, the facility receives approval to bill for the stay and assigns date for the initial continued stay review (CSR).
- If the admission cannot be approved based on the information received, additional information will be requested.
- If Medicaid determines that the admission is not medically necessary, the facility will be notified within two working days after a determination has been made.

Continued Stay Reviews

The hospital's utilization review personnel are responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

The initial continued stay review should be performed on the date assigned by Medicaid. Later reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay.

Each continued stay review date assigned should be recorded in the patient's record.

If the facility's utilization review personnel determine that the patient does not meet the criteria for continued stay, the case should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed.

If a final decision of denial is made, the hospital notifies the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within 10 days after the denial is made.

The facility's utilization review personnel are responsible for notifying Medicaid whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status.

104.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, or family planning.

The provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost-sharing (copayment) amount imposed.

NOTE:

Copayment is not a third party resource. Do not record copayment on the UB-92.

104.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Psychiatric hospital providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-92 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

104.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

104.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

104.5.3 Revenue Codes

Refer to the Alabama UB-92 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

104.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

104.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

104.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 Claim Filing Instructions	Section 5.3
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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105 Rehabilitative Services - DHR, DYS, DMH, DCA

Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness, substance abuse, or co-occurring mental illness and substance abuse diagnoses. These services are provided to recipients on the basis of medical necessity.

Direct services may be provided in the client's home, a supervised living situation, or organized community settings, such as community mental health centers, public health clinics, nursing homes, etc. Direct services can be provided in any setting, except in licensed hospital beds, that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

The policy provisions for rehabilitative services providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 47.

105.1 Enrollment

EDS enrolls rehabilitative services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, and the *Alabama Medicaid Agency Administrative Code*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a rehabilitative services provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursements for rehabilitation-related claims.

NOTE:

All nine digits are required when filing a claim.

Rehabilitative services providers are assigned a provider type of 89 (State Rehabilitative Services). The valid specialties for State Rehabilitative Services are:

- Rehabilitative Services - DMH (M2)
- Rehabilitative Services – DHR, DYS, DCA (M8)
- Psychiatry (Psychiatrist only) (26)

Enrollment Policy for Rehabilitative Services Providers

To participate in the Alabama Medicaid Program, rehabilitative services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1), (2), OR (3) and both (4) AND (5) below.

1. A provider must be certified as a community mental health center by DMH/MR and must have demonstrated the capacity to provide access to the following services through direct provision or referral arrangements:

   — Inpatient services through referral to community hospitals and through the attending physician for community hospitalizations

   — Substance abuse services including intensive outpatient services and residential services

2. For the provision of Substance Abuse Rehabilitative Services an entity:

   - Must be an organization that is currently certified by the Alabama Department of Mental Health and Mental Retardation (DMH/MR) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and
   - Must submit an application to and receive approval by DMH/MR to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.

3. The Department of Human Resources (DHR), the Department of Youth Services (DYS), and the Department of Children's Services (DCA) are eligible to be rehabilitative services providers for children under age 21 if they have demonstrated the capacity to provide an array of medically necessary services, either directly or through contract.

   Additionally, DHR may provide these services to adults in protective service status. At a minimum, this array includes the following:

   - Individual, group, and family counseling

   — Crisis intervention services

   — Consultation and education services

   — Case management services

   — Assessment and evaluation

4. A provider must demonstrate the capacity to provide services off-site in a manner that assures the client's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.

5. A provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Medicaid does not cover all services listed above, but the provider must have demonstrated the capacity to provide these services.

105.1.1 Minimum Qualifications for Rehabilitative Services Mental Illness Professional Staff

Rehabilitative Services Mental Illness Professional Staff qualifications are as follows:

- A physician licensed under Alabama law to practice medicine or osteopathy
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A certified social worker licensed under Alabama law
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as a part of the requirements for the degree
  - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience as described in DMH/MR standards
- Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions
- A pharmacist licensed under Alabama law may provide medication monitoring

105.1.2 Minimum Qualifications for Rehabilitative Services Substance Abuse Professional Staff

Rehabilitative Services Substance Abuse Professional Staff qualifications are as follows:

- Clinical screening and assessments of a substance abuse client must be performed by a person with at least two years of substance abuse treatment experience who meets any one or more of the following qualifications:
  - Licensed as a physician, psychologist, certified social worker, or counselor
  - Possesses a master's degree in a clinical area

- Treatment planning and counseling of substance abuse clients must be performed by any one or more of the following qualified professionals:
  - A person with a master's degree in a clinical area with a clinical practicum
  - A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting
  - A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience
  - A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary process for certification. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

— Services must be provided by practitioners consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law

— Services rendered to persons with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above, unless an exception is specifically noted and defined in the service descriptions

105.1.3 Minimum Qualifications for DHR/DYS/DCA Child & Adolescent Services, DHR Adult Protective Services Professional Staff

DHR/ DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional Staff qualifications are as follows:

— A physician licensed under Alabama law to practice medicine or osteopathy

— A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners

— A psychologist licensed under Alabama law

— A professional counselor licensed under Alabama law

— A marriage and family therapist licensed under Alabama law

— A social worker licensed under Alabama law

— A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses

— A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing

— An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:

  - Has successfully completed a practicum as a part of the requirements for the degree

  - Has six months of post master's level professional experience supervised by a master's level or above clinician with two years of post graduate professional experience

- Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions
- A pharmacist licensed under Alabama law may provide medication monitoring

105.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Treatment eligibility is limited to individuals with a diagnosis within the range of 290-316, assigned by a licensed physician or psychologist, of mental illness or substance abuse as listed in the most current International Classification of Diseases - Clinical Modification (ICD-CM). Medicaid does not cover the V codes for adult treatment services; however, it does cover intake evaluation and diagnostic assessment even if the resulting diagnosis is a V code. For treatment services provided to children under 21, or those adults receiving DHR protective services, the only V code Medicaid covers for reimbursement is unspecified psychosocial circumstance.

105.2.1 Covered Services

While Medicaid recognizes that family involvement in the treatment of individuals in need of rehabilitative services is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the client’s treatment needs. Medicaid does not cover services for non-Medicaid eligible family members independent of meeting the client’s treatment needs.

Only the following rehabilitative services qualify for reimbursement under this program:

- Intake Evaluation
- Physician/Medical Assessment and Treatment
- Diagnostic Testing
- Crisis Intervention
- Individual Counseling
- Family Counseling
- Group Counseling
- Medication Administration
- Medication Monitoring
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Rehabilitative Day Program
- Mental Illness Child and Adolescent Day Treatment
- Treatment Plan Review

- Mental Health Consultation
- Adult Substance Abuse Intensive Outpatient Services
- Child and Adolescent Substance Abuse Intensive Outpatient Services
- In-home Intervention
- Pre-hospitalization Screening
- Basic Living Skills
- Family Support
- Assertive Community Treatment (ACT)
- Program for Assertive Community Treatment (PACT)
- Methadone Treatment

This section contains a complete description of each covered service along with benefit limitations.

Services must be provided in a manner that meets the supervisory requirements of the respective certifying authority or as authorized by state law.

Intake Evaluation (90801-HE 90801-HF)

HE = Mental Illness HF = Substance Abuse

Definition

Initial clinical evaluation of the client's request for assistance. Substance abuse clients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, client's reported physical and medical condition, the need for additional evaluation and/or treatment, and the client's fitness for rehabilitative services.

Key service functions include the following:

- A clinical interview with the client and/or family members, legal guardian, or significant other
- Screening for needed medical, psychiatric, or neurological assessment, as well as other specialized evaluations
- A brief mental status evaluation
- Review of the client's presenting problem, symptoms, functional deficits, and history
- Initial diagnostic formulation
- Development of an initial treatment plan for subsequent treatment and/or evaluation
- Referral to other medical, professional, or community services as indicated

Eligible Staff - Mental Illness Services

Clinical evaluation and assessments of a mental illness client may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work, who meets at least one of the following qualifications:
    - Has successfully completed a practicum as a part of the requirements for the degree
    - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience as described in DMH/MR standards

Eligible Staff - Substance Abuse Services

Clinical evaluation and assessments of a substance abuse client may be performed by a person with at least two years of substance abuse treatment experience who possesses any one or more of the following qualifications:

- Licensed as a psychologist, social worker, or professional counselor
- Has a master's degree in a clinical area that included a clinical practicum

Eligible Staff - DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Clinical evaluation and assessments of a child and adolescent services/adult protective services client may be performed by a person who possesses any one or more of the following qualifications:

- A physician licensed under Alabama law to practice medicine or osteopathy
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work, and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as part of the requirements for the degree
  - Has six months of post master's level professional experience supervised by a master's level or above clinician with two years of postgraduate professional experience
- An individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above.

Added: Child and Adolescent In-Home Intervention (H2022-HA),

Billing Unit:	Episode
Maximum Units:	One per year
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (H0032), Child and Adolescent In-Home Intervention (H2022-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment and that protects the client's rights to privacy and confidentiality.

Additional Information

An intake evaluation must be performed for each client considered for initial entry into a treatment program. This requirement applies to any organized program or course of covered services that a client enters or attends to receive scheduled or planned rehabilitative services. Individuals who are transferred between programs within an agency do not require a new intake at the time of transfer.

The intake evaluation process determines the client's need for rehabilitative services based upon an assessment that must include relevant information from the following areas:

- Family history
- Educational history
- Relevant medical background
- Employment/Vocational history
- Psychological/psychiatric treatment history
- Military service history
- Legal history
- Alcohol/Drug use history
- Mental status examination
- A description/summary of the significant problems that the client experiences

The intake evaluation process also results in the development of a written treatment plan (service plan, individualized family service plan, plan of care, etc.) completed by the fifth client visit or within ten working days after admission into a day treatment or residential program. The treatment plan will do the following:

- Identify the clinical issues that will be the focus of treatment.
- Specify those services necessary to meet the client's needs.
- Include referrals as appropriate for needed services not provided directly by the agency.
- Identify expected processes/outcomes toward which the client and therapist will be working to impact upon the specific clinical issues.
- Be approved in writing by a licensed psychologist, certified social worker, professional counselor, a marriage and family therapist, a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses, a registered nurse licensed under Alabama law with master's degree in psychiatric nursing, a physician licensed under Alabama law, or a physician assistant licensed under

Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners.

— Service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, crisis intervention and resolution, mental health consultation, pre-hospitalization screening, and treatment plan review. Changes in the treatment plan must be approved by a person licensed under Alabama law to practice psychology, certified social work, professional counseling, marriage and family therapy, or medicine; or a registered nurse licensed under Alabama law with master's degree in psychiatric nursing. For child and adolescent services or adults receiving DHR protective services, the person who approves the treatment plan must meet the criteria in Requirements for Client Intake, Treatment Planning, and Service Documentation section.

Physician Medical Assessment and Treatment (90862-HE 90862-HF)

Definition

Contact between a client, another service agency provider, or independent practitioner and a licensed physician, physician assistant, or certified nurse practitioner occurring in an individual, group, or family setting for the purpose of medical/psychiatric development of a medication regimen, the provision of therapeutic services, or the provision of case consultation.

Key service functions include the following:

— Specialized medical/psychiatric assessment of physiological phenomena

— Psychiatric diagnostic evaluation

— Medical/psychiatric therapeutic services

— Assessment of the appropriateness of initiating or continuing the use of psychotropic or detoxification medication

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Physician medical assessment and treatment may be performed by a physician licensed under Alabama law to practice medicine or osteopathy, a physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners, or a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses.

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year

Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Substance Abuse Intensive Outpatient Services (H0015), Child and Adolescent Substance Abuse Intensive Outpatient Services (H0015-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

All services rendered by a physician or nurse practitioner that meet the definition above should be billed under this code including those rendered via teleconference with a direct service or consultation recipient.

Diagnostic Testing done by psychologist (96101-HE 96101-HF)

Definition

Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the psychologist or psychiatrist and interpretation of the test results.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure code 96101 -Diagnostic testing may only be performed by:

- A psychiatrist licensed under Alabama law

OR

— A psychologist licensed under Alabama law

Billing Unit:	One hour
Maximum Units:	5 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Diagnostic Testing done by technician (96102-HE 96102-HF)

Definition

Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the technician and interpreted by a qualified health care professional.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure code 96102 -Diagnostic testing may be performed by: a person who possesses any one or more of the following qualifications:

- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
    - Has successfully completed a practicum as a part of the requirements for the degree

Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience.

Billing Unit:	One hour
Maximum Units:	5 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Diagnostic Testing administered by a computer (96103-HE 96103-HF)

Definition

Administration of standardized objective and/or projective tests (eg, MMPI) of an intellectual, personality, or related nature by a computer and interpreted by a qualified health care professional.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Diagnostic testing-procedure code 96103 must be administered by a computer and interpreted by a qualified health care professional.

Billing Unit:	One
Maximum Units:	1 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Crisis Intervention (H2011)

Definition

Immediate emergency intervention by a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse with the client, family, legal guardian, and/or significant others to ameliorate a client's maladaptive emotional/behavioral reaction. Service is designed to resolve the crisis and develop symptomatic relief, increase knowledge of where to turn for help at a time of further difficulty, and facilitate return to pre-crisis routine functioning.

Key service functions include the following:

- Specifying factors that led to the client's crisis state, when known
- Identifying the maladaptive reactions exhibited by the client
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the client for treatment at an alternative setting, when indicated

Eligible Staff - Mental Illness Services

Crisis intervention and resolution may be performed by a person who possesses any one or more of the following qualifications:

- A physician licensed under Alabama law to practice medicine or osteopathy or a certified registered nurse practitioner (CRNP) practicing within the scope approved by the Alabama Board of Nursing
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
    - Has successfully completed a practicum as a part of the requirements for the degree
    - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience
- An individual who has completed an approved case management training course

Eligible Staff - DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager, or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager,or above.

Billing Unit:	15 minutes
Maximum Units:	12 per day, 4380 per calendar year
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT(H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

If the client is unable to sign a receipt for service or if the service is rendered by phone, the documentation in the client's record should so indicate. The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Individual Counseling - (90804-HE 90804-HF)

Definition

A treatment plan focused intervention between a client and a rehabilitative services or child and adolescent services/adult protective services professional. Treatment is designed to maximize strengths and to reduce behavioral problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational and/or community adjustment.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the client's treatment plan
- On-going assessment of the client's presenting condition and progress made in treatment

Eligible Staff - Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Individual counseling may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
    - Has successfully completed a practicum as a part of the requirements for the degree
    - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience

Eligible Staff - Substance Abuse Services

- Clinical screening and assessment of a substance abuse client must be performed by a person with at least two years of substance abuse treatment experience who meets any one or more of the following qualifications:

Licensed as a physician, psychologist, certified social worker, or counselor;

Possesses a master's degree in a clinical area.

- Treatment planning and counseling of substance abuse clients must be performed by any one or more of the following qualified professionals:

A person with a master's degree in a clinical area with a clinical practicum;

A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting;

A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience;

A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary process for certification. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

- Services must be provided by practitioners consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law.
- Services rendered to clients with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above, unless an exception is specifically noted and defined in the service descriptions.

Billing Unit:	30 minutes
Maximum Unit:	3 per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Family Counseling 90846-HE 90846-HF (without patient present)
90847-HE 90847-HF (with patient present)
90849-HE 90849-HF (multiple family group)

Definition

A treatment plan focused intervention involving a client, his or her family unit, and/or significant others, and a rehabilitative services, substance abuse, or child and adolescent services/adult protective services professional. Treatment is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational, and/or community adjustment.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the client's treatment plan
- On-going assessment of the client's presenting condition and progress being made in treatment

Eligible Staff - Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Family counseling may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as a part of the requirements for the degree
  - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience

Eligible Staff - Substance Abuse Services (Methadone clients only)

Services may be provided by a person with at least one year of substance abuse treatment experience who meets any one or more of the following qualifications:

- A person licensed as a psychologist, certified social worker, or professional counselor
- A person with a master's degree in a clinical area
- A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience

— A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary accreditation process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

Billing Unit:	30 minutes
Maximum Units:	3 per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Group Counseling (90853-HE 90853-HF)

Definition

A treatment plan focused intervention involving a group of clients, and a rehabilitative services, substance abuse, or child and adolescent services/adult protective services professional. Treatment utilizes interactions of group members to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational, and/or community adjustment.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the client's treatment plan
- On-going assessment of the client's presenting condition and progress being made in treatment

Eligible Staff - Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Group counseling may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
    - Has successfully completed a practicum as a part of the requirements for the degree
    - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience

Eligible Staff - Substance Abuse Services (Methadone clients only)

Group counseling for substance abuse services clients may be performed by a person with at least one year of substance abuse treatment experience who meets any one or more of the following qualifications:

- A person licensed as a psychologist, certified social worker, or professional counselor
- A person with a master's degree in a clinical area
- A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience

— A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience based, voluntary accreditation process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized

Billing Unit:	30 minutes
Maximum Units:	3 per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

Added: Adult

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR Protective Services.

Medication Administration 90772-HE 90772-HF (Injectable meds) H0033-HE H0033-HF (oral meds)

Definition

Administration of oral or injectable medications as directed by a physician.

Eligible Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Medication administration for child and adolescent services/adult protective services clients may be performed by a person who possesses any one or more of the following qualifications:

— A registered nurse licensed under Alabama law

— A licensed practical nurse licensed under Alabama law under the direction of a physician

Deleted: ~~all forms of Day Treatment (H2012, H2012-HA)~~

Added: Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA),

Billing Unit	Episode
Maximum Units	1 per day, 365 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

This service does not include the intravenous administration of medications, nor does it include the preparation of medication trays in a residential setting. Medicaid covers this service under substance abuse for methadone clients only. Procedure codes 90772 HE, 90772 HF, H0033 HE, or H0033 HF may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Utilization will be monitored through retrospective reviews.

Medication Monitoring (H0034)

Definition

Face-to-face contact between the client and a rehabilitative services, or child and adolescent services/adult protective services professional, pharmacist, RN, or LPN for the purpose of reviewing the overt physiological effects of psychotropic medications; monitoring compliance with dosage instructions; instructing the client and/or caregivers of expected effects of psychotropic medications; assessing the client's need to see the physician; and recommending changes in the psychotropic medication regimen.

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Medication monitoring for mental illness and child and adolescent services/adult protective services clients may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- A pharmacist licensed under Alabama law
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as a part of the requirements for the degree
  - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience

- Registered nurse licensed under Alabama law
- Licensed Practical Nurse licensed under Alabama law

Billing Unit	15 minutes
Maximum Units	2 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Deleted: ~~all forms of Day Treatment (H2012, H2012-HA)~~

Added: Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA),

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The code V unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Partial Hospitalization Program (H0035)

Definition

A physically separate and distinct organizational unit that provides intensive, structured, active, clinical treatment with the goal of acute symptom remission, immediate hospital avoidance, reduction of inpatient length of stay, or reduction of severe persistent symptoms and impairments that have not responded to treatment in a less intensive level of care.

Key service functions include the following services, which must be available with the program as indicated by individual client need:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Individual, group, and family counseling
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving; as opposed to basic living skills, such as money management, cooking, etc.)
- Activity therapy closely related to the presenting problems that necessitated admission (e.g., aerobics, maintaining a recovery diary, creative expression (art, poetry, drama) pertaining to the recovery process)
- Medication administration
- Medication monitoring
- Family education closely related to the presenting problems, such as diagnosis, symptoms, medication, coping skills, etc.
- Patient education closely related to the presenting problems, such as diagnosis, symptoms, medication, etc., rather than academic training

Eligible Staff – Mental Illness Services

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

Billing Unit:	A minimum of 4 hours
Maximum Units:	1 per day, 130 days per year
Billing Restrictions:	May not be billed in combination with Individual (90804), Family (90846, 90847, 90849), or Group Counseling (90853), Physician Medical Assessment and Treatment (90862), Medication Administration (90772 HE, 90772 HF, H0033), Medication Monitoring (H0034), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017). These restrictions apply while a client is attending/actively enrolled in Partial Hospitalization whether or not the restricted services occur on the same day as Partial Hospitalization.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment and that protects the client's rights to privacy and confidentiality.

Additional Information

H0035 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 130 units per year. Utilization will be monitored through retrospective reviews.

Adult Intensive Day Treatment (H2012)

Definition

An identifiable and distinct program that providers highly structured services designed to bridge acute treatment and less intensive services, such as Rehabilitative Day Program and Outpatient, with the goals of community living skills acquisition/enhancement, increased level of functioning, and enhanced community integration. Intensive Day Treatment shall constitute active, intermediate level treatment that specifically address the client's impairments, deficits, and clinical needs.

The following services must be available within the program as indicated by individual client need:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program
- Individual, group, and family counseling
- Activity/recreational therapy (e.g., sports, leisure activities, hobbies, crafts, music, socialization, field trips)
- Social skills training (e.g., conversation and interpersonal skills)
- Coping skills training (e.g., stress management, symptom management, problem solving)
- Utilization of community resources
- Family education closely related to the presenting problems such as diagnosis, symptoms, medication, coping skills, etc.)
- Basic living skills (e.g., Adult Basic Education, GED, shopping, cooking, housekeeping, grooming)
- Medication administration
- Medication monitoring
- Client education closely related to presenting problems, such as diagnosis, symptoms, medication, etc. rather than academic training

Eligible Staff – Mental Illness Services

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 hours per year
Billing Restrictions:	May not be billed in combination with Individual (90804), Family (90846, 90847, 90849), or Group Counseling (90853), Medication Administration (90772 HE, 90772 HF, H0033), Medication Monitoring (H0034), Partial Hospitalization Program (H0035), and Rehabilitative Day Program (H2017). These restrictions apply while a client is attending/actively enrolled in Intensive Day Treatment whether or not the restricted services occur on the same day as Intensive Day Treatment.

Deleted: ~~Partial Hospitalization~~

Added: Intensive Day Treatment

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Rehabilitative Day Program (H2017)

Definition

An identifiable and distinct program that provides long-term recovery services with the goals of improving functioning , facilitating recovery, achieving personal life goals, regaining feelings of self-worth, optimizing illness management, and helping clients to become productive participants in family and community life. The Rehabilitative Day Program constitutes active structure, rehabilitative interventions that specifically address the individual's life goals, builds on personal strengths and assets, improves functioning, increases skills, promotes a positive quality of life, and develops support networks. The Rehabilitative Day Program should provide (1) and (2) below and at least one more service from the following list of services based on the needs and preferences of clients participating in the program.

Key service functions include the following:

1. Initial screening to evaluate the appropriateness of the client's participation in the program
2. Development of an individualized program plan

— Structured work oriented activities (e.g., learning and practicing good work habits and/or developing skills to help consumer prepare for specific jobs appropriate to their level of ability)

— Educational skills (e.g., Adult Basic Education, GED, computer skills, support and assistance with returning to school)

— Employment assistance (services designed to help client attain and sustain volunteer work, part-time employment, or a full-time job)

— Sheltered employment opportunities (e.g., thrift store, garden center, or sheltered workshop)

— Goal-oriented groups (e.g., groups designed to help clients identify, discuss, achieve and/or maintain personal life goals, such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family, etc.)

— One-to-one goal-oriented sessions (e.g., one-to-one services designed to help a client identify, discuss, achieve and/or maintain personal life goals, such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family, etc.)

— Skill building (e.g., skills training sessions focused on learning, improving, and maintaining daily living skills, such as grocery shopping, use of public transportation, social skills, budgeting, laundry, and housekeeping, to help clients develop and maintain skills they need to achieve and/or sustain personal life goals

— Utilization of community resources

Eligible Staff – Mental Illness

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

Billing Unit:	15 minutes
Maximum Units:	16 per day, 4160 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization Program (H0035) or Intensive Day Treatment (H2012).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Child and Adolescent Mental Illness Day Treatment (H2012-HA)

Definition

A combination of goal-oriented rehabilitative services designed to improve the ability of a client to function as normally as possible in his or her regular home, school, and community setting when impaired by the effects of a mental or emotional disorder. Programs that provide an academic curriculum as defined by or registered with the State Department of Education and that students attend in lieu of a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Individual, group and family counseling
- Education for the client's parents or guardians regarding emotional and cognitive development and needs
- Services that enhance personal care skills
- Services that enhance family, social, and community living skills
- Services that enhance the use of leisure and play time

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services

The program must be staffed and have a program coordinator as required by the applicable certifying/licensing authority.

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Individual (90804), Family (90846, 90847, 90849), or Group Counseling (90853), Medication Administration (90772 HE, 90772 HF, H0033), Medication Monitoring (H0034). These restrictions apply while a client is actively enrolled in Day Treatment whether or not the restricted services occur on the same day as Day Treatment.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Treatment Plan Review (H0032)

Definition

Review and/or revision of a client's individualized treatment plan by a qualified staff member who is not the primary therapist for the client. This review will evaluate the client's progress toward treatment objectives, the appropriateness of services being provided, and the need for a client's continued participation in treatment. This service does not include those activities or costs associated with direct interaction between a client and his or her primary therapist regarding the client's treatment plan. That interaction must be billed through an alternative service, such as individual counseling.

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

- Treatment plan review, for mental illness and child and adolescent services/adult protective services clients, may be performed by a person who possesses any one or more of the following qualifications:
  - A psychologist licensed under Alabama law
  - A social worker licensed under Alabama law
  - A registered nurse licensed under Alabama law who has completed a masters in psychiatric nursing
  - A professional counselor licensed under Alabama law
  - A marriage and family therapist licensed under Alabama law
  - For services billed through DHR, a supervisor employed by DHR as a Service Supervisor or a Senior Social Work Supervisor
  - For services billed through DHR or DYS, an individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling, or other areas, and who (a) has successfully completed a practicum as part of the requirement for the degree or (b) has six months of post-master's level or above clinical with two years of postgraduate professional experience

Billing Unit:	15 minutes
Maximum Units:	1 event with up to 2 units per quarter, 8 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90801), Child and Adolescent In-Home Intervention (H2022-HA)

Added: Child and Adolescent In-Home Intervention (H2022-HA)

Location

This service may be provided wherever the client's clinical record is stored. This service may be billed while a client is in an inpatient setting since it is not a face to face service.

Additional Information

The client's treatment plan must be reviewed at least every three months. In cases where only an intake or diagnostic assessment is provided with no further treatment, treatment plan reviews are not covered. One treatment plan review will be covered following a three-month interval of no services delivered; any subsequent reviews with no intervening treatment are disallowed.

Providers must document this review in the client's clinical record by noting on the treatment plan that it has been reviewed and updated or continued without change. Medicaid covers this service for mental illness diagnoses only. The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services. The person who completes the treatment plan review for DHR children, adolescents, or adults must meet the criteria in Section 105.2.3.

Mental Health Consultation (H0046)

Definition

Assisting other external service agency providers or independent practitioners in providing appropriate services to an identified Medicaid client by providing clinical consultation.

Key service functions include written or verbal interaction in a clinical capacity in order to assist another provider to meet the specific treatment needs of an individual client and to assure continuity of care to another setting.

Eligible Staff – Mental Illness

Mental health consultations for mental illness services clients may be performed by a person who possesses any one of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as a part of the requirements for the degree
  - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience

Eligible Staff – DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Mental health consultations for child and adolescent services/adult protective services clients may be delivered by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above.

Billing Unit:	15 minutes
Maximum Units:	24 per day, 312 per year
Billing Restrictions:	ACT (H0040), PACT (H0040-HQ), In-Home Intervention (H2021, H2022-HA)

Location

There are no excluded settings. This service may be billed while a client is in an inpatient setting since it is not a face to face service.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Consults may be billed for the staff time spent obtaining prior authorizations and overrides for prescription medications. In addition to the eligible staff listed above LPNs may bill for their time directly related to performing this activity. LPNs **are not** eligible to bill for consults for any other type of activity. Acceptable documentation can be a progress note entered in the client's record or the approved authorization/override form filed in the record and dated and signed by the staff member performing the work.

Adult Substance Abuse Intensive Outpatient Services (H0015)

Definition

A combination of time limited, goal oriented rehabilitative services designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Medical services including prescription of medication and medication management
- Group and family counseling
- Substance abuse education
- Pre-discharge planning
- Family therapy focusing on client and family education regarding substance abuse and community support
- Linkage to community resources

Eligible Staff – Substance Abuse Services

This program must be staffed and have a program coordinator as required in the current *Community Substance Abuse Standards Manual*.

Billing Unit:	1 hour
Maximum Units:	6 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (90862)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Up to three family members included in family counseling may be counted for reimbursable units.

Child and Adolescent Substance Abuse Intensive Outpatient Services (H0015-HA)

Definition

A structured treatment designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle. Programs that provide an academic curriculum as defined by and registered with the State Department of Education and that students attend in lieu of services provided by a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Key services functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program
- Group and family counseling
- Education for the client's parents or guardians regarding substance abuse and associated problems
- Substance abuse education for client
- Medical services including the prescription of medication and medication management

Eligible Staff – Substance Abuse Services

The program must be staffed and have a program coordinator as required in the current *Community Substance Abuse Standards Manual*.

Billing Unit:	1 hour
Maximum Units:	6 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (90862).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Up to three family members included in family counseling may be counted for reimbursable units.

(Adult) In-Home Intervention (H2021~~, H2022-HA~~)

Definition

Home based services provided by a treatment team to serve individuals who refuse other outpatient services and/or who need temporary additional support due to increased symptoms or transition from a more intense level of services, to defuse an immediate crisis situation, stabilize the living arrangement, and/or prevent out of home placement of the client.

Key service functions include the following:

— Individual or family counseling

— Crisis intervention

— Mental Health Consultation

Deleted: ~~and Education~~

— Basic Living Skills

— Family Support

— Case Management

— Medication Monitoring

Eligible Staff – Mental Illness

In-home intervention for mental illness clients may be provided by a two-person team minimally composed of the following:

— A rehabilitative services professional staff member and

— A registered nurse licensed under Alabama law or

— A person with a bachelor's degree (who has completed case management training)

Billing Unit: 15 minutes (adults)

Maximum Units: 24 per day, 2016 per year (adults)

Billing Restrictions:

Deleted: ~~and Education~~

May not be billed in combination with Crisis Intervention (H2011), Individual Counseling (90804), Family Counseling (90846, 90847, 90849), Mental Health Consultation (H0046), Case Management, Family Support (H2027), Basic Living Skills (H0036) or Medication Monitoring (H0034)

Location

Please note that in-home intervention, while by definition and practice is usually provided in the client's home, infrequently may be provided in other locations. Such exceptions will not render the service ineligible for billing as In-Home Intervention.

Additional Information

Medicaid covers this service for mental illness diagnoses only.

When the Adult In-Home Intervention team members are together in the same location providing services to adults as a team, H2021 must be billed and billing restrictions will apply. When the team members work independently of each other, each team member must document as to the specific service rendered and bill under the applicable code [i.e. Individual Counseling (90804), Mental Health Consultation (H0046), etc.] and the billing restrictions will not apply. Travel time to and from the service location must be excluded from the billing.

Utilization will be monitored through retrospective reviews.

Child and Adolescent In-Home Intervention (H2022-HA)

Definition

Time limited home based services provided by a treatment team in order to defuse an immediate crisis situation, stabilize the family unit, and prevent out of home placement of the child or adolescent consumer, who presents with a serious emotional disturbance and who is at risk of out of home placement.

Key service functions include the following:

— Individual Counseling

— Family Counseling

Deleted: ~~and Education~~

— Family Support

— Basic Living Skills

— Crisis intervention (24 hour availability)

— Medication Monitoring

— Mental Health Consultation

— Case Management Services

— Treatment Plan Review

Eligible Staff – Mental Illness

In-home intervention for mental illness clients may be provided by a two-person team minimally composed of the following:

- A master's level mental health professional with one year of post master's experience in child and adolescent or family therapy

— A person with a bachelor's degree

— Each team member must successfully complete an approved case management training program and In-home Training Program

Billing Unit:	One day (children)
Maximum Units:	One per day, 140 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90801), Crisis Intervention (H2011), Individual Counseling (90804), Family Counseling (90846, 90847, 90849), Treatment Plan Review (H0032), Mental Health Consultation (H0046), Case Management, Family Support (H2027), Basic Living Skills (H0036) or Medication Monitoring (H0034) while a family is enrolled in In-Home intervention.

Deleted: ~~and Education, or~~

Location

Please note that In-Home intervention, while by definition and practice is usually provided in the child or adolescent consumer's home, infrequently may be provided in non-traditional settings including educational, child-welfare, family court, local parks, or clinic, etc. Such exceptions will not render the service ineligible for billing.

Additional Information

- Medicaid covers this service for mental illness diagnoses only.
- Only persons who meet the definition for Serious Emotional Disturbance (SED) and who are at imminent danger of removal from the home are eligible for this service.
- The team will always be together during the provision of services to children and their families. These services should be billed on a per diem basis while the family is enrolled and receiving in-home intervention services even though a service might not be provided every day.
- Span-billing may be utilized by multiplying the appropriate number of units for the month by the daily rate.
- Covered for children and adolescents only (age 5 to 18 years of age).
- The active caseload for a team will not exceed six (6) families.
- In-home must be available other than 8:00 A.M. to 5:00 P.M.
- All In-home clients must be referred to a Case Manager after the In-home team has completed the In-home Intervention.
- The intensive nature of this service should be reflected in the average hours of direct service per family per week.
- In-Home Intervention should follow service delivery patterns taught in the DMH approved In-Home Training Program to maintain the consistency and fidelity of the model.
- Treatment Plan must be completed within 30 days of the first face-to-face contact with the consumer. The Treatment Plan should address the treatment needs identified by the approved assessment tool.
- Signatures for services are secured on the day the service is delivered.
- In-Home Intervention Services are discontinued and enrollees are referred to other services when the team is no longer a two-person team. Examples would include the loss of one of the team members, extended illness, maternity leave, etc. exceeding a two week period.
- Utilization will be monitored through retrospective reviews.

Pre-hospitalization Screening (H0002-HE H0002-HF)

Definition

Face-to-face contact between a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse and a client to determine the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

Key service functions include the following:

- A clinical assessment of the client's need for local or state psychiatric hospitalization
- An assessment of whether the client meets involuntary commitment criteria, if applicable
- Preparation of reports for the judicial system and/or testimony presented during the course of commitment hearing
- An assessment of whether other less restrictive treatment alternatives are appropriate and available
- Referral to other appropriate and available treatment alternatives

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Pre-hospitalization screening may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse licensed under Alabama law
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
    - Has successfully completed a practicum as a part of the requirements for the degree
    - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of postgraduate clinical experience.

Billing Unit:	30 minutes
Maximum Units:	4 per day, 16 per year
Billing Restrictions:	None

Location

Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Providers may bill for time spent in court testimony while a client is in an inpatient unit.

Basic Living Skills (H0036 – Individual; H0036-HQ – Group)

Definition

Psychosocial services provided on an individual or group basis to enable a client to maintain community tenure and to improve his or her capacity for independent living.

Key services functions include the following:

- Training and assistance in developing or maintaining skills such as personal hygiene, housekeeping, meal preparation, shopping, laundry, money management, using public transportation, medication management, healthy lifestyle, stress management, and behavior education appropriate to the age and setting of the client
- Patient education about the nature of the illness, symptoms, and the client's role in management of the illness

Eligible Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Basic living skills may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Meets the qualifications for MI, SA, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above
- Is a registered nurse licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	1664 units per year
	20 per day (individual)
	8 per day (group)
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Family Support (H2027 – Individual; H2027-HQ – Group)

Definition

Service provided to families of rehabilitative services clients to assist them in understanding the nature of the illness of their family member and how to help the client be maintained in the community.

Key service functions include, as appropriate, but are not limited to education about the following:

- The nature of the illness
- Expected symptoms
- Medication management
- Ways in which the family member can cope with the illness

Eligible Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Family support services may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Meets the qualifications for MI, SA, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above
- Is a registered nurse licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	416 units per year
	8 per day for services provided to an individual client's family
	8 per day for services provided to a group of clients' families
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021, H2022-HA) Family Counseling (90846 HE, 90846 HF, 90847 HE, 90847 HF, 90849 HE, 90849 HF), ACT (H0040), PACT (H0040-HQ)

Deleted: ~~Therapy~~

Added: Counseling

Location

Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Assertive Community Treatment (ACT) (H0040)

Program for Assertive Community Treatment (PACT) (H0040-HQ)

Definition

Treatment services provided primarily in a non-treatment setting by a member of an ACT or PACT team, staffed in accordance with DMH/MR certification standards to adults with serious mental illness who are in a high-risk period due to an exacerbation of the illness and/or returning from an episode of inpatient/residential psychiatric care, or who are consistently resistant to traditional clinic-based treatment interventions and are difficult to engage in an ongoing treatment program.

Key service functions include, but are not limited to, the following:

- Intake
- Physician assessment and treatment
- Medication administration
- Medication monitoring
- Individual, group, and/or family counseling
- Crisis intervention
- Mental health consultation
- Case management
- Family support
- Basic living skills

The only services that may be billed in addition to ACT or PACT are Partial Hospitalization (H0035), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017). Billing in combination with Rehabilitative Day Program should occur only on a transitional basis as a client moves from a team intervention to a less acute array of individually delivered services.

Eligible Staff – Mental Illness

There must be an assigned (ACT or PACT) team that is identifiable by job title, job description, and job function. The team must be staffed in accordance with DMH/MR certification standards. Each member of the team must be known to the client and must individually provide services to each client in the team's caseload. The team will conduct a staffing of all assigned cases at least twice weekly. The caseload cannot exceed a 1:12 staff to client ratio on an ACT team where the part-time psychiatrist is not counted as one staff member or a 1:10 staff to client ratio on a PACT team.

Billing Unit:	One day
Maximum Units:	365 days per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90801), Physician Medical Assessment and Treatment (90862), Medication Administration (90772-HE), Medication Monitoring (H0034), Basic Living Skills (H0036), Family Support (H2027), Individual (90804-HE), Family (90846-HE, 90847-HE, 90849-HE), Group Counseling (90853-HE), Crisis Intervention (H2011), or Mental Health Consultation (H0046).

Added: Evaluation

Location

The only excluded settings are nursing homes. ACT and PACT services may be billed on a daily basis even though the client might not be seen or contacted by the team each day. ACT and PACT services may be billed while a client is hospitalized briefly for stabilization or medical treatment. Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate service environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Documentation of the required staffings and all client contacts by ACT and PACT team members shall be included in the client's medical record. All service documentation shall follow the guidelines in Section 105.2.3. Client signatures are not required for ACT and PACT key service functions; however, services which are provided outside the ACT and PACT benefit will require client signatures. H0040 and H0040-HQ may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per calendar year. Utilization will be monitored through retrospective reviews.

Methadone Treatment (H0020)

Definition

Methadone treatment is a periodic service designed to offer the individual an opportunity to effect constructive changes in his/her lifestyle by using Methadone in conjunction with the provision of rehabilitation and medical services. Methadone treatment is also a tool in the detoxification and rehabilitation process of narcotic-dependent individuals. For the purpose of detoxification, Methadone is used as a substitute narcotic drug. It is administered in decreasing doses for a period not to exceed 21 days. For individuals with history of psychoactive substance dependence or severe narcotic dependency prior to admission to the service, Methadone may also be used in maintenance treatment. In these cases, it may be administered or dispensed in excess of 21 days at relative stable dosage levels with the treatment goal of an eventual drug-free state.

Eligible Staff –Substance Abuse

The program must be staffed and have a Program Coordinator as required in the current *Community Substance Abuse Standards Manual* or subsequent revisions.

Billing Unit:	One day
Maximum Units:	365 per year
Billing Restrictions:	None

Location

Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

Additional Information

No more than 35 clients who do not meet the requirements for Phase III under the *Community Substance Abuse Standards Manual* will be assigned to a counselor, provided that the counselor may increase the ratio to 1:50 by adding 15 clients to the caseload who have been in opiate replacement treatment and qualify for Phase III requirements under the *Community Substance Abuse Standards Manual*. Clients who receive take-home doses under the hardship waivers, but do not otherwise satisfy Phase III requirements shall not be deemed Phase III clients.

H0020 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Utilization will be monitored through retrospective reviews.

105.2.2 Reimbursement

The Medicaid reimbursement for each service provided by a rehabilitative services provider is based on the following criteria and does not exceed the lowest of the following amounts:

- The customary charges of the provider but not more than the prevailing charges in the locality for comparable services under comparable circumstances
- The amount billed
- The fee schedule established by Medicaid as the maximum allowable amount
- Reimbursement for services provided by state agencies is based on actual costs as follows:
- Agencies must submit an annual cost report not later than 60 days following the close of the fiscal year. This report must indicate not only the costs associated with providing the services, but also statistical data indicating the units of service provided during the fiscal year.
- Medicaid will review cost reports for reasonableness and an average cost per unit of service will be computed.
- Medicaid will use the average cost, trended for any expected inflation, as the reimbursement rate for the succeeding year.
- If the cost report indicates any underpayment or overpayment for services during the reporting year, Medicaid will make a lump sum adjustment.
- New rates are effective January 1 of each year.

Actual reimbursement is based on the rate in effect on the date of service. Only those services that qualify for reimbursement are covered under this program.

105.2.3 Requirements for Client Intake, Treatment Planning, and Service Documentation

An intake evaluation must be performed for each client considered for initial entry into organized programs or course of covered services. Individuals who are transferred between programs within an agency do not require a new intake at the time of transfer.

To determine a client's need for rehabilitative services, providers must perform an intake evaluation based on assessment of the following information:

- Family history
- Educational history
- Relevant medical background
- Employment/vocational history
- Psychological/psychiatric treatment history
- Military service history
- Legal history
- Alcohol/drug use history
- Mental status examination

— A description of the significant problems that the client is experiencing

Providers use the standardized substance abuse psychosocial assessment as the intake instrument for substance abuse clients.

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth client visit with the primary therapist or within ten working days after admission into a day treatment program, substance abuse intensive outpatient program, or residential program. The treatment plan must include the following:

— Identification of the clinical issues that will be the focus of treatment

— Specific services necessary to meet the client's needs

— Referrals as appropriate for needed services not provided directly by the agency

— Identification of expected outcomes toward which the client and therapist will be working to impact upon the specific clinical issues

— Unless clinically contraindicated, the client will sign/mark the treatment plan to document the consumer's participation in developing and/or revising the plan. If the client is underage or adjudicated incompetent, the parent/foster parent/legal guardian must sign the treatment plan.

The treatment plan must be approved in writing by any one of the following:

- A psychologist licensed under Alabama law
- A social worker licensed under Alabama law
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A registered nurse licensed under Alabama law who has completed a master's in psychiatric nursing
- A professional counselor licensed under Alabama law
- A physician licensed under Alabama law
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A marriage and family therapist licensed under Alabama law
- A supervisor employed by DHR as a Service Supervisor or a Senior Social Work Supervisor
- For services billed through DHR, DYS, or DCA, an individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling, or other areas that require equivalent course work and who meets at least one of the following qualifications: (a) has successfully completed a practicum as part of the requirement for the degree or (b) has six months of post-master's level professional experience supervised by a master's level or above clinical with two years of postgraduate professional experience

Service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, crisis intervention and

resolution, mental health consultation, pre-hospitalization screening, and treatment plan review. Changes in the treatment plan must be approved as described above.

The preferred course of treatment for persons with co-occurring disorders (MI/SA) is integrated services where both mental illness and substance abuse clinical issues are addressed in the same treatment setting, whether that setting primarily provides mental illness or substance abuse treatment. In cases where integrated services are not possible, a dually diagnosed client may receive mental illness and substance abuse services simultaneously from one or more certified providers. In cases where mental illness and substance abuse services are provided independently, the daily caps specific to each service are cumulative for the day and are not interactive.

In all cases, the diagnosis and treatment plan should reflect both disorders and the interventions needed for both.

After completion of the initial treatment plan, staff must review the client's treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. Providers must document this review in the client's clinical record by noting on the treatment plan that it has been reviewed and updated or continued without change. Staff, as specified above, must perform this review.

Treatment plan reviews are not covered in cases where only an intake or diagnostic assessment is provided with no further treatment. One treatment plan review is covered following a three-month interval of no services delivered. Any subsequent reviews with no intervening treatment are disallowed.

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested must comply with any applicable certification or licensure standards and must include the following, at a minimum:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed

The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

Documentation of Medicaid recipients' signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the client's signature and the date of service. Treatment plan review, mental health consultation, pre-hospitalization screening, crisis intervention, family support, ACT, PACT, and any non-face-to-face services that can be provided by telephone do not require client signatures.

ACT and PACT services are billed as a bundled service on a daily rate even though the client might not be seen or contacted by the team each day. Documentation of the required staffings and any service provided to or on behalf of a client must be included in the client's medical record.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

105.3 Prior Authorization and Referral Requirements

Rehabilitative services procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines. Rehabilitative services do not require a Patient 1st referral.

105.4 Cost Sharing (Copayment)

Copayment does not apply to rehabilitative services.

105.5 Completing the Claim Form

Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Rehabilitative services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

105.5.1 Time Limit for Filing Claims

Medicaid requires all claims for rehabilitative services to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions for more information regarding timely filing limits and exceptions.

105.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes, within the range of 290-316, must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. The V code unspecified psychosocial circumstance is covered only for children and adolescents or adults receiving DHR protective services. Claims filed for pregnant women (SOBRA) must include V222 (pregnant state, incidental) as well as the appropriate MI/SA diagnosis code.

105.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Use the modifiers to distinguish mental illness/substance abuse, adult/child and adolescent, individual/group services.

NOTE:

Use the "Z" codes for **dates of service through 12/31/03**. Use HCPCS codes, with modifiers if applicable, for **dates of service beginning 01/01/04**. Use modifiers to distinguish mental illness/substance abuse services, individual/group services, adult/child & adolescent services.

Benefits of the Rehabilitative Services Program are limited to the procedures listed below:

Code	***Description***
Z5227 90801-HE 90801-HF ***HE=MI*** ***HF=SA***	Intake Evaluation (limit one per calendar year)
Z5228 90862-HE 90862-HF	Physician/Medical Assessment and Treatment (limited to 6 units per day, 52 units per year) (15 minutes = 1 unit)
Z5229 96101-HE 96101-HF 96102-HE 96102-HF 96103-HE 96103-HF	Diagnostic Testing (limited to 5 units per year) (1 hour= 1 unit) (96101) administered by psychologist (96102) administered by technician (96103) administered by computer
Z5230 H2011	Crisis Intervention and Resolution (limited to 12 units per day, 4380 units per year) (15 minutes = 1 unit)
Z5231 90804-HE	Individual Counseling/Mental Illness (limited to 3 units per day, 104 units per year) (30 minutes = 1 unit)

Code	***Description***
Z5232 90846HE 90846-HF 90847-HE 90847-HF 90849-HE 90849-HF	Family Counseling (limited to 3 units per day, 104 units per year) (30 minutes = 1 unit) (90846) without patient present (90847) with patient present (90849) multiple family group
Z5233 90853-HE 90853-HF	Group Counseling (limited to 3 units per day, 104 units per year) (30 minutes = 1 unit)
Z5234 90772-HE 90772-HF H0033-HE H0033-HF	Medication Administration (limited to 1 unit per day, 365 episodes per year) (Episode = 1 unit) Injectable meds (90772) Oral meds (H0033)
Z5235 H0034	Medication Monitoring (limited to 2 units per day, 52 units per year) (15 minutes = 1 unit)
Z5236 H0036	Basic Living Skills, Individual (limited to 20 units per day) (15 minutes=1 unit) (1664 units per year)
Z5237 H0036-HQ ***HQ=Group***	Basic Living Skills, Group (limited to 8 units per day) (15 minutes=1 unit) (1664 units per year)
Z5238 H2027	Family Support, Individual (limited to 8 units per day) (15 minutes=1 unit) (416 units per year).
Z5239 H2027-HQ	Family Support, Group (limited to 8 units per day) (15 minutes=1 unit) (416 units per year)
Z5240 H0035	Partial Hospitalization Program (limited to 1 unit per day, 130 units per year) (4 hours = 1 unit)
Z5241 H2012	Intensive Day Treatment (limited to 4 units per day, 1040 units per year) (1 hour = 1 unit)
Z5242 H0032	Treatment Plan Review (limited to 2 units per quarter, 8 units per year) (15 minutes = 1 unit)
Z5243 H0046	Mental Health Consultation (limited to 312 units per year, 24 units per day) (15 minutes = 1 unit)
Z5244 H2021- H2022-HA	In-Home Intervention (limited to 24 units per day, 2016 units per year) (15 minutes = 1 unit) (adults) (limited to 168 units per year) (one day = 1 unit) (children)
Z5380 Deleted 1/1/03	Medicare exempt partial hospitalization claims physician
Z5401 Deleted 1/1/03	Medicare deductible and coinsurance
Z5431 H2017	Rehabilitative Day Program (limited to 16 units per day, 4160 units per year) (15 minutes= 1 unit)

Code	Description
Z5433 H2012-HA ***HA=Child & Adolescent***	Child & Adolescent Day Treatment (limited to 4 units per day, 1040 units per year) (1 hour-= 1 unit)
Z5435 H2012-HA	Child & Adolescent Day Treatment (limited to 4 units per day, 1040 units per year) (1 hour = 1 unit)
Z5436 H0015	Adult Substance Abuse Intensive Outpatient Services (limited to 6 units per day, 1040 units per year) (1 hour = 1 unit)
Z5437 H0015-HA	Child & Adolescent Substance Abuse Intensive Outpatient Services (limited to 6 units per day, 1040 units per year) (1 hour = 1 unit)
Z5438 H0002-HE H0002-HF	Pre-hospitalization Screening (limited to 4 units per day, 16 units per year) (30 minutes = 1 unit)
Z5450 H0040 H0040-HQ	(ACT) - (limited to 1 unit per day, 365 units per year) (1 day = 1 unit) PACT (limited to 1 unit per day, 365 units per year) (1 day = 1 unit)
Z5451 H0020	Methadone Treatment (limited to 1 unit per day, 365 units per year) (1 day = 1 unit)
Z5452 90804-HF	Individual Counseling/Substance Abuse (limited to 3 units per day, 104 units per year) (30 minutes = 1 unit)

105.5.4 Place of Service Codes

The following place of service codes apply when filing claims for rehabilitative services:

POS Code	Description
11	Office
12	Home
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
52	Psychiatric Facility Partial Hospitalization
53	Community Rehabilitative Services Center
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center

105.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

105.5.6 Billing Instructions for Medical-related Services

Instructions for Claims with Dates of Service August 1, 2000 and Thereafter

1. Bill Medicare on a UB-92.
2. Services covered by Medicare should be automatically crossed over to Medicaid as a UB-92 outpatient crossover. If for some reason the claim never crosses over or the claim is denied after crossing over, send an Institutional Medicaid/Medicare-related claim form to Medicaid using the same information as it was sent to Medicare. Indicate coinsurance, deductible, and allowed amounts as applied by Medicare.
3. If Medicare does not pay on any part of the services, bill the amount due for the services on a CMS-1500 claim form using procedure codes listed in the provider manual. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically. For paper claims, enter “key TPL input code M” in block 19 of the CMS-1500 form.

105.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
ASC Procedures List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

106 Targeted Case Management

Case management services are services that assist eligible individuals in gaining access to needed medical, social, educational and other services. Targeted Case Management (TCM) services assist specific eligible recipients, or targeted individuals, to access other services.

Targeted Case Management services may be provided to recipients who reside in their own home, the household of another, or in a supervised residential setting. No case management services will be provided to recipients in a hospital, skilled nursing facility, intermediate care facility, prison, jail, or other total care environment.

Targeted Case Management services are provided to eligible recipients in the following eight target groups:

Target Group	***Recipients***	***Description***
Target Group 1	Mentally ill adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with mental illness
Target Group 2	Mentally retarded adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with mental retardation
Target Group 3	Handicapped children	Medicaid-eligible individuals age 0-21 who are considered handicapped
Target Group 4	Foster children	Medicaid-eligible individuals age 0-21 who are in the care, custody, or control of the state of Alabama
Target Group 5	Pregnant women	Medicaid-eligible women of any age in need of maternity services
Target Group 6	AIDS/HIV-positive individuals	Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive
Target Group 7	Adult protective service individuals	Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation
Target Group 8	Technology Assisted (TA) Waiver for Adults	Medicaid-eligible individuals age 21 and over who meet the eligibility criteria for the TA Waiver

The policy provisions for TCM providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 40.

106.1 Enrollment

Providers will submit a written request to the LTC Program Management Unit for enrollment to the Targeted Case Management (TCM) Services Program. The request must contain the TCM target group to be covered: the name, address, and phone number of the provider agency; the name, address, and phone number of the payee (if different from the provider); the name and phone number of the contact person; and the tax ID number of the payee.

Subcontract providers must have a contract with the primary provider. A copy of this contract will be submitted with the request to enroll as a TCM provider.

The Program Management Unit will assign a provider number to the agency requesting enrollment. A memo will be forwarded to the LTC Provider/Recipient Services Unit with the assigned provider number, procedure code, and rate with the enrollment request information. The Provider/Recipient Services Unit will submit a request to load the pricing file on Level I or Level III, as appropriate, to the Fiscal Agent Liaison. The Fiscal Agent Liaison will load the information to the pricing file and submit the provider file to EDS for enrollment.

The LTC Provider/Recipient Services Unit will notify the Program Management Unit when the enrollment process has been completed. The LTC Program Management Unit will notify the provider in writing of the effective date of enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a TCM provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for case management-related claims.

NOTE:
All nine digits are required when filing a claim.

TCM providers are assigned a provider type of 46 (Targeted Case Management). Valid specialties for TCM providers include the following:

- Mentally Ill Adults (TE)
- Mentally Retarded Adults (TF)
- Handicapped Children (TG)
- Foster Child (TH)
- Pregnant Women (TI)
- AIDS/HIV Positive Individuals (TJ)
- Adult Protective Services (TK)
- Technology Assisted (TA) Waiver Eligible Adults (EG)

Enrollment Policy for TCM Providers

To participate in the Alabama Medicaid Program, Targeted Case Management providers must meet the following requirements:

- Demonstrate the capacity to provide the core elements of case management, including assessment, care and services plan development, linking and coordination of services, and reassessment and follow-up
- Demonstrate case management experience in coordinating and linking community resources as required by the target population
- Demonstrate experience with the target population
- Provide the administrative capacity to ensure quality of services in accordance with state and federal requirements
- Maintain a financial management system that provides documentation of services and costs
- Demonstrate the capacity to document and maintain individual case records in accordance with state and federal requirements
- Demonstrate the ability to ensure a referral process consistent with Section 1902(a)23 of the Social Security Act, freedom of choice of provider
- Demonstrate the capacity to meet the case management service needs of the target population
- Provide an approved training program certified by Medicaid to address the needs and problems of the recipients served
- Provide a quality assurance program for case management services approved and certified by Medicaid. The quality assurance program includes record reviews at a minimum of every six months.
- Fully comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990
- Fully comply with applicable federal and state laws and regulations

106.1.1 Minimum Qualifications for Individual Targeted Case Managers

Individual Targeted Case Managers must meet the following minimum educational qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field or social work program
- Possess certification as a registered nurse

Individual Targeted Case Managers for Pregnant Women (Target Group 5), and AIDS/HIV-Positive Individuals (Target Group 6), must have a Bachelor of Arts or Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education.

Individual Case Managers for Foster Children (Target Group 4) and Adult Protective Service individuals (Target Group 7) must be employed by DHR and meet the following qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human service field, or
- Possess certification as a registered nurse

In addition to the minimum educational requirements, Targeted Case Managers must complete training in a case management curriculum approved by Medicaid and other applicable state agencies. Specific requirements for each target group are listed in the following paragraphs.

106.1.2 Minimum Qualifications for Each Target Group

Minimum Qualifications for Target Group 1 Providers

TCM providers for Mentally Ill Adults (Target Group 1) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health and Mental Retardation.

TCM providers for Mentally Ill Adults (Target Group 1) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts & Comprehensive Community Health Centers. TCM providers for Mentally Ill Adults must be certified and provide services through a contract with the Department of Mental Health and Mental Retardation.

Minimum Qualifications for Target Group 2 Providers

TCM providers for Mentally Retarded Adults (Target Group 2) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Alabama Department of Mental Health and Mental Retardation.

TCM providers for Mentally Retarded Adults (Target Group 2) must be either Regional Boards incorporated under Act 310 of the 1967 Alabama Acts & Comprehensive Community Health Centers who have demonstrated the ability to provide targeted case management services directly, or the Alabama Department of Mental Health and Mental Retardation (DMH/MR). Providers must be certified by the Alabama DMH/MR.

Minimum Qualifications for Target Group 3 Providers

TCM providers for Handicapped Children (Target Group 3) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 4 Providers

TCM providers for Foster Children (Target Group 4) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Groups 5 and 6 Providers

TCM providers for Pregnant Women (Target Group 5) and AIDS/HIV-Positive Individuals (Target Group 6) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 7 Providers

TCM providers for Adult Protective Services (Target Group 7) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Targeted Case Management Service Providers for Adult Protective Service Individuals (Target Group 7) must demonstrate experience with the target population in investigating abuse, neglect, or exploitation in domestic settings and in providing follow-up services to victims of abuse, neglect, or exploitation.

Minimum Qualifications for Target Group 8 Providers

TCM providers for Technology Assisted Waiver eligible adult individuals ((Target Group 8) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

106.2 Benefits and Limitations

This section describes benefits and limitations for Targeted Case Management providers. It contains the following subsections:

- Core Elements of Targeted Case Management
- Target Group Definitions
- Documentation Requirements
- Limitations

106.2.1 Core Elements of Targeted Case Management

Case management services assist Medicaid-eligible recipients in gaining access to needed medical, social, educational, and other services. The case manager provides these services through telephone contact with recipients, face-to-face contact with recipients, telephone contact with collaterals, or face-to-face contact with collaterals. Collaterals are the Medicaid-eligible client's immediate family and/or guardians, federal, state, or local service agencies (or agency representatives), and local businesses who work with the case manager to assist the recipient.

Targeted Case Management services consist of the following six core elements, which are defined in the paragraphs that follow:

- Needs assessment
- Case planning
- Service arrangement
- Social support
- Reassessment and follow-up
- Monitoring

Needs assessment

A TCM provider performs a written comprehensive assessment of the recipient's assets, deficits, and needs. The TCM provider gathers the following information:

- Identifying information
- Socialization and recreational needs
- Training needs for community living
- Vocational needs
- Physical needs
- Medical care concerns
- Social and emotional status
- Housing and physical environment
- Resource analysis and planning

Case planning

TCM providers must develop a systematic, recipient-coordinated plan of care that lists the actions required to meet the identified needs of the recipient based on the needs assessment. The plan is developed through a collaborative process involving the recipient, his family or other support system, and the case manager. It must be completed in conjunction with the needs assessment within the first 30 days of contact with the recipient.

Service arrangement

Through linkage and advocacy, the case manager coordinates contacts between the recipient and the appropriate person or agency. The case manager calls or visits these persons or agencies on the recipient's behalf.

Social Support

Through interviews with the recipient and significant others, the case manager determines whether the recipient possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case manager assists the recipient in expanding or establishing such a network through advocacy and linking the recipient with appropriate persons, support groups, or agencies.

Reassessment and Follow-up

Through interviews and observations, the case manager evaluates the recipient's progress toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the case manager contacts persons or agencies providing services to the recipient and reviews the results of these contacts, together with the changes in the recipient's needs shown in the reassessments, and revises the case plan if necessary.

Monitoring

The case manager determines what services have been delivered and whether they adequately meet the needs of the recipient. The plan of care may require adjustments as a result of monitoring.

106.2.2 Target Group Definitions

This section defines the eight target groups served by TCM providers.

Target Group 1 – Mentally Ill Adults

Target Group 1 consists of functionally limited individuals age 18 and over with multiple needs who require mental health case management. Such persons have a DSM-III-R diagnosis (other than mental retardation or substance abuse), impaired role functioning, and a documented inability to independently access and sustain involvement with needed services.

Target Group 2 – Mentally Retarded Adults

Target Group 2 consists of individuals who are 18 years of age or older with a diagnosis of mental retardation, as defined by the American Association of Mental Retardation (formerly AAMD). The individual's diagnosis must be determined by a Qualified Mental Retardation Professional (QMRP) and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation. Such persons may have other or secondary handicapping conditions.

Target Group 3 – Handicapped Children

Target Group 3 consists of individuals, age 0-21 considered to be handicapped as defined in the following six subgroups:

- Mentally retarded/related conditions
- Seriously emotionally disturbed
- Sensory impaired
- Disabling health condition(s)
- Developmentally delayed
- Multi-handicapped

Mentally Retarded/Related Conditions

All recipients in this subgroup must be age 0-17. A recipient is considered mentally retarded when a diagnosis of mental retardation is determined. This determination must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

Recipients with related conditions are individuals who have a severe chronic disability described by all of the following criteria:

- Attributable to Cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons
- Likely to continue indefinitely
- Results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction or capacity for independent living

Seriously Emotionally Disturbed

A recipient is considered seriously emotionally disturbed if they meet at least one criterion from column 1, Mental Health Treatment History, or 2, Indicators or Mental Health Treatment Needs, and two criteria from column 3, Current Functioning Problem Areas.

Mental Health Treatment History	***Indicators of Mental Health Treatment Needs***	***Current Functioning***
Has undergone mental health treatment more intensive than outpatient care (emergency services or inpatient services) Has experienced structured, supportive residential treatment, other than hospitalization, for a total of at least two months in their lifetime Has been assigned to a program of psychotropic medication Has received mental health outpatient care for a period of at least six months, or for more than 20 sessions, or has been admitted for treatment on two or more occasions	Family history of alcohol or drug abuse Family history of mental health treatment Failure to thrive in infancy or early development indicated in medical records Victim of child abuse, neglect, or sexual abuse Pervasive or extreme acts of aggression against self, others, or property (homicidal or suicidal gestures, fire setting, vandalism, or theft) Runaway episode(s) of at least 24 hours' duration	Does not attend school (and has not graduated), is enrolled in a special education curriculum, or has poor grades Dysfunctional relationship with family and peers Requires help in basic, age-appropriate living skills Exhibits inappropriate social behavior Experiences serious discomfort from anxiety, depression, irrational fears, and concerns (indicated by serious eating or sleeping disorders, extreme sadness, or social isolation)

NOTE:

Consider current functioning problem areas of one-year duration or with substantial risk of over one year duration.

Sensory Impaired

Blind recipients have no usable vision after the best possible correction. They must rely on tactile and auditory senses to obtain information.

Partially sighted recipients have a visual acuity of 20/70 or less in the better eye with the best possible correction. They also have a peripheral field so restricted that it affects their ability to learn, or a progressive loss of vision which may in the future affect their ability to learn.

Deaf recipients have a hearing impairment that is so severe that they are impaired in processing linguistic information through hearing, with or without amplification. This impairment adversely affects educational performance.

Blind multihandicapped recipients have a visual impairment (either blind or partially sighted as defined above) and a concurring handicapping condition.

Deaf multihandicapped recipients have a hearing impairment (deaf as defined above) and a concurring handicapping condition.

Deaf-blind recipients have both hearing and visual impairments. The combination of sensory impairments causes such severe communication and other developmental and educational problems that the recipient cannot be properly accommodated in the educational programs offered by the Alabama School for the Blind or the Alabama School for the Deaf.

Disabling Health Condition(s)

Recipients are eligible for Targeted Case Management services if they have the following disabling conditions, which are severe, chronic, and physical in nature and require extensive medical and habilitative/rehabilitative services.

- Central nervous system dysraphic states such as spina bifida, hydranencephaly, and encephalocele
- Cranio-facial anomalies such as cleft lip and palate, Apert's syndrome, and Crouzon's syndrome
- Pulmonary conditions such as cystic fibrosis
- Neuro-muscular conditions such as cerebral palsy, arthrogryposis, and juvenile rheumatoid arthritis
- Seizure disorders such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type
- Hematologic/immunologic disorders such as hemophilia, sickle cell disease, aplastic anemia, and agammaglobulinemia
- Heart conditions such as aortic coarctation, and transposition of the great vessels
- Urologic conditions such as extrophy of bladder
- Gastrointestinal conditions such as Hirschsprung's Disease, omphalocele, and gastroschisis

- Orthopedic problems such as clubfoot, scoliosis, fractures, and poliomyelitis
- Metabolic disorders such as panhypopituitarism
- Neoplasms such as leukemia, and retinoblastoma
- Multisystem genetic disorders such as tuberosclerosis, and neurofibromatosis

Developmentally Delayed

A child age birth to three years is eligible for TCM services if they are experiencing developmental delays greater than or equal to 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

- Cognitive development
- Physical development, including vision and hearing
- Language and speech development
- Psychosocial development
- Self-help skills

A recipient is also eligible if they have been diagnosed with a physical or mental condition that has a high probability of resulting in a development delay.

Multihandicapped

An individual who has a combination of two or more handicapping conditions as described above is considered multi-handicapped. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions adversely affects development.

Target Group 4 – Foster Children

Target Group 4 consists of children age birth to 21 who receive preventive, protective family preservation or family reunification services from the State, or any of its agencies, as a result of State intervention or upon application by the child's parent(s), custodian(s), or guardian(s).

The group also consists of children age birth to 21 who are in the care, custody, or control of the State of Alabama, or any of its agencies, due to one of the following three situations.

- The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975

- The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute
- The voluntary placement agreement, voluntary boarding house agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian

Target Group 5 – Pregnant Women

Target Group 5 consists of Medicaid-eligible women of any age in need of maternity services.

Target Group 6 – AIDS/HIV-Positive Individuals

Target Group 6 consists of Medicaid-eligible individuals of any age who have been diagnosed with AIDS or are HIV-positive as evidenced by laboratory findings.

Target Group 7 – Adult Protective Service Individuals

Target Group 7 consists of individuals 18 years of age or older who meet either of the following criteria:

- At risk of abuse, neglect, or exploitation
- At risk of institutionalization due to their inability or their caretaker's inability to provide the minimum sufficient level of care in the home

Target Group 8 - Technology Assisted (TA) Waiver for Adults

Target Group 8 individuals consist of Medicaid eligible individuals age 21 and older, who meet the eligibility criteria for the Technology Assisted (TA) Waiver for Adults.

106.2.3 Documentation Requirements

The TCM provider must make available to Medicaid at no charge all information describing services provided to eligible recipients. The provider must also permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies.

The TCM provider must maintain complete and accurate medical, psychiatric and fiscal records that fully disclose the extent of the service. The records shall be retained for three years plus the current year to substantiate that the services billed to Medicaid were actually delivered to the Medicaid recipient and to substantiate the charges billed to Medicaid. However, if audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three year period, the TCM provider must retain the records until resolution.

Record retention for TCM files will remain three years plus the current year. Records for TCM provided through waivers shall be retained for three years during the initial waiver period and five years after renewal of the waivers.

Provider's records must contain the following information:

- Name of recipient
- Dates of service
- Name of provider agency and person providing services
- Nature, extent, or units of services provided
- Place of service

TCM providers must maintain the following documentation in the recipient's record when billing for Foster Children (Target Group 4) and Adult Protective Service Individuals (Target Group 7):

- A current comprehensive service plan that identifies the medical, nutritional, social, educational, transportation, housing and other service needs that have not been adequately accessed
- A time frame to reassess service needs

Services must consist of at least one of the following activities:

- Establishment of a comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of -the recipient
- Assistance for the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
- Assessment of the recipient and service providers to determine that the services received are adequate in meeting the identified needs
- Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events

Social Services Work Sampling Study

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), reimbursement rates are based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation and identifies that services have been provided.

106.2.4 Limitations

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), an encounter rate consisting of a maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services. A unit of case management service consists of at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services.

For all other target groups, a unit of service is reimbursed in increments of five minutes.

The case manager must document all contacts in the recipient's record. Contacts must be for the coordination of services for a specific identified recipient.

Recipients receiving case management services through a waiver are not eligible for targeted case management.

Case management services for mentally retarded adults are provided to individuals with a diagnosis of mental retardation who are 18 years of age or older.

Case management services for all other target groups are not limited to a maximum number of hours per calendar year.

106.3 Prior Authorization and Referral Requirements

TCM procedure codes generally do not require prior authorization, except for the target groups noted below.

TCM providers must obtain prior authorization from EDS to avoid duplicate payments for targeted case management services in the following target groups:

- Handicapped Children (Target Group 3)
- Foster Children (Target Group 4)

Direct all inquiries and requests relating to prior authorization for a specific target group to EDS' Provider Communication Unit at 1(800) 688-7989.

Interagency Transfers

If a recipient in a target group requiring prior authorization requests to change case managers from one agency to another, the TCM provider must complete a Request for Interagency Transfer form. This form authorizes EDS to reassign the prior authorization 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.

106.4 Cost Sharing (Copayment)

The copayment does not apply to services provided for targeted case management.

106.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

TCM providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

106.5.1 Time Limit for Filing Claims

Medicaid requires all claims for TCM providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

106.5.2 Diagnosis Codes

See Section 106.5.3 (Procedure Codes and Modifiers) for the allowable diagnosis codes. The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

106.5.3 Procedure Codes and Modifiers

TCM providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional and institutional claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes, modifiers, and diagnosis codes apply when filing claims for TCM services:

Target Group	*Old Code thru 12/31/03*	*Diagnosis Code for Old Code*	*New Code effective 01/01/04*	*Diagnosis Code for New Code*	*PA Required ?*
5 (Pregnant Women	Z5186	V220 – V242 V270 – V289 V3100 – V3900 630 – 632 63300 – 63391 63400 – 63792 6380 – 6399 64000 –	G9008-HD	V220 – V242 V270 – V289 V3100 – V3900 630 – 632 63300 – 63391 63400 – 63792 6380 – 6399 64000 – 64193 64200 – 64294 64300 – 64393	No

Target Group	***Old Code thru 12/31/03***	***Diagnosis Code for Old Code***	***New Code effective 01/01/04***	***Diagnosis Code for New Code***	***PA Required ?***
		64193 64200 – 64294 64300 – 64393 64400 – 64421 64510 – 64603 64610 – 64624 64630 – 64631 64640 – 64664 64670 – 64673 64680 – 64684 64690 – 64693 64700 – 64894 65100 – 65393 65400 – 65494 65500 – 66393 66400 – 67694		64400 – 64421 64510 – 64603 64610 – 64624 64630 – 64631 64640 – 64664 64670 – 64673 64680 – 64684 64690 – 64693 64700 – 64894 65100 – 65393 65400 – 65494 65500 – 66393 66400 – 67694	
2 MR Adults	Z5187	317 – 319	G9008-U2	317 – 319	No
1 MI Adults	Z5188	2900 – 2900 2930 – 3020 3060 – 3064 30650 – 30653 30659 – 30659 3067 – 3069 3070 – 3071 30720 – 30723 3073 – 3073 30740 – 30749 30750 – 30754 30759 – 30759 3076 – 3077 30780 – 30781 30789 – 30789 3079 – 3079 3080 – 3084 3089 – 3089 3090 – 3091 30921 – 30924 30928 – 30929 3093 – 3094 30981 – 30983	G9008-U1	29500 – 29595 29600 – 29666 2967 – 2967 29680 – 29699 2970 – 2989 29900 – 29991 30000 – 30029 3003 – 3007 30081 – 30089 3009 – 3010 30110 – 30113 30120 – 30122 3013 – 3014 30150 – 30159 3016 – 3017 30181 – 30189 3019 - 3019	No

Target Group	***Old Code thru 12/31/03***	***Diagnosis Code for Old Code***	***New Code effective 01/01/04***	***Diagnosis Code for New Code***	***PA Required ?***
		30989 – 30989 3099 – 3099 3100 – 3102 3108 – 3109 311 – 311 31200 – 31223 31230 – 31235 31239 – 31239 3124 – 3124 31281 – 31282 31289 – 31289 3130 – 3131 31321 – 31323 3133 – 3133 31381 – 31383 31389 – 31389 3139 – 3139 31400 – 31401 3141 – 3142 3148 – 3149 31500 – 31502 31509 – 31509 3151 – 3152 31531 – 31532 31539 – 3155 3158 – 3159 316 – 316			
3 MR Child	Z5213	V6149	G9005-U3	319	Yes
3 SED Child	Z5214	V6149	G9002-U3	3009	Yes
3 Sensory Impaired Child	Z5215	V6149	G9008-U3	78199	Yes
3 Disabling Health Child	Z5216	V6149	G9008-U3	780	Yes
3 Multi Handicapped Child	Z5217	V6149	G9008-U3	7429	Yes
4 Foster Child	Z5218	V6129	T2023-U4	2999	Yes
6 AIDS/ HIV	Z5219	042	G9012-U6	042 07953	No
3 DD Child	Z5296	V6149	G9006-U3	3159	Yes
8 TA Waiver	Z5342	As appropriate	G9008-U5	V550	No
7 APSI	Z5378	V6149	T2023-U7	797	No

106.5.4 Place of Service Codes

The following place of service codes apply when filing claims for TCM services:

POS Code	Description
11	Office
12	Home
24	Ambulatory Surgical Center
33	Custodial Care Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
81	Independent Laboratory

106.5.5 Required Attachments

There are no required attachments for Targeted Case Management providers.

106.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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107 Waiver Services

Medicaid covers Home and Community-Based Services (HCBS) through the Elderly and Disabled (E&D) Waiver, the State of Alabama Independent Living (SAIL) Waiver (formerly Homebound Waiver), the Technology Assisted (TA) Waiver for Adults and the HIV/AIDS Waiver to categorically needy individuals who would otherwise require institutionalization in a nursing facility.

Medicaid covers the Alabama Home and Community-Based Waiver for Persons with Mental Retardation(MR Waiver),formerly MR/DD and the Living at Home (LHW) Waiver to Medicaid-eligible individuals who would otherwise require the level of care available in an intermediate care facility for the mentally retarded (ICF-MR).

The purpose of providing HCBS to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as a waiver service. HCBS are provided through a Medicaid waiver for an initial period of three years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS) .

The E&D Waiver is a cooperative effort among the Alabama Medicaid Agency, Alabama Department of Public Health (ADPH), and the Alabama Department of Senior Services (ADSS). The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36.

The SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama-Department of Rehabilitation Services (ADRS). The policy provisions for SAIL Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 57.

The MR and LHW Waivers are a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation (DMH/MR). The policy provisions for MR and LHW Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapters 35 and 52 respectively.

The Technology Assisted (TA) Waiver for Adults serves individuals who received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan who will no longer be eligible for this service upon turning age 21, and for whom private duty nursing continues to be medically necessary based upon approved private duty nursing criteria. The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. The policy provisions for providers of the TA Waiver for Adults can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 54.

NOTE:

Providers rendering private duty nursing services as a result of an EPSDT screening should refer to the Alabama Medicaid Provider Manual, Chapter 31 for policy provisions.

The HIV/AIDS Waiver is a cooperative effort among the Alabama Medicaid Agency and the Alabama Department of Public Health (ADPH). The policy provisions for HIV/AIDS Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 58.

107.1 Enrollment

Applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual* should apply with the designated waiver Operating Agency for the E&D, SAIL, MR, Living at Home and HIV/AIDS Waivers. Applicants for the TA Waiver are enrolled directly through EDS.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

Operating Agencies who contracts with Medicaid as a provider of waiver services are issued a (9) nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for waiver claims. Subcontractors of waiver services receive reimbursement through the Operating Agencies. TA Waiver for Adults providers who contract with Medicaid to provide private duty nursing services are issued an (8) eight-digit Alabama Medicaid provider number that enables the provider to receive direct reimbursement for services rendered.

NOTE:

All eight or nine digits are required when filing a claim.

Providers of waiver services are assigned a provider type of 78 (Waiver Service). Valid specialties for these providers include the following:

- Elderly and Disabled Waiver (ED)
- SAIL Waiver (EC)
- MR Waiver (EE)
- Living at Home Waiver (EF)
- Technology Assisted (TA) Waiver for Adults (EG)
- HIV/AIDS Waiver (EH)

Enrollment Policy for Waiver Service Providers

To participate in the Alabama Medicaid Program, providers must meet the following requirements:

- Must have a contractual agreement with Medicaid directly or through an Operating Agency
- Must meet the provider qualifications as outlined in the approved Waiver Document for the appropriate HCBS waiver.

107.2 Benefits and Limitations

The following table lists the services covered by each type of waiver:

Waiver	***Services Covered***
Elderly and Disabled Waiver	Case Management Services Homemaker Services Personal Care Services Adult Day Health Services Respite Care Services (Skilled and Unskilled) Companion Services Home Delivered Meals (Frozen Shelf-Stable and Breakfast Meals)
SAIL Waiver	Case Management Services Personal Care Services Environmental Accessibility Adaptations Personal Emergency Response System (PERS) Initial Setup Personal Emergency Response System (PERS) Monthly Medical Supplies Assistive Technology Evaluation for Assisted Technology Assistive Technology Repairs Personal Assistance Services
Home- and community-based services for MR waiver	Residential Habilitation Training Residential Habilitation-Other Living Arrangement Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Prevocational Services Supported Employment Occupational Therapy Services Speech and Language Therapy Physical Therapy Behavior Therapy-(Levels 1-3) Companion Services In-Home Respite Care Out-of-Home Respite Care Institutional Respite Personal Care Personal Care on Worksite Personal Care Transportation Environmental Accessibility Adaptations Specialized Medical Equipment and Supplies Skilled Nursing(RN/LPN) Assistive Technology Crisis Intervention Community Specialist

Added: Specialized Medical Equipment and Supplies

Deleted: ~~Medical Supplies~~

Waiver	*Services Covered*
Home and community-based services for Living at Home Waiver	In-home Residential Habilitation Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Supported Employment Prevocational Services In-Home Respite Out-of-Home Respite Personal Care Personal Care on Worksite Personal Care Transportation Physical Therapy Occupational Therapy Speech Therapy Behavior Therapy-(Levels 1-3) Skilled Nursing Environmental Accessibility Adaptations Specialized Medical Equipment Community Specialist Crisis Intervention
Home and community-based services for Technology Assisted (TA) Waiver for Adults	Private Duty Nursing (RN/LPN) Personal Care/Attendant Service Medial Supplies and Appliances Assistive Technology
Home and community-based services for HIV/AIDS Waiver	Case Management Services Homemaker Services Personal Care Services Respite Care Services (Skilled and Unskilled) Skilled Nursing Services Companion Services

107.2.1 Financial Eligibility

Financial eligibility for the E&D waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Individuals who would be eligible for SSI if income from parent(s) or a spouse were not deemed available to them

Financial eligibility for the MR waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate

Financial eligibility for the SAIL waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation

- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial eligibility for Living at Home Waiver is limited to the following individuals:

- Individuals receiving SSI

Financial eligibility for Technology Assisted Waiver for Adults and the HIV/AIDS Waiver is limited to the following individuals:

- Individuals receiving SSI
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.2 Medical Eligibility

Eligibility criteria for the E&D,TA Waiver for Adult and HIV/AIDS Waivers are based on current admission criteria for nursing facility care. Admission criteria are described in Chapter 26 of the non-state Provider Manual, Nursing Facility.

The target groups for SAIL Waiver Services must meet the admission criteria for a nursing facility. The HCBS provider must specifically provide services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60.

SAIL waiver services are provided, but not limited, to persons with the following diagnoses:

- Quadriplegia
- Traumatic brain injury
- Amyotrophic lateral sclerosis
- Multiple sclerosis
- Muscular dystrophy
- Spinal muscular atrophy
- Severe cerebral palsy
- Stroke
- Other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan Syndrome)

Eligibility criteria for HCBS for MR and LHW recipients are the same as eligibility criteria for an ICF-MR facility. MR and LHW persons who meet categorical medical and/or social requirements for Title XIX coverage will be eligible for HCBS under the waiver. Applicants found eligible are not required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care. In addition to the financial and medical

eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.3 Limitations

Medicaid does not provide waiver services to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting under the SAIL and HIV/AIDS waivers. SAIL and HIV/AIDS case management activities to facilitate the transition are limited to a maximum of 180 days prior to discharge into the community.

Medicaid or its operating agencies may deny home and community-based services if it determines that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; and if an individual meets the goals and objectives of being on the waiver program.

NOTE:

SAIL waiver recipients must be age 18 years or older. LHW & MR waiver recipients must be age 3 years or older. TA waiver recipients must be age 21 or older and must have received private duty nursing services through the EPSDT Program under the Alabama Medicaid State Plan. HIV/AIDS Waiver recipients must be age 21 or older.

107.2.4 Explanation of Covered Services

This section describes the covered services available through the HCBS Waiver Program. Please note that descriptions for services may differ from program to program.

Adult Day Health Services (S5102/Modifier UA - E&D)

Adult Day Health Service provides social and health care for a minimum of 4 hours per day in a community facility approved to provide such care. Adult Day Health Service includes health education, self-care training, therapeutic activities, and health screening.

Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in the HCBS Waiver for the Elderly and Disabled. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

A unit is defined as a per diem rate.

Homemaker Services (S5130/Modifier UA - E&D) (S5130/Modifier U6 – HIV/AIDS)

Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning and personal services. Provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or is unable to manage the home and care for himself.

A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

A unit is defined as 15 minutes.

Case Management Services (T1016/Modifier UA - E&D) (T1016/Modifier UB - SAIL) (T1016/Modifier U6-HIV/AIDS)

Case management is a system under which a designated person or organization is responsible for locating, coordinating, and monitoring a group of services. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. The case manager is also responsible for authorization of waiver services, terminations, and transfers and maintenance of recipient records.

Case management is provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

Case management activities under the SAIL & HIV/AIDS Waiver may also be used to assist individuals residing at least 90 days in institutional settings, such as hospital and nursing facilities, to transition into community setting. Transitional case management services may be provided up to 180 days prior to discharge from an institution.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UA - E&D) (T1019/Modifier U6 – HIV/AIDS)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

A person providing personal care services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and supervised by a registered nurse, and meet the qualifications of a Personal Care Attendant as specified in the approved waiver document. This service cannot be provided by a family member.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UB - SAIL)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

This person may be a relative or a friend of the relative when documentation shows that a relative or friend is qualified and there is proof of a lack of other qualified providers in a remote area.

A unit is defined as 15 minutes.

Respite Care (T1005/Modifier UA - E&D)
(T1005/Modifier U6 - HIV/AIDS)
Respite Care Unskilled (S5150/Modifier UA - E&D)
(S5150/Modifier U6 - HIV/AIDS)

Respite care is given to individuals unable to care for themselves on a short-term basis due to the absence or the need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual.

Respite care may be provided for up to a maximum of 720 hours per waiver year. Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual; this service cannot be provided by a family member.

A unit is defined as 15 minutes. The maximum number of units that can be billed is 2,880 per waiver year.

Companion Services (S5135/Modifier UA - E&D)
S5135/Modifier U6 – HIV/AIDS)

Companion services provide support and supervision that is focused on safety and non-medical care such as the following:

- Reminding recipient to bathe, to take care of personal grooming and hygiene, and to take medication
- Observing or supervision of snack and meal planning
- Accompanying recipient to necessary medical appointments and grocery shopping
- Assisting with laundry and light housekeeping duties that are essential to the care of the recipient.

Under no circumstances should any type of skilled medical service be performed. Companion services are provided in accordance with a therapeutic goal and are not purely recreational in nature. A person providing companion services must meet the qualifications of a companion worker as specified in the approved waiver document.

A unit is defined as 15 minutes.

NOTE:

Companion services are only available to recipients who live alone, and may not exceed four hours daily.

Day Habilitation (T2020/ Modifier UC/HW— MR-Level 1)
(T2020/Modifier UC/TF-MR-Level 2)

(T2020/Modifier UC/TG-MR-Level 3)

(T2020/Modifier UC/HK-MR-Level 4)

(T2020/Modifier UC/HW/SE-MR-Level 1-w/transportation)

(T2020/Modifier UC/TF/SE-MR-Level 2-w/transportation)

(T2020/Modifier UC/TG/SE-MR-Level 3-w/transportation)

(T2020/Modifier UC/HK/SE-MR-Level 4-w/transportation)

(T2020/Modifier UD/HW - LHW - Level 1)
(T2020/Modifier UD/TF - LHW - Level 2)
(T2020/Modifier UD/TG - LHW - Level 3)
(T2020/Modifier UD/HK – LHW – Level 4)

(T2020/Modifier UD/HW/SE – LHW –Level 1-w/transportation)

(T2020/Modifier UD/TF/SE – LHW – Level 2-w/transportation)

(T2020/Modifier UC/TG/SE- LHW – Level 3-w/transportation)

(T2020/Modifier UC/HK/SE – LHW – Level 4-w/transportation)

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home or facility in which the recipient resides.

Services are normally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. If a recipient attends Day Habilitation for less than four (4) hours as a result of a physician visit, and the transportation and escort is provided by the Day Habilitation Program staff, reimbursement will be permitted.

Day Habilitation Training services are provided by a Habilitation Aide and supervised by a Qualified Mental Retardation Professional (QMRP) in coordination with the individual's plan of care. The Habilitation Aide will be required to complete the training requirements as outlined in the waiver document.

*****The level utilized for Day habilitation services in the LHW is determined by the individual's ICAP score.

The provider for Day Habilitation services can be reimbursed based on eight levels of services.

A unit is defined as a per diem rate.

Residential Habilitation Training (T2016/Modifier UC –MR)

Residential Habilitation Training provides intensive habilitation training including training in personal, social, community living, and basic life skills.

Staff may provide assistance and training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

Residential Habilitation Training services may be delivered or supervised by a Qualified Mental Retardation Professional (QMRP) in accordance with the individual's plan of care. Residential Habilitation Training services can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

A Habilitation Aide is required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR. Retraining will be conducted as needed, at least annually.

A unit is defined as a per diem rate.

Respite Care - In Home (S5150/Modifer UC - MR)
(S5150/Modifier UD - LHW)

Respite Care - Out-of-Home (T1005/Modifier UC –MR)
(T1005/Modifier UD LHW)
Respite Care – Institutional (T2044/Modifier UC-MR)

Respite care is given to individuals unable to care for themselves on a short term basis due to the absence or the need for relief of persons normally providing the care. Respite care may be provided in the recipient's home, place of residence, or a facility approved by the State which is not a private residence.

Respite care out of the home may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, respite care out of the home may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out of

home respite, no additional Medicaid reimbursement will be made for other services in the institution.

This service cannot be provided by a family member.

A unit is defined as 15 minutes. For institutional respite, a unit is defined as a per diem rate.

Residential Habilitation - Other Living Arrangement (OLA)
(T2017/Modifier UC –MR)
(T2017/Modifier UD - LHW)

Residential Habilitation Training in other living arrangements is a service under which recipients reside in integrated living arrangements such as their own apartments or homes. The basic concept of this service is that for some individuals, learning to be independent is best accomplished by living independently.

These services are delivered in the context of routine day-to-day living rather than in isolated "training programs" that require the individual to transfer what is learned to more relevant applications. Habilitation may range from a situation where a staff member resides on the premises to those situations where the staff monitors recipients at periodic intervals.

The staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

Residential habilitation training services for individuals in other living arrangements may be delivered or supervised by a QMRP in accordance with the individual's plan of care. Residential habilitation training can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR. Retraining will be conducted as needed, at least annually.

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

A unit is defined as 15 minutes.

Supported Employment (T2018/Modifier UC –MR)
(T2018/Modifier UD – LHW)

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment also includes activities needed to sustain paid employment by waiver recipients, including supervision and training.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

When supported employment services are provided at a work site in which persons with disabilities are employed, payment will be made only for the adaptations, supervision, and training required by waiver recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business settings.

Supported employment services are not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or Section 602 (16) and (17) of the Education of the Handicapped Act.

Routine transportation, as by van within a 15-mile radius, is included in the fee for these services. This does not preclude other arrangements such as transportation by family or public conveyance.

A unit is defined as a per diem rate.

Prevocational Services (T2014/Modifier UC –MR)
(T2014/Modifier UD – LHW)

Prevocational services are not available to recipients who are eligible for benefits under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Education of the Handicapped Act.

Prevocational services prepare an individual for paid or unpaid employment, but are not job task oriented. Prevocational services include teaching such concepts as compliance, task completion, attention, problem solving, and safety.

Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Waiver recipients are compensated at a rate of less than 50 percent of the minimum wage.

A unit is defined as a per diem rate.

Physical Therapy (97110/Modifier UC-MR) (97110/Modifier UD-LHW)

Added: Physical Therapy (97110/Modifier UC-MR) (97110/Modifier UD-LHW)

Physical therapy includes services that assist in determining an individual's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

Such services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

Deleted: ~~Personal Care (T1019/Modifier UC-MR) (T1019/Modifier UC/HW – MR) (T1019/Modifier UD – LHW) (T1019/Modifier UD/HW LHW~~

This service also helps with progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

Physical Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Physical Therapist must meet all state licensure requirements and be designated as a regulated Physical Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Occupational Therapy Services (97535/Modifier UC –MR) (97535/Modifier UD – LHW)

Occupational therapy services include the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure or obtain necessary function.

Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Occupational Therapist must meet all state licensure requirements and be designated as a regulated Occupational Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Speech and Language Therapy (92507/Modifier UC –MR) (92507/Modifier UD – LHW)

Speech and language therapy services include screening and evaluation of individuals with speech and hearing impairments. Comprehensive speech and language therapy is prescribed when indicated by screening results.

This service provides treatment for individuals who require speech improvement and speech education. These are specialized programs designed for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

Therapists may also provide training to staff and caregivers (such as a recipient's family and/or foster family). The Speech/Language Therapist must meet all state licensure requirements.

A unit is defined as 15 minutes.

Personal Emergency Response System (PERS)
(S5160/Modifier UB - Installation - SAIL)
(S5161/Modifier UB – Monthly - SAIL)

PERS is an electronic device that enables certain high-risk patients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated. Prior authorization is required for S5160.

A unit is defined as a monthly rate.

Added: (T1019/Modifier UD/HW-LHW)

Personal Care (T1019/Modifier UC –MR) (T1019/Modifier UC/HW – MR)
(T1019/Modifier UD – LHW) (T1019/Modifier UD/HW-LHW)

Personal care services are services provided to assist residents with activities of daily living such as eating, bathing, dressing, personal hygiene, and activities of daily living. Services may include assistance with preparation of meals, but not the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting, and vacuuming, which are essential to the health and welfare of the recipient.

While in general personal care will not be approved for a person living in a group home or other residential setting, under the MR Waiver and LHW, personal care may be approved by the Division of Mental Retardation for specific purposes that are not duplicative.

Effective October 1, 2006, personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate procedure code for this service, provided at the worksite, to distinguish it from other personal care activities.

The personal care attendant will work under the supervision of a QMRP and will be observed every 90 days. The personal care attendant is also required to complete the training requirements prior to providing services.

A unit is defined as 15 minutes.

Personal Care Transportation (T2001/Modifier UD – LHW)
(T2001/Modifier UC – MR)

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. The Personal Care Transportation service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also

assure the most cost-effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

A unit is defined as a mileage rate.

Companion Services (S5135/Modifier UC –MR)

Companion services are non-medical supervision and socialization provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation and shopping, but may not perform these activities as discrete services.

The provision of companion services does not entail hands-on medical care.

Companions may perform light housekeeping tasks that are incidental to the care and supervision of the recipient.

This service is provided in accordance with a therapeutic goal in the plan of care and is not merely recreational in nature. This service must be necessary to prevent institutionalization of the recipient.

The person providing companion service must meet the qualifications of a companion worker as specified in the waiver document. They also must have completed all training requirements.

A unit is defined as 15 minutes.

Behavior Therapy

(H2019/Modifier UC/HP - MR - Level 1)

(H2019/Modifier UC/HN – MR- Level 2)

(H2019/Modifier UC/HM – MR-Level 3)

(H2019/Modifier UD/HP – LHW – Level 1)

(H2019/Modifier UD/HN – LHW – Level 2)

(H2019/Modifier UD/HM – LHW – Level 3)

Behavior Therapy Service provides systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration, whose health is at risk and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may include consultation provided to families, other caretakers and habilitation service providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried and its continued use must be reviewed and re-justified every thirty days.

The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to the supervision requirements described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

The maximum units of service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

Providers of service must maintain a service log that documents specific days on which services are delivered. Group therapy will not be reimbursed.

Providers at Level 1 must have either a Ph.D. or M.A. and be certified as a Behavior Analyst by the Behavior Analysis Certification Board.

Providers at level 2 must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years of experience working with persons with developmental disabilities. Level 2 providers with a doctorate do not require supervision and may provide all of the service functions. Master's degreed individuals require supervision equaling two hours per week by a level 1 provider or level two Ph.D. provider may provide all of the service functions. Level 3 providers must be either a QMRP (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst and work only in the technical service area. With two years experience and authorization by the Administering Agency, the Board Certified Behavior Analyst Associate may qualify as a level 2 provider and work in both the service component areas(professional and technical) with supervision.

All level 1 and 2 providers, certified or not, must complete an orientation training provided by DMH/MR.

A unit is defined as 15 minutes.

Environmental Accessibility Adaptations (S5165/Modifier UB – SAIL)
(S5165/Modifier UC –MR)
(S5165/Modifier UD – LHW)

Environmental modifications are those physical adaptations to the home, required by the recipient's plan of care, that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function with greater independence in the home. This service must be necessary to prevent institutionalization of the recipient.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient.

Environmental Modifications exclude adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver recipient, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are also excluded from this Medicaid-reimbursed benefit. All services provided must comply with applicable state or local building codes. This service requires prior authorization.

Total costs of environmental accessibility adaptations under the LHW shall not exceed $5,000 per year, per individual.

Under the SAIL Waiver the maximum amount for this service is $5,000 per recipient for the entire stay on the waiver. Any expenditure in excess of $5000 must be approved by the State Coordinator and the Medicaid designated personnel. This service may also be provided under the SAIL Waiver to assist an individual to transition from an institutional level of care to SAIL. The modifications should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver expenditures. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

A unit is defined as a per diem rate.

Specialized Medical Equipment
(T2029/Modifier UD - LHW)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient's plan of care, and they must be necessary to maintain the recipient's ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record. Medicaid reimbursement for this service under the LHW is limited to $5,000 per client, per waiver year.

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

A unit is defined as a per diem.

Specialized Medical Equipment and Supplies
(T2028/Modifier UC-MR)

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

Assistive Technology (T2029/Modifier UB – SAIL)
(T2029/Modifier UC MR)
(T2029/Modifier U5 - TA Waiver for Adults)

Assistive technology includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities.

Assistive technology services also includes any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application. Items reimbursed with waiver funds are in addition to any medical equipment furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the recipient. This service must be necessary to prevent institutionalization of the recipient. All items shall meet applicable standards of manufacture, design and installation. This service requires prior authorization.

The amount for this service under the TA Waiver for Adults is $20,000 per client. Any expenditure in excess of $20,000 must be approved by the Medicaid Agency. All assistive technology items on the TA Waiver for Adults require prior authorization.

The amount for this service under the SAIL Waiver is $15,000.00 per waiver recipient. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the designated Medicaid personnel.

A unit is defined as a per diem rate.

Skilled Nursing (S9123/Modifier UC–RN; S9124/Modifier UC- LPN - MR)
(S9123/Modifier UD - LHW)
(S9123/Modifier U6 – HIV/AIDS)

Skilled nursing services are services listed in the plan of care that are within the scope of the Alabama Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. This service must be necessary to prevent institutionalization of the recipient.

A unit is defined as 1 hour.

Medical Supplies (T2028/Modifier UB – SAIL)

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 and deodorant, etc.

These medical supplies will only be provided when authorized by the recipient's physician. Providers of this service will be those who have a signed provider agreement with Medicaid. Medicaid reimbursement is limited to $2,300 per recipient per waiver year for the SAIL Waiver.

A unit is defined as a per diem rate.

Evaluation for Assistive Technology (T2025/Modifier UB - SAIL)

This service will provide for an evaluation and determination of the client's need for assistive technology. The evaluation must be physician-prescribed, be provided by a physical therapist licensed to do business in the state of Alabama, and is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

When applicable, a written copy of the physical therapist's evaluation must accompany prior authorization request, and a copy must be kept in the recipient's file. This service must be listed on the recipients plan of care before provided. Reimbursement for this service will be the standard cost per evaluation, as determined by Alabama Medicaid and ADRS. This service must be necessary to prevent institutionalization of the recipient.

A unit is defined as a per diem rate.

Assistive Technology Repairs (T2035/Modifier UB - SAIL)

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items must meet applicable standards of manufacture, design and installation. Repairs must be arranged by the case manager and documented in the plan of care and case narrative. Prior authorization is not required for this service. Reimbursement for repairs shall be limited to $2,000 annually per recipient. Repair total must not exceed the amount originally paid for the equipment or device.

A unit is defined as a per diem rate.

Waiver Frozen Meals (S5170/Modifier UA - E & D)
Waiver Shelf-Stable Meals (S5170/Modifier SC - E & D)
Breakfast Meals (S5170 - E & D)

Home Delivered meals are provided to an individual age 21 or older who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home delivered meals.

This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability dependency, who require nutritional assistance to remain in the community and do not have a caregiver available to prepare a meal for them. Meals provided by this service will not constitute a full daily nutritional regimen.

This service will be provided as specified in the plan of care, which may include: seven (7) or fourteen (14) frozen meals per week. In addition to frozen meals, the service may include the provisions of two (2) or more shelf-stable meals (not to exceed six meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

A unit is defined as:

Seven-(7) pack of frozen meals equal to 1 unit.

Two (2) shelf-stable meals equal to 1 unit.

Seven-(7) pack of breakfast meals equal to 1 unit.

Personal Assistance Services (S5125/Modifier UB – SAIL)

Personal Assistant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual, if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on or off the job.

This service will support that population with physical disabilities who are seeking competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community, which employs an individual with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service must be sufficient in amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A unit is defined as 15 minutes.

Personal Care/Attendant Service (T1019/Modifier U5 – TA Waiver for Adults)

Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ALDs). It may include assistance with independent activities of daily living (IADLs) such as meal preparation, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client’s family.

PC/AS is designed to increase an individual’s independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

A unit is defined as 15 minutes.

Medical Supplies and Appliances (T2028/Modifier U5 – TA Waiver for Adults)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient’s plan of care, and they must be necessary to maintain the recipient’s ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record. Medicaid reimbursement for this service under the TA waiver is limited to $1,800 per client, per waiver year. An additional amount above that of $1,800 may be requested by the client and prior approved by Medicaid if medically necessary.

A unit is defined as a per diem rate.

Private Duty Nursing (S9123/Modifier U5 – RN; S9124/Modifier U5 – LPN - TA Waiver for Adults)

The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized. The objective of the Private Duty Nursing Service is to provide skilled medical monitoring, direct care, and intervention for individuals 21 and over to maintain him/her through home support. This service is necessary to avoid institutionalization and the individual must meet criteria outlined in the approved waiver document prior to receipt of services.

A unit is defined as 1 hour.

Community Specialist (H2015-UD – LHW)

(H2015-UC – MR)

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management.

A unit of service is defined as 15 minutes.

Crisis Intervention (H2011–UD - LHW)

(H2011-UC - MR)

Crisis Invention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual's removal from his current living arrangement.

When need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved by the regional community service office of the DMH/MR prior to the service being initiated.

Crisis intervention services will not count against the $18,000 per person per year cap in this waiver, since the need for the service cannot accurately be predicted and planned for ahead of time.

A unit of service is defined as 15 minutes.

107.2.5 Characteristics of Persons Requiring ICF-MR Level of Care Through the MR Waiver(formerly MR/DD) and Living at Home Waiver

Services provided in an intermediate care facility for the mentally retarded in Alabama are those services that provide a setting appropriate for a functionally mentally retarded person in the least restrictive productive environment currently available.

Generally, persons eligible for the ICF-MR level of care provided through the MR and LH Waiver need such a level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three (3) or more of the following areas of life activity:

- Self Care
- Receptive and expressive language
- Learning
- Self-direction
- Capacity for independent living
- Mobility

ICF-MR care requires the skills of a QMRP to provide directly or supervise others in the provision of services. ICF-MR services address the functional deficiencies of the beneficiary to allow the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment that promotes the individual's developmental process.

Determining Eligibility for MR and LH Waiver

Determination regarding eligibility for care under the MR & LH Waiver is made by a Qualified Mental Retardation Professional (QMRP). An interdisciplinary team (described below) recommends continued stay. The recommendation is certified by a QMRP and a physician.

Qualifications of Interdisciplinary Review Team

An interdisciplinary team consisting of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, recommends continued stay.

The nurse will be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person will have knowledge and training in the area of mental retardation or related disabilities with a minimum of two years' experience.

The social worker will be a graduate of a four-year college with an emphasis in social work. This person will have knowledge and training in the area of mental retardation or related disabilities with a minimum of two years' experience.

The psychologist will possess a Ph.D. in Psychology. This person will be a licensed psychologist with general knowledge of test instruments used with the mentally retarded or related disabilities with a minimum of two years' experience.

Other professional disciplines may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the recipients:

- Special Education
- Speech Pathologist
- Audiologist
- Physical Therapist
- Optometrist
- Occupational Therapist
- Vocational Therapist
- Recreational Specialist
- Pharmacist
- Doctor of Medicine
- Psychiatrist
- Other skilled health professionals

Individual Assessments

Medicaid requires an individual plan of care for each MR & LH waiver service recipient. The Individual Habilitation Plan (IHP) is subject to review by Medicaid and CMS.

The DMH/MR (or its contract service providers) use assessment procedures to screen recipients for eligibility for the Waiver services as an alternative to institutionalization. Assessment procedures are based on eligibility criteria for ICF-MR developed jointly by DMH/MR and Medicaid.

Review for "medical assistance" eligibility may be performed by a qualified practitioner in the DMH/MR, by its contract service providers, or by qualified (Diagnostic and Evaluation Team) personnel of the individual or agency arranging the service.

Recipients are re-evaluated on an annual basis. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

A written assessment is a method for determining a recipient’s current long-term care needs. This comprehensive instrument is used to access each individual recipient’s functional, medical, social, environmental, and

behavioral status. Information obtained should be adequate enough to make a level of care decision and for case managers to develop an initial plan of care.

Re-evaluations are done on an annual basis or when needed. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

107.2.6 Informing Beneficiaries of Choice

Medicaid is responsible for ensuring that beneficiaries of the waiver service program are advised of feasible service alternatives and receive a choice regarding which type of service they wish to receive (institutional or home- and/or community-based services).

Medicaid advises applicants for NF, ICF, ICF-MR services, or their designated responsible party, of feasible alternatives to institutionalization at the time of their entry into the waiver system. All applicants found eligible will be offered the alternative unless there is reasonable expectation that the services required would cost more than institutional care.

When residents of long-term care facilities become eligible for home and community-based services under this waiver, the resident will be advised of the available services and given a choice of service providers.

107.2.7 Cost for Services

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

107.2.8 Records Used for Medicaid Audits

Providers must maintain financial accountability for funds expended on HCBS and provide a clearly defined audit trail.

Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

The state agencies as specified in the approved waiver document as operating agencies of home and community-based services, will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments for services are adjusted to actual cost at the end of each waiver year.

The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

The state agencies as specified in the approved waiver document provide documentation of actual costs of services and administration. The Quarterly Cost Report includes all actual costs incurred by the operating agency for the previous quarter and include costs incurred for the current year-to-date. The

state agencies submit this document to Medicaid before the first day of the third month of the next quarter.

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed.

The providers of the HCBS waivers will have their records audited at least annually at the discretion of Medicaid. Medicaid will recover payments that exceed actual allowable cost.

Medicaid reviews recipients' habilitation and care plans and services rendered by a sampling procedure. The review includes appropriateness of care and proper billing procedures.

Providers of the HCBS waivers are required to file a complete uniform cost report of actual statistics and costs incurred during the entire preceding year. The cost reports for E&D and MR must be received by Medicaid on or before December 31. Cost reports for the SAIL Waiver must be received on or before June 1. Extension may be granted only upon written request. If a complete cost report is not filed by the due date or an extension is not granted, a penalty of $100 per day for each day past the due date will be imposed on the provider. The penalty will not be a reimbursable Medicaid cost. For detailed information on penalties see MR Waiver Fiscal Procedures Manual. Providers of the LHW, TA Waiver for Adults, and HIV/AIDS Waiver are not required to submit uniform cost reports. The method of payment is on a fee-for-service basis.

Quarters for MR and E&D are defined as follows:

Quarter	***Reporting Period***	***Due Date***
1st	October – December	Due before March 1
2nd	January – March	Due before June 1
3rd	April – June	Due before September 1
4th	July – September	Due before December 1

Quarters for SAIL are defined as follows:

Quarter	***Reporting Period***	***Due Date***
1st	January – March	Due before June 1
2nd	April – June	Due before September 1
3rd	July – September	Due before December 1
4th	October – December	Due before March 1

107.2.9 HCBS Payment Procedures

Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled.

The basis for the fees are usually based on audited past performance with consideration given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/02 to 11/15/02 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a previously paid claim, the claim will be rejected.

Payment will be based on the number of units of service reported on the claim for each procedure code.

The Operating Agencies (OA), as specified in the approved waiver document are governmental agencies and will receive actual cost for services rendered. The actual fee for service may differ among OAs.

Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

- A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.
- An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.
- The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since Administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Public Health (ADPH) and the Alabama Department of Senior Services (ADSS).

Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a six (6) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

NOTE:

The operating agencies are governmental; therefore, the interim rates for services must be adjusted to cost and the claims for services provided during that year must be reprocessed to adjust payments to the actual cost incurred by each operating agency. The rates for each service for each operating agency may differ. For the E&D waiver, operating agencies have 120 days from the end of a waiver year to file their claims. The operating agencies for MR, and SAIL waivers have 180 days from the end of a waiver year to file. Since the actual cost incurred by each operating agency sets a ceiling on the amount it can receive, no claims for the dates of service within that year will be processed after the adjustment is made. For the LHW and the HIV/AIDS Waiver, the operating agency must file all claims for services within 12 months from the date of service. For the TA Waiver for Adults, the providers must file all claims for services rendered within 12 months from the date of service provision.

107.2.10 Records for Quality Assurance Audits

The operating agencies for the E&D, MR, LH and HIV/AIDS waivers are required to maintain all records pertaining to the waiver recipients. They should also maintain the following information for audit purposes:

- Daily activity logs
- Narratives
- Evaluations and reevaluations
- Complaints and grievances
- Billing and payment records
- Plan of Care
- Delivery of services
- Any other important tools used to determine the success of the waiver services

This information is used to ensure that the state is in accordance with the approved waiver document and services are appropriate for the individual being served.

This information shall be made available to Medicaid and any other party in the contractual agreement at no cost.

NOTE:

Records for Quality Assurance audits for the TA Waiver for Adults conducted by the in-house Medicaid Reviewer will be maintained at the Alabama Medicaid Agency.

107.2.11 Appeal Procedure (Fiscal Audit)

Medicaid conducts fiscal audits of all services. At the completion of a field audit there will be an exit conference with the provider to explain the audit findings. The provider will have the opportunity agree or disagree with the findings.

Medicaid reviews the field audit and provider comments and prepares a letter to make the appropriate findings official. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Provider Audit Division, Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624.

Medicaid forwards decisions made as a result of the informal conference to the provider by letter. If the provider believes that the results of the informal conference are still adverse, the provider will have 15 days from the date of the letter to request a fair hearing.

Quality Assurance (QA) reviews are performed on an annual basis by Medicaid. At the end of this review there will be an exit conference with the providers to explain the findings. The provider will have an opportunity to agree or disagree.

Medicaid reviews the findings and prepares an official letter. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official review letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Quality Assurance Division, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

If the provider is not satisfied with the findings of the informal conference, the provider may request a fair hearing.

107.3 Prior Authorization and Referral Requirements

Certain procedure codes for waivers require prior authorization. Refer to Section 4, Obtaining Prior Authorization, for general guidelines.

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

Application Process

The case manager receives referrals from hospitals, nursing homes, physicians, the community, and others for persons who may be eligible for HCBS.

The plan of care, which is developed by the case manager and applicant's physician, is part of this assessment. The plan of care includes the following:

- Objectives
- Services
- Provider of services
- Frequency of services

The Alabama Medicaid Agency requires providers to submit an application in order to document dates of service provision to long term care recipients maintained by the long term care file. Application approvals will be done automatically through systematic programming. The LTC Admissions/Records Unit will perform random audits on a percentage of records to ensure that documentation exists to support the medical level of care criteria, physician certification, as well as other state and federal requirements.

Case managers and/or designated staff of the HCBS waiver Operating Agency(ies) will assess the client to determine the risk for institutionalization and determine if the medical level of care is met according to Medicaid criteria.

Assessment data will be entered and submitted electronically through the use of the EDS Bulletin Board System. If problems are encountered such as mismatched Social Security Numbers and/or Medicaid numbers, date conflicts, invalid provider numbers, or financial ineligibility, the auto-application will be denied and returned. Information will be provided to the user of the appropriate action(s) to take to correct the problem and will be allowed to resubmit the application.

The application, upon completion of processing, will systematically assign approval dates in one-year increments. For initial assessments, once the application is submitted with an indication of an initial assessment, the system will apply the begin date as the date of submission plus one year, which is extended to the last day of the month. For re-determinations, the application is submitted with an indication of a re-determination and the system will pick up the end date already on the file and extend for one year.

No charges for services rendered under the waiver program prior to the approval payment dates will be paid.

Application Process for TA Waiver for Adults

The Alabama Department of Rehabilitation Services (ADRS) targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services.

An assessment document will be completed by the targeted case manager, in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an

individual. Reasons for changes must be documented on the client's care plan, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency's Long Term Care Project Development/Program Support Unit.

The LTC Project Development/Program Support Unit will submit the medical application to our Associate Medical Director for review to determine if the individual meets the criteria for nursing facility care, in accordance with Rule No 560-X-10-.10 of the Alabama Medicaid Administrative Code. The LTC Project Development/Program Support Unit will submit the "Waiver/Slot Confirmation Form" to the District Office for processing financial determination.

If approved, the applicant and the targeted case manager will be notified in writing.

If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14 of the *Alabama Medicaid Administrative Code*.

When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be at least every six (6) months.

Fair Hearings

An individual whose application to the waiver program is denied may request a hearing through the appropriate operating agency (the Alabama Department of Public Health (ADPH), the Alabama Department of Senior Services (ADSS), the Alabama Department of Rehabilitation Services (ADRS), or the Alabama Department of Mental Health/Mental Retardation (ADMH/MR)). An individual whose application to the TA Waiver for Adults is denied may request a fair hearing through the Alabama Medicaid Agency.

An individual who is denied HCBS may request a fair hearing in accordance with Chapter 3 of the *Alabama Medicaid Administrative Code*.

Applicants will be notified in writing within ten days of denial or termination of service.

A written request for a hearing must be filed within 60 days following notice of action for which an individual is dissatisfied.

107.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Waiver service providers.

107.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Waiver service providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted. TA Waiver for Adults providers must file claims on a UB-92 claim form when filing hard copy. Medicare-related claims must be filed using the Institutional/Medicare-related claim form for TA Waiver recipients.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

107.5.1 Time Limit for Filing Claims

The operating agencies for the E&D waiver have 120 days at the end of the waiver year to process claims. The operating agencies for the MR and SAIL waivers have 180 days at the end of the waiver year to process claims. Living at Home Waiver, Technology Assisted Waiver for Adults and the HIV/AIDS Waiver claims are to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

107.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

Diagnosis Codes (SAIL)

SAIL Waiver services are limited to the following diagnosis codes:

277.00-277.9	330.0-337.9	343.0-344.9	430-438.0
310.0-310.9	340	359.9	711.00-716.99

107.5.3 Procedure Codes

The following procedure codes apply when filing claims for Elderly and Disabled Waiver services:

Code	***Description***	***PA Required?***
T1016-UA	Case Management	No
T1019-UA	Personal Care	No
S5102-UA	Adult Day Health	No
T1005-UA	Respite Care – Skilled— Billed per hour	No
S5150-UA	Respite Care – Unskilled	No
S5130-UA	Homemaker	No
S5135-UA	Companion	No
S5170-UA	Waiver Frozen Meals	No
S5170-SC	Waiver Shelf-Stable Meals	No
S5170	Waiver Breakfast Meals	No

The following procedure codes apply when filing claims for SAIL Waiver services. These services are limited to recipients age 18 and over.

Code	***Description***	***PA Required?***
T1016-UB	Case Management	No
T1019-UB	Personal Care Services	No
S5165-UB	Environmental Accessibility Adaptations	Yes
T2028-UB	Medical Supplies – (exempt from TPL)	No
S5160-UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-UB	Assistive Technology	Yes
S5125-UB	Personal Assistance Services	No
T2025-UB	Evaluation for Assistive Technology -.	No
T2035-UB	Assistive Technology Repairs.	No

The following procedure codes apply when filing claims for Mental Retardation services

Code	***Description***	***PA Required?***
T2020-UC & HW	Day Habilitation Services- Level 1	No
T2020-UC & TF	Day Habilitation Services-Level 2	No
T2020-UC & TG	Day Habilitation Services-Level 3	No
T2020-UC & HK	Day Habilitation Services-Level 4	No

Code	*Description*	*PA Required?*
T2020-UC & HW & SE	Day Habilitation Services w/ transportation- Level 1	No
T2020-UC & TF & SE	Day Habilitation Services w/transportation-Level 2	No
T2020-UC & TG & SE	Day Habilitation Services w/transportation-Level 3	No
T2020-UC & HK & SE	Day Habilitation Services w/transportation-Level 4	No
T2016-UC	Residential Services	No
S5150-UC	In-home Respite Care	No
T1005-UC	Out-of-Home Respite	No
T2044-UC	Institutional Respite	No
T2017-UC	Residential Services - Other Living Arrangements	No
T2018-UC	Supported Employment Services	No
T2014-UC	Prevocational Services	No
97110-UC	Physical Therapy	No
97535-UC	Occupational Therapy	No
92507-UC	Speech and language Therapy	No
T1019-UC	Personal Care	No
T1019-UC & HW	Personal Care on Worksite	No
T2001-UC	Personal Care Transportation	No
S5135-UC	Companion Services	No
H2019-UC & HP	Behavior Therapy-Level 1	No
H2019-UC & HN	Behavior Therapy-Level 2	No
H2019-UC & HM	Behavior Therapy-Level 3	No
S5165-UC	Environmental Accessibility Adaptations	No
T2029-UC	Assistive Technology	No
S9123-UC	Skilled Nursing-RN	No
S9124-UC	Skilled Nursing-LPN	No
T2028-UC	Specialized Medical Equipment & Supplies	No
H2015-UC	Community Specialist	No
H2011-UC	Crisis Intervention	No

The following procedure codes apply when filing claims for Living at Home Waiver services:

Code	**Description (All services exempt from TPL and MC)**	**PA Required?**
T2017-UD	In-Home Residential Habilitation	No
T2020-UD & HW	Day Habilitation (Level 1)	No
T2020-UD & TF	Day Habilitation (Level 2)	No
T2020-UD & TG	Day Habilitation (Level 3)	No
T2020-UD & HK	Day Habilitation (Level 4)	No
T2020-UD & HW & SE	Day Habilitations w/transportation – Level 1	No

Code	Description (All services exempt from TPL and MC)	PA Required?
T2020-UD & TF & SE	Day Habilitations w/transportation – Level 2	No
T2020-UD & TG & SE	Day Habilitations w/transportation - Level 3	No
T2020-UD & HK & SE	Day Habilitations w/transportation – Level 4	No
T2018-UD	Supported Employment	No
T2014-UD	Prevocational Services	No
S5150-UD	Respite In-Home	No
T1005-UD	Respite Out-of-Home	No
T1019-UD	Personal Care	No
T1019-UD & HW	Personal Care on Worksite	No
T2001-UD	Personal Care Transportation	No
97110-UD	Physical Therapy	No
97535-UD	Occupational Therapy	No
92507-UD	Speech Therapy	No
H2019-UD & HP	Behavior Therapy-Level 1	No
H2019-UD & HN	Behavior Therapy-Level 2	No
H2019-UD & HM	Behavior Therapy-Level 3	No
S9123-UD	Skilled Nursing	No
S5165-UD	Environmental Accessibility Adaptations	No
T2029-UD	Specialized Medical Equipment/Supplies	No
H2015-UD	Community Specialist	No
H2011-UD	Crisis Intervention	No

NOTE:

Effective for dates of service prior to January 1, 2007, all services for the LHW require prior authorization (PA). The PA number issued authorizes the service(s) to be provided, the length of time that the service(s) should be provided to the client, and the maximum units of each service that should be rendered to the individual as indicated in the authorized plan of care.

The following procedure codes apply when filing claims for TA Waiver for Adults services:

Code	*Description*	*PA Required?*
S9123-U5	Private Duty Nursing - RN	No
S9124-U5	Private Duty Nursing - LPN	No
T1019-U5	Personal Care/Attendant Service	No
T2028-U5	Medical Supplies and Appliances	No
T2029-U5	Assistive Technology	Yes

The following procedure codes apply when filing claims for HIV/AIDS Waiver services:

Code	*Description*	*PA Required?*
T1016-U6	Case Management Services	No
T1019-U6	Personal Care Services	No
T1005-U6	Respite Care Services – Skilled	No
S5150-U6	Respite Care Services - Unskilled	No
S5130-U6	Homemaker Services	No
S9123-U6	Skilled Nursing	No
S5135-U6	Companion Service	No

107.5.4 Place of Service Codes

The following place of service codes apply when filing claims for Waiver service:

POS Code	*Description*
12	Home (Residential) —MR Waiver, SAIL Waiver, LHW, TA Waiver for Adults, and the HIV/AIDS Waiver
21	Inpatient Hospital-SAIL Waiver and HIV/AIDS Waiver
31	Skilled Nursing Facility or Nursing Home-SAIL Waiver and HIV/AIDS Waiver
32	Nursing Facility-SAIL Waiver and HIV/AIDS Waiver
51	Inpatient Psychiatric Facility-SAIL Waiver and HIV/AIDS Waiver
54	Intermediate Care Facility/Mentally Retarded-SAIL Waiver and HIV/AIDS Waiver
99	Other Unlisted Facility —MR Waiver, Elderly & Disabled Waiver, LHW, TA Waiver for Adults, SAIL, HIV/AIDS

107.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

107.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
UB92 Claim Filing Instructions	Section 5.3

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108 Early Intervention Services

Early Intervention (EI) Services are specialty-oriented services delivered to infants/toddlers enrolled in Alabama's Early Intervention System (AEIS). Alabama's eligibility definition for Early Intervention is: a child birth to three years of age with a diagnosed mental or physical condition which has a high probability of resulting in developmental delay or who is experiencing a 25% delay in one or more of the five developmental areas: cognitive, physical to include vision/hearing, communication, social/emotional and adaptive. EI services include the following services provided in the natural environment unless otherwise denoted on the Individualized Family Service Plan (IFSP):

Early Intervention Services include:

- Intake Evaluation
- Basic Living Skills
- Audiology
- Family Support
- Physician Evaluation and Management Services
- Occupational Therapy (OT)
- Physical Therapy (PT)
- Psychological Testing
- Speech and Language Pathology
- Vision Services
- Treatment Plan Review

Eligible infants/toddlers receive EI Services through providers who contract with Medicaid to provide services to the eligible population.

108.1 Enrollment

EDS enrolls EI providers who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Standards For Serving Young Children With Disabilities and Their Families In Alabama* (EI personnel standards), the *Alabama Medicaid Administrative Code,* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an EI Provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursement for EI-related claims by Medicaid fiscal agent.

NOTE:

All nine digits are required when filing a claim.

- EI providers are assigned a provider type of 44 (Services).

Valid providers for Early Intervention through contractual agreements include the following:

- Alabama Institute for Deaf and Blind (AIDB)
- Children's Rehabilitation Services (ADRS/CRS)

NOTE:

CRS Specialty Clinics are not part of Early Intervention.

- Department of Mental Health/Mental Retardation (DMH/MR)
- Division of Early Intervention (ADRS/EI)

Enrollment Policy

Providers are qualified personnel who provide services within the natural environment unless otherwise denoted on the IFSP and provide services through a team approach.

Providers must meet recognized standards for infants/toddlers under AEIS and include the following disciplines, at a minimum:

- Audiologists
- Family Therapists
- Nurses
- Registered Dietitians
- Occupational Therapists
- Orientation & Mobility Specialists
- Physical Therapists
- Psychologists
- Social Worker
- Service Coordinators
- Special Instructors
- Speech & Language Pathologists
- Vision Specialists

108.2 Benefits and Limitations

All providers must participate in the development of the IFSP. All services must be provided as outlined on the IFSP.

Case management/service coordination is an integral part of Alabama's EI System. Case managers/service coordinators provide services such as evaluation/assessment, IFSP development, and coordination of services. Please see Chapter addressing Targeted Case Management for Handicapped Children.

IFSP Team

The IFSP teams are usually comprised of family support personnel, parents/family members, and other EI personnel as they relate to the identified needs of the infant/toddler. The team will establish a written IFSP. The IFSP team then implements this plan.

108.2.1 Covered Services

EI Services do not include services rendered under other Medicaid programs.

EI Services are covered when provided by a Medicaid-enrolled early intervention provider and are subject to retrospective review which may result in monies being recouped.

Types of covered services provided include, but are not limited to:

- Intake Evaluation
- Basic Living Skills
- Therapy (physical, speech/language, occupational)
- Family Support
- Audiology services
- Physician Evaluation and Management services
- Psychological testing
- Vision services
- Treatment Plan Review

An IFSP is required for each infant/toddler and Family Support Personnel is responsible for arranging specialty and needed services for the family.

The following is a description of each EI service. Please see the EI Services Grid for Billing Unit, Daily Maximum, Maximum Units and Billing Restrictions.

Intake Evaluation (90801 with TL modifier)

Definition

Initial evaluation to determine child's eligibility for EI. Child will undergo an evaluation of all five developmental areas with a second procedure to confirm delay in at least one of the developmental areas. The evaluator(s) will determine child's functioning level and provide written report which will indicate child's functioning level in terms of percentage of delay or no delay. Eligibility determination will be made by a multidisciplinary team. Ongoing assessment will be conducted to determine the child's continued eligibility for EI.

Key service functions include the following:

- A voluntary family assessment conducted in a personal interview
- Evaluation of the child's functioning level in the five developmental areas: cognitive, physical (includes vision & hearing), communication, social/emotional and adaptive
- Review of pertinent medical records or other developmental information
- Screening of vision and hearing
- Written report

Qualified staff

Evaluations & assessments may be performed by individuals who meet the test protocol for administering such tests as the Battelle, Bailey, Hawaii, E-LAP, DOCS, IDA, etc. These individuals include:

Added: (completion of the AEIS SI Core Curriculum is not required)

- Targeted case manager
- Family Support personnel (completion of the AEIS SI Core Curriculum is not required)
- Certified social worker licensed under Alabama law
- Occupational, Physical or Speech therapist licensed under Alabama law
- Audiologist licensed under Alabama law
- Individuals meeting ICC personnel standards for Family Training/Counseling/Home visits
- Registered nurse licensed under Alabama law
- Registered dietitian licensed under Alabama law
- Psychologist licensed under Alabama law
- School psychologist or psychometrist meeting Alabama's ICC personnel standards
- Individuals who have a bachelor's degree in ECSE/VI/HI with an Alabama Class B certification or who meet Alabama's ICC personnel standards

- Orientation & Mobility specialists as certified by the Association for Education & Rehabilitation of the Blind and Visually Impaired

Location

Service may be delivered in the child's natural environment or service provider location.

Basic Living Skills (H0036 with TL modifier)

Definition

Functional evaluation of the child in the child's natural environment. The purchasing, leasing or otherwise providing for the acquisition of assistive technology devices. Selecting, designing, adapting, or maintaining an AT device, in order to assist with basic living skills. Any training and/or technical assistance in developing or maintaining basic living skills to improve functional capacity.

Key service functions include the following:

- Evaluating the child's functioning level and determining need of assistive device
- Acquiring the device and providing maintenance or adaptation to the device.
- Providing child, family and providers on the appropriate use of the device so that the child receives the maximum benefit.
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Occupational, Physical or Speech therapist licensed under Alabama law
- Certified social worker licensed under Alabama law
- Rehabilitation technology specialist
- Other individuals as defined by the ICC Personnel standards

Location

Service may be delivered in the child's natural environment or service provider location.

Audiology (92507, 92508, 92510, 92531-92547, 92601, 92602, V5273, and V5299— all codes must be submitted with TL modifier)

Definition

Identification of children with auditory impairment. A determination of range, nature and degree of hearing loss and communication functions of the child. The provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training. The determination of the child's need for individual amplification, including selecting, fitting and dispensing appropriate listening and vibrotactile devices and evaluating the effectiveness of those devices.

Key service functions include the following:

- Identifying auditory impairment based on appropriate audiologic screening techniques
- Determining the range and degree of hearing loss and communication functions
- Providing auditory training, aural rehabilitation, speech reading and listening device orientation
- Selecting, fitting and dispensing appropriate listening and vibrotactile devices and evaluating the effectiveness of those devices
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Audiologist licensed under Alabama law
- Speech therapist licensed under Alabama law
- Hearing Aid Dealers
- Licensed Doctor of Medicine

Location

Service may be delivered in the child's natural environment or service provider location.

Family Support (H2027 with TL modifier)

Definition

Services provided to assist the family of an eligible child in understanding the special needs of the child and enhancing the child's development.

Preparing a social/emotional developmental assessment of the child within the family context. Making home visits to evaluate a child's living conditions and patterns of parent-child interaction. Working with the family's living situation (home, community and other locations where early intervention services are provided) that affect the child's maximum utilization of early intervention services.

Providing families with information, skills and support related to enhancing the skill development of the child. Working with the child to enhance the child's development. The planned interaction of personnel, materials, time and space that leads to achieving the outcomes in the child's IFSP. Promoting the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction.

Providing families with a single point of contact for EI services. Assisting and enabling the child/family eligible for EI to receive the rights, procedural safeguards and services authorized under the Individuals With Disabilities Education Act (IDEA), Part C.

Completing all EI procedural safeguard requirements to allow a child (referral) to go through the evaluation/assessment process to determine eligibility for early intervention. Discussion of what is available through early intervention and all rights will be reviewed with the family. Coordination of the evaluation to determine eligibility and results will be part of the intake process. Discussion of other resources if the child is found to be ineligible for EI.

Key service functions include the following:

- Training the family regarding specific information regarding the child's disability
- How to carry out activities as indicated on the IFSP
- Counseling related to the child's disability and the family's ability to cope with the child's condition
- Home visits are a support to accomplished activities under the IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP
- Identifying and coordinating community resources and services to enable the child and family to receive maximum benefit from EI services
- Providing individual and family-group counseling with parents and other family members, and appropriate social skill building activities with the child and parents
- Social/emotional developmental assessment
- Home visits to evaluate a child's living conditions

- Enhancing the developmental skills of the child
- Teaming with other therapeutic disciplines to conduct activities that support outcomes in the child's IFSP
- Providing structured intervention and a routine, functional approach to children diagnosed with autism spectrum disorder
- Coordinating the evaluations/assessments for the determination of the initial EI eligibility and ongoing eligibility
- Facilitating and participating in the development, review and evaluation of the IFSP to include all team members
  - Facilitating the timely delivery of services
  - Assisting families in gaining access to the EI services and other services identified in the IFSP
  - Coordinating and monitoring the delivery of appropriate EI services
  - Contact with family via telephone, home visit, etc.
  - Review of EI procedural safeguards
  - Providing the family with other resources and appropriately closing the child if the child is determined ineligible for EI

Qualified staff

Added: Individuals must meet… service under Medicaid.

Individuals must meet the ICC approved personnel standards. For those individuals required to complete the AEIS SI Core Curriculum, this must be accomplished prior to providing this service under Medicaid.

- Individuals with a Bachelor's degree in ECSE, VI or HI and an Alabama Class B teacher certification or who meet Alabama's ICC personnel standards
- Licensed Professional Counselor
- Marriage & Family Therapy Associate per Board approved rules
- Individual with a Master's degree in Rehabilitation Counseling
- Psychologist licensed under Alabama law
- Certified social worker licensed under Alabama law
- Individuals who have a bachelor's degree in a related human services field; such as, allied health, behavioral science, child/human/family development, child life families studies, communication disorders, education, health and recreation, health services administration, psychology, rehabilitation, social science, social welfare, sociology*
- Registered nurse under Alabama law*
- *Both groups of qualified staff must also complete "Journey Through EI in Alabama" (within 6 months of employment) and "Applications of Journey Through EI in Alabama (within first year of employment)

Location

Service may be provided in the child's natural environment or in the service provider location

Physician Evaluation and Management Services (99382 with TL modifier)

Definition

Services provided by a physician to determine a child's developmental status and need for early intervention services.

Key services functions include the following:

- To evaluate the child's on-going eligibility for AEIS.
- To determine if the child has a physical or mental condition that would make the child eligible, if no such diagnosis previously existed and the child was no longer experiencing a 25% delay to maintain eligibility for AEIS.
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Licensed doctor of medicine

Location

Service may be provided in the child's natural environment or in service provider location.

Occupational Therapy (97003, 97004, 97110, 97530, 97532, and 97533 — all codes must be submitted with the TL modifier)

Definition

Services to address the functional needs of the child related to adaptive development, adaptive behavior and play and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in the home and community settings.

Key service functions include the following:

- Identification, assessment and intervention
- Adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills
- Prevention or minimization of the impact of initial or future impairment, delay in development or loss of functional ability
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Occupational therapist licensed under Alabama law
- Occupational therapist assistant licensed under Alabama law and supervised by an licensed Occupational therapist

Location

Service may be provided in the child's natural environment or service provider location.

Physical Therapy (97001, 97002, 97110, 97112, 97530, 97532, 97533, and 97760— all codes must be submitted with the TL modifier)

Definition

Services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation.

Key service functions include the following:

- Screening, evaluation and assessment of infants and toddlers to identify movement dysfunction
- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Physical therapist licensed under Alabama law
- Physical therapist assistant licensed under Alabama law and supervised by a licensed Physical Therapist

Location

Service may be provided in the child's natural environment or in the service provider location

Psychological testing (96101 and 96102 with TL modifier)

Definition

Administering psychological and developmental tests and other assessment procedures. Interpreting assessment results. Obtaining, integrating and interpreting information about the child behavior and child and family conditions related to learning, mental health and development. Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training and education programs.

Key service functions include the following:

- Administering developmental tests
- Interpreting assessment results
- Planning psychological services and counseling to family related to the child's development
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Psychologist licensed under Alabama law
- Psychological technician licensed under Alabama law
- School psychologist certified by the Alabama State Department of Education for AA Certificate and/or holds the National Certification in School Psychology
- School Psychometrist certified by the Alabama State Department of Education for the A Certificate and/or listed in the Alabama Roster of Approved Psychologists and Psychometrists for Testing Children Referred for Placement in Special Education Classes

Location

Service may be provided in the child's natural environment or in the service provider location

Speech-Language Pathology (92506, 92507, 92508, and 92510— all codes must be submitted with the TL modifier)

Definition

Identification of children with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in the development of communication skills. Provision of services for the habilitation, rehabilitation or prevention of communicative or oropharyngeal disorders and delays in the development of communication skills.

Key service functions include the following:

- Identifying and evaluating delays in the development of communication skills
- Providing services to address the developmental delays of the child's communication skills
- Speech services include a variety of techniques, to include, but not limited to: speech, cued speech, auditory-verbal therapy, etc.
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Location

Service may be provided in the child's natural environment or in service provider location.

Vision services (99173 with TL modifier)

Definition

Evaluation & assessment of visual functioning, including the diagnosis and appraisal of specific visual disorder, delays and abilities. Referral for medical or other professional services necessary for the habilitation and rehabilitation of visual functioning disorders or both. Communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Key service functions include the following:

- Determining the visual functioning level of the child
- Orientation and mobility training for all environments
- Visual training
- Independent living skills training
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Individuals with a bachelor's degree in the Education of the Visually Impaired and have an Alabama Class B teacher certificate
- Orientation & Mobility specialists as certified by the Association for Education & Rehabilitation of the Blind and Visually Impaired
- Licensed doctor of Optometry or Ophthalmologist
- Occupational or Physical therapist licensed under Alabama law

Location

Service may be provided in the child's natural environment or in service provider location.

Treatment Plan Review (H0032 with TL modifier)

Definition

Review and/or revision of a client's IFSP by qualified staff members. Treatment outcomes will be written in family friendly terms, based on the family's priorities and concerns. A variety of disciplines may be involved based on the results of the multidisciplinary evaluation and assessment that determined the child's eligibility for EI. The meeting for this review will only occur if the family is present.

- The IFSP is reviewed with the family
- Treatment outcomes are functional in nature
- Modification or revision of treatment outcomes or services are made as necessary and coordinated through the Family Support Personnel
- After the initial IFSP is written, the plan will be reviewed, at a minimum, every six months

Qualified staff

See staff listed under previous EI services

Location

Service may be provided in the child's natural environment or in service provider location.

108.2.2 Reimbursement

Claims may be submitted for reimbursement for multiple early intervention services to a recipient on any given day. However, a provider may only submit one claim per day for a particular service to a recipient. For example, an infant may receive family support, special instruction and speech therapy all on the same day. Each face to face contact with the infant would constitute an encounter. Each discipline will be able to submit a claim for reimbursement: family support, the special instructor and speech therapist would submit for their individual services to the child per the IFSP. If a provider is qualified to provide more than one EI service then each claim for reimbursement and documentation should clearly distinguish which service was rendered and there should be a clear delineation of types of services to the infant/toddler.

Covered services are face-to-face contacts during which a professional team member provides an EI service to an infant/toddler. They are identified based on the data from the individual EI records.

The definition of a professional team member depends upon the type of service being delivered.

108.2.3 Maintenance of Records

The provider must make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider will permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. The provider maintains complete and accurate fiscal records that fully disclose the extent and cost of services.

The provider maintains documentation of progress notes and dates of service.

The provider maintains all records for a period of at least three years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three-year period, the provider retains the records until the legal action is resolved. The provider must keep records in a format that facilitates the establishment of a complete audit trail in the event the items are audited.

108.3 Prior Authorization and Referral Requirements

Early Intervention codes do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

A Patient's First referral is **not** required for EI Services.

108.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by EI Providers.

108.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

EI Providers that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Online adjustment functions
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

108.5.1 Time Limit for Filing Claims

Medicaid requires all claims for EI services to be filed within one year from the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

108.5.2 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

108.5.3 Place of Service

Claims should be filed with Place of Service (POS) Code 11 (office) or 12 (home).

The following procedure codes have been approved for billing by Early Intervention providers.

EI Services Grid

(All these Procedure Codes **require** a TL modifier)

Procedure Code	***Billing Unit***	***Daily Maximum***	***Maximum Units-Annual***	***Description***	***Same Day Services Not Allowed (Billing Restrictions)***
90801	Episode	3	6	Intake Evaluation	All other EI services except TCM and Family Support Personnel NOTE: Two different disciplines may bill for this service on the same day.
H0036	1	2	24	Basic Living Skills	May not be billed by two different disciplines on the same day with the same provider specialty
92507 92508 92510 92531-92547 92601 92602 V5273 V5299	1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1	104 104 240 48 96 96 1 12	Audiology services	May not be billed by two different disciplines on the same day with the same provider specialty
H2027	15 min	24	600	Family Support	May not be billed by two different disciplines on the same day with the same provider specialty. SW may not be provided in conjunction with services from AL Dept of Human Resources
99382	30 min	4	10	Physician Evaluation and Management Services	May not be billed by two different disciplines on the same day with the same provider specialty
97003 97004 97110 97530 97532 97533	1 1 15 min 15 min 15 min 15 min	1 1 4 4 4 4	1 1 192 192 192 192	Occupational Therapy	May not be billed by two different disciplines on the same day.

Procedure Code	*Billing Unit*	*Daily Maximum*	*Maximum Units-Annual*	*Description*	*Same Day Services Not Allowed (Billing Restrictions)*
97001 97002 97110 97112 97530 97532 97533 97760	1 1 15 min 15 min 15 min 15 min 15 min 15 min	1 1 4 4 4 4 4 4	1 1 192 192 192 192 192 192	Physical Therapy	May not be billed by two different disciplines on the same day.
96101 96102	1 hour 1 hour	5 5	48 48	Psychological testing	May not be billed by two different disciplines on the same day with the same provider specialty
92506 92507 92508 92510	1 1 1 1	1 1 1 1	6 104 104 240	Speech-Language Pathology	May not be billed by two different disciplines on the same day with the same provider specialty
99173	1	1	52	Vision services	May not be billed by two different disciplines on the same day with the same provider specialty
H0032	30 min	7	21	Treatment Plan Review	Individuals must be part of the IFSP team and only one person per discipline can bill for this service on any given day

108.5.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

108.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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A Well Child Check-Up (EPSDT)

The purpose of EPSDT services is:

- To actively seek out all eligible families and educate them on the benefits of preventive health care
- To help recipients effectively use health resources and encourage them to participate in the screening program at regular intervals
- To provide for the detection of any physical and mental problems in children and youth as early as possible through comprehensive medical screenings in accordance with program standards
- To provide for appropriate and timely services to correct or ameliorate any acute or chronic conditions

This appendix offers information about the EPSDT program. It consists of the following sections:

Section	***Contents***
Understanding EPSDT	Provides an overview of EPSDT, including descriptions of screening types and services offered under EPSDT
Performing Screenings	Provides information on becoming an EPSDT screening provider, verifying recipient eligibility, critical components of screenings, and how to submit claims for EPSDT screenings
Providing and Obtaining Referrals	Describes the process for providing referrals to specialists and obtaining referrals from screening providers. This section includes instructions for Patient 1st and non-Patient 1st recipients.
Coordinating Care	Describes the administrative requirements of the EPSDT program, including consent forms and retention of medical records.
Off-site Screenings	Provides an overview of the off-site screening program, including enrollment requirements, components required, eligibility verification, referral process and reimbursement information.
Vaccines for Children	Describes the Vaccines for Children program, including enrollment instructions, which procedure codes to bill, how to bill for administration fees, and a copy of the immunization schedule.

A.1 Understanding EPSDT

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age.

The EPSDT program was expanded in the Omnibus Budget Reconciliation Act of 1989 to allow additional services. The acronym EPSDT stands for:

Early	A Medicaid-eligible child should begin to receive high quality preventive health care as early as possible in life.
Periodic	Preventive health care occurring at regular intervals according to an established schedule that meets reasonable standards of medical, vision, hearing, and dental practice established by recognized professional organization.
Screening	A comprehensive, unclothed head-to-toe physical examination to identify those who may need further diagnosis, evaluation, and/or treatment of their physical and mental problems.
Diagnosis	The determination of the nature or cause of physical or mental disease, conditions, or abnormalities identified during a screening.
Treatment	Any type of health care or other measures provided to correct or ameliorate defects, physical and mental illnesses, or chronic conditions identified during a screening.

Periodicity Schedule

Periodic screenings must be performed in accordance with the schedule listed below. This schedule is based upon the recommendations of the American Academy of Pediatrics Guidelines for Health Supervision III.

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- Annually through 20 years of age beginning with third birthday

NOTE:

Medicaid will reimburse for only one screening per calendar year for children over the age of three. Screening benefit availability may be verified through AVRS, EDS Provider Electronic Solutions software, or the Provider Assistance Center at EDS. Please refer to Chapter 3, Verifying Recipient Eligibility, for more information.

If a periodic screening has not been performed on time according to the periodicity schedule (for instance, if the 2 months' periodic screening was missed), a screening may be performed at an “in between” age (for example, at 3 months) and billed as a periodic screening. In other words, the child should be brought up to date on his/her screening according to his/her age. Re-screenings should occur within 2 weeks (before or after) of the established periodicity schedule. This policy applies to recipients 0-24 months of age.

EPSDT screenings fall under six broad categories:

Type of Screening	***Description***
Initial Screening	Initial screenings indicate the first time an EPSDT screening is performed on a recipient by an EPSDT screening provider.
Periodic Screening	Periodic screenings are well child checkups performed based on a periodicity schedule. The ages to be screened are 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child’s third birthday.
Interperiodic Screening	Interperiodic screenings are considered problem-focused and abnormal. These are performed when medically necessary for undiagnosed conditions outside the established periodicity schedule and can occur at any age.
Vision Screening	Vision screenings must be performed on children from birth through age two by observation (subjective) and history. Objective testing begins at age three, and should be documented in objective measurements.
Hearing Screening	Hearing screenings must be performed on children from birth through age four by observation (subjective) and history. Objective testing begins at age five, and should be recorded in decibels.
Dental Screening	Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Beginning with age three, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A.2 Using PT+3 with EPSDT services

A patient education method (PT+3) has recently been developed for working with illiterate or marginally literate individuals. The PT+3 allows providers to make the most of patient contacts as opportunities to provide developmentally appropriate information for recipients and their families.

The acronym PT+3 means:

P = Personalize the problem

T = "TAKLE" the problem:

- T = set a Therapeutic Tone,
- A = Assess the knowledge level of the patient,
- K = provide Knowledge,
- L = Listen for feedback,
- E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

PT+3 is a standardized protocol that provides the skills and structure for health care providers to assist young or marginally literate patients in learning and remembering essential points from a health care encounter. PT+3 is designed to increase patient knowledge and compliance. Patients seem to like and understand the simplified information and providers like the process. Using PT+3 saves time for providers and enhances the medical visit for the recipient. PT+3 enables individuals to remember the most important aspects of the medical visit.

Specially designed low literacy materials are available for children (EPSDT Brochures), teens, ("How to Talk to Your Children"), and adults ("Facts about Birth Control") and are free to providers including EPSDT, Patient 1st, and Medicaid family planning providers who receive training in the use of the PT+3 method of education. For more information regarding PT+3, please fax your request to (334) 353-5203, attention "Outreach & Education." Please include your name and telephone number.

A.3 Performing Screenings

This section describes becoming an EPSDT screening provider, verifying recipient eligibility, scheduling screenings, critical components of screenings, and submitting claims for EPSDT screenings.

A.3.1 Becoming an EPSDT Screening Provider

Participation as an EPSDT screening provider is voluntary. To become an EPSDT screening provider, a provider must be an approved Alabama Medicaid provider and must have a valid nine-digit Alabama Medicaid provider number. New providers should refer to Chapter 2, Becoming a Medicaid Provider, for instructions on receiving an application.

Current Medicaid providers who wish to become an EPSDT screening provider should contact the EDS Provider Enrollment Unit at the following address to obtain EPSDT screening provider enrollment forms, or you may download the information from Internet:

EDS Provider Enrollment
P.O. Box 241685
Montgomery, Alabama 36124-1685
1 (888) 223-3630
Internet:

Provider Types Eligible for Participation

Only certain Alabama Medicaid provider types may become approved EPSDT screening providers. In some cases, these providers are restricted to where they can perform screenings:

This Provider Type	***May Perform Screenings at the Following Locations:***
Physicians	Anywhere a physician is authorized to practice
Nurse practitioners	At a physician's office, Rural Health Clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital
Registered Nurses	At a rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital **NOTE:** Two-year degree RNs who wish to perform EPSDT screenings must first complete a Medicaid-approved pediatric health assessment course (PAC) or show proof of completion of a similar program of study. BSN's are exempt from taking a PAC.
Physician Assistants	At a physician's office, rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital

Providers are not limited to those who are qualified to provide the full range of medical, vision, hearing, and dental screening services. Although a qualified provider may be enrolled to furnish one or more types of screening services, the Alabama Medicaid Agency encourages qualified providers to provide the full range of medical, vision, hearing, and dental screening services to avoid fragmentation and duplication of services.

NOTE:

Medical screenings, including the physical, must be performed by a physician, certified nurse practitioner, registered nurse, or physician's assistant, who is approved to perform well child check-ups. Other trained personnel may perform some screening components (for instance, measurements or finger sticks).

Potential EPSDT off-site providers must submit specific documents (see Section A.6) and be approved to participate as an off-site provider.

A.3.2 Verifying Recipient Eligibility

Reimbursement will be made only for eligible Medicaid recipients. Eligibility and benefit limits should be verified **prior to rendering** services to **ANY** Medicaid recipient.

NOTE:

Every effort should be made to assure that medical, vision, and hearing screenings, including immunizations, are accomplished in one visit, and that fragmentation or duplication of screening services is prevented. Section A.7, Vaccines for Children, describes the immunization schedule.

Recipient eligibility should be verified before providing services for several reasons:

- It will inform you of recipient eligibility
- You will be informed if the recipient is assigned to a managed care provider and who the managed care provider is and his/her telephone number
- You may inquire further to determine how many screenings have been performed to determine benefit availability
- It will provide you with the 13th digit of the recipient's Medicaid number for claim filing purposes

Refer to Chapter 3, Verifying Recipient Eligibility, for the various options available and for general benefit information and limitations.

A.3.3 Outreach

Outreach activities are critical to successful health screening services. The outreach process assures that eligible families are contacted, informed, and assisted in securing health-screening services.

The Alabama Medicaid Agency, in conjunction with the Department of Human Resources, informs the applicant of EPSDT services. For those recipients who do not participate in Patient 1st, a list of current EPSDT screening providers are made available for selection by the recipient. SSI (Category 4) eligible recipients are informed of EPSDT services. Until a child is assigned to a managed care provider (usually notified by mail), the Medicaid-eligible child is permitted to see any Alabama Medicaid provider for EPSDT services without a referral from a managed care provider (i.e., Patient 1st provider).

Once the child has been assigned to a managed care provider, all subsequent visits to other providers must have a prior approved written referral (Form 362) from the managed care provider. However, the following recipients are exempt from the managed care program:

- Foster children
- Dual eligibles (Medicare & Medicaid)
- SOBRA-eligible adults
- Those in institutions and/or group homes
- Recipients in the Lock-in program (restricted to one physician and one pharmacy).

For more information regarding managed care systems, refer to Chapter 39, Patient 1st of this manual or call the Provider Assistance Center at (800) 688-7989.

The Alabama Medicaid Agency's goal is to provide effective outreach services for Medicaid-eligible recipients. EPSDT outreach efforts are aimed at two groups: (a) new Medicaid recipients and (b) all Medicaid-eligible recipients under 21 years of age who have not had a well child screening in the last 12 months. These recipients are notified annually. The recipient is informed about EPSDT services through an outreach letter and is encouraged to make an appointment for an EPSDT screening. Once the recipient is assigned a managed care provider, it is the managed care provider's responsibility to ensure screenings (well child checkups) are performed on time. For those recipients who do not participate in a managed care system, the EPSDT screening provider is responsible for ensuring the screenings are performed on time.

A.3.4 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

The scope of services include and are designed to support and assist your office personnel with identifying, contacting, coordinating, and providing follow up for visits with your office for children who are behind on their EPSDT screenings, immunizations, vision/hearing screenings, dental screenings, identify recipients who have high utilization of emergency room visits; follow up services for newborn hearing screenings, elevated blood lead levels, abnormal sickle cell and metabolic results; follow up on referrals, missed appointments, identify children at greatest risk for targeted outreach, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, EPSDT Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "General", then select "About". A list of EPSDT Care Coordinators by county and telephone numbers is available to support your office personnel.

A.3.5 Scheduling Screenings

The Alabama Medicaid Agency requires that persons requesting screening services receive the services within 120-180 days from the date the request was made. These persons should be given priority by the screening agency when scheduling appointments.

EPSDT selected providers and Primary Medical Providers (PMP) receive a periodic re-screen list each month. The provider should utilize the periodic re-screen list to notify the EPSDT-eligible recipient when the medical screening is due. An appointment should be made for the next screening on the periodicity schedule. These functions are an integral part of the full screening provider's responsibility and are essential for care coordination. Providers have a total of 120 days from due date or award date (listed on printout) to accomplish screening, necessary referral, and treatment for the recipients listed on the printout.

EPSDT-eligible Medicaid beneficiaries who request well child checkups must be provided regularly scheduled examinations and assessments at the intervals established by Medicaid policy.

Scheduling of initial and periodic screenings is the responsibility of the screening provider. Managed care providers are responsible for overall care coordination for medical, vision, hearing, and dental screenings for recipients who participate in a managed care program. The EPSDT screening provider is responsible for overall care coordination as listed above for those recipients who do not participate in a managed care system.

The EPSDT screening provider should not perform a screening if written verification exists or if notified by another provider that the child has received the most recent age appropriate screening. Also, the EPSDT screening provider should receive prior approval from the managed care provider (if applicable). An additional interperiodic screening may be performed if requested by the parent or if medically necessary.

Please refer to Section A.5, Care Coordination, for more information on screening provider responsibilities.

A.3.6 Critical Components of Screenings

This section describes critical components of periodic, interperiodic, and vision/hearing/dental screenings. It also describes recommended health education counseling topics by age group.

Periodic Screenings

Component	***Description***
Unclothed physical exam	This is a comprehensive head-to-toe assessment that must be completed at each screening visit and include at least the following: • Temperature, and height/weight ratio • Head circumference through age two • Blood pressure and pulse at age three and above • Measure body-mass index when clinically indicated Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
Comprehensive family/medical history	This information must be obtained at the initial screening visit from the parent(s), guardian, or responsible adult who is familiar with the child's history. The history must include an assessment of both physical and mental health development and the history must be updated at each subsequent visit.
Immunization status	Immunizations and applicable records must be updated according to the current immunization schedule of the Advisory committee on Immunization Practices (ACIP). Dates and providers must be recorded in the medical record indicating when and who gave the vaccines, if not given by the screening provider. The state law has been changed so that private and public healthcare providers may share immunization data. Medicaid recipients shall be deemed to have given their consent to the release by the state Medicaid Agency of information to the State Board of Health or any other health care provider, by virtue immunization data should be recorded in the medical record.

Component	*Description*
TB skin test	Children who should be considered for tuberculin skin testing at ages 4-6 and 11-16 years Children whose parents immigrated (with unknown TST status) from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown TST status) should be an indication for a repeat TST Children without specific risk factors who reside in high-prevalence areas; in general, a high-risk neighborhood or community does not mean an entire city is at high risk; rates in any area of the city may vary by neighborhood or even from block to block; physicians should be aware of these patterns in determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates Children at increased risk for progression of infection to disease: Those with other medical conditions including diabetes mellitus, chronic renal failure, malnutrition and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these persons are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosupressive therapy for any child with an underlying condition that necessitates immunosupressive therapy. Bacille Calmette-Guérin (BCG) immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus. Initial TST initiated at the time of diagnosis or circumstance, beginning at 3 months of age.* Table 2. Definitions of Positive Tuberculin Skin Test (TST) Results in Infants, Children, and Adolescents* TST should be read at 48 - 72 hours after placement **Induration >5mm** Children in close contact with known or suspected infectious cases of tuberculosis disease: Households with active or previously active cases if treatment cannot be verified as adequate before exposure, treatment was initiated after the child's contact, or reactivation of latent tuberculosis infection is suspected Children suspected to have tuberculosis disease: Chest radiograph consistent with active or previously active tuberculosis Clinical evidence of tuberculosis disease ‡ Children receiving immunosuppressive therapy ‡ or with immunosuppressive conditions, including HIV infection

Component	*Description*
TB skin test (cont.)	**Reaction ≥15mm** Children 4 years of age or older without any risk factors *These definitions apply regardless of previous Bacille Calmette-Guérin (BCG) immunization: erythema at TST site does not indicate a positive test. HIV indicates human immunodeficiency virus. + Evidence by physical examination or laboratory assessment that would include tuberculosis in the working differential diagnosis (e.g. Meningitis). ‡ Including immunosuppressive doses of corticosteroids
Developmental assessment	A comprehensive developmental history is required, if appropriate, to determine the existence of motor, speech, language, and physical problems or to detect the presence of any developmental lags. An age-appropriate developmental assessment is required at each screening. Documentation of the Developmental Assessment Tool should be present in the child's medical record. Information must be acquired on the child's usual functioning as reported by the child's parent, teacher, health care professional, or other knowledgeable individual. **Developmental screenings should be culturally sensitive and valid. Developmental screening assessments must be performed by a RN, BSN; CRNP, PA, or M.D.**
Nutritional status screening	Nutritional status must be assessed at each screening visit. Screenings are based on dietary history, physical observation, height, weight, head circumference (ages two and under), hemoglobin/hematocrit, and any other laboratory determinations carried out in the screening process. A plotted height/weight graph chart is acceptable when performed in conjunction with a hemoglobin or hematocrit if the recipient falls between the 10th and 95th percentile.
Health education including anticipatory guidance	Health education and counseling for parent(s) or guardian and the youth (if age appropriate) are required at each screening visit. Health education is designed to assist the parent in understanding what to expect in terms of development. Health education also provides information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Providers may use the PT+3 teaching method for anticipatory guidance counseling. PT+3 should be documented in the medical record (i.e., progress notes) listing the three points emphasized.

Vision Testing/Screenings

Vision screenings are available either as a result of the EPSDT referral or as a result of a request/need by the recipient. A subjective screening for visual problems must be performed on children from birth through age two by history and observation. Gross examinations should be documented as grossly normal or abnormal. Objective testing begins at age three. Visual acuity screening must be performed through the use of the Snellen test, Allen Cards, photo refraction, or their equivalent. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, perform a subjective assessment. The reason(s) for not being able to perform the test must be documented in the medical record. Proceed with billing the vision screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the vision screening. Be sure to complete the vision screening within 30-45 days from the original screening date.

If a suspected visual problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child check-ups, including routine vision and hearing screenings. Post payment reviews are performed to determine appropriate utilization of services.

Trained office staff may perform a vision screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a vision screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a vision screening
- Employee performs a vision screening under supervision on a minimum of three patients successfully.

Hearing Testing/Screenings

Hearing screenings are available either as a result of an EPSDT referral or as a result of a request/need by the recipient. A subjective screening for hearing problems must be performed on children from birth through age four by history and observation. Gross examination should be documented as grossly normal or abnormal. Objective testing begins at age five. Hearing screenings must be performed through the use of a pure tone audiometer at 500 and 4,000 Hz at 25 decibels for both ears. If a child fails to respond at either frequency in either ear, a complete audiogram must be done. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, do a subjective assessment. The reason(s) for not being able to complete the test must be documented in the medical record. Proceed with billing the hearing screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the hearing screening. Be sure to complete the hearing screening within 30-45 days from the original screening date.

If a suspected hearing problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Trained office staff may perform a hearing screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a hearing screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a hearing screening

- Employee performs a hearing screening under supervision on a minimum of three patients successfully.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child check-ups, including routine vision and hearing screenings. Post payment reviews are performed to determine appropriate utilization of services.

Dental Services

Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental screenings must be performed on children from birth through age two by observation/inspection and history. Beginning with age three, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A periodic oral examination is recommended once every six months for eligible Medicaid recipients under 21 years of age. Dental services include emergency, preventive, and therapeutic services as well as orthodontic treatment when medically necessary. A referral, or documentation that recipient is under the care of a dentist is required at age three and older. Follow-up is no longer mandatory. Any time a need for dental care is identified, regardless of the child's age, the child should be referred to a dentist.

Beginning with age one, providers should educate and document that caretakers have been advised of the importance (anticipatory guidance) of good oral healthcare and the need to make a dental appointment. Additional documentation suggestions include providing the caretaker with one of the following phone numbers: dentist, Agency's Dental Program phone number to assist with locating a dentist (334) 242-5997, or the Recipient Inquiry Unit (RIU) number to assist with locating a dentist (800) 362-1504.

Dental care under the Program is available either as a result of the EPSDT referral or as a result of request/need by the recipient. Conditions for each situation are as follows:

1. EPSDT Referral – If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is three years of age or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and treatment. After the recipient's dental care is initiated, the consultant's portion of the Referral Form (Form 362) must be completed by the dentist and the appropriate copy must be returned to the screening provider.
2. Recipient Seeking Treatment – If a recipient who has not been screened through the EPSDT Program requires dental care, care may be provided without having a Referral Form. Dental care provided on request of the recipient is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT screening provider to obtain a complete medical assessment.

NOTE:

Dental health care services are available for eligible children under age 21, as part of the EPSDT program. To obtain information about dentists, you may call the Dental Program at (334) 353-5959.

Laboratory Screenings

Laboratory screening procedures must be performed in coordination with other medical screening services at the same visit, whenever possible. If verifiable results are available from another provider that any required laboratory procedure was performed within 30 days prior to the screening visit and there is no indication of a diagnosis that would warrant that the test be redone, it is not necessary to perform the test again. However, the test results or a copy of the test results should be documented in the medical record.

NOTE:

Providers have the option of obtaining the Hgb or Hct and the lead test during the nine month or twelve month well child check-up (EPSDT screening).

The following is a list of tests and procedures of laboratory screenings:

Laboratory Test	***Description***
Metabolic screening	Alabama infants are screened through the Alabama Newborn Screening Program for six metabolic/inheritable disorders (Phenylketonuria, Hypothyroidism, Sickle Cell Disease, Galactosemia, Biotinidase, and Congenital Adrenal Hyperplasia). Effective September 2004, analytes will be tested for the following disorders: maple syrup urine disease, homocystinuria, tyrosinemia, citrullinemia, medium chain acyl-coa dehydrogenase deficiency (MCAD), propionic acidemia, methylmalonic academia, and carnitine transport defect. Testing for detecting disorders in amino acid, fatty acid oxidation and organic acid metabolism will be obtained by using Tandem Mass Spectrometry (MS/MS), and will be added as pilot studies are completed. Additional information on testing disorders may be obtained by accessing the Newborn Screening Program website at: www.adph.org/NEWBORNSCREENING/ . All screening tests are conducted by Alabama Department of Public Health's Bureau of Clinical Laboratories. All newborn testing through the screening program is mandated by **Statutory Authority Code of Alabama 1975, Section 22-20-3**. Every hospital or facility providing delivery services is required to screen all infants for these potentially devastating genetics disorders. A single PKU and T4 is adequate when performed at least 24 hours after birth in a well infant or when performed at 6-7 days of age in a premature or ill infant. Children with no record of the PKU, hypothyroidism, and CAH tests having been performed previously, during one of the neonatal visits, should be tested between birth and six months of age. Children over six months of age who have never been tested need only be screened when ordered by a physician. Routine second testing for galactosemia is not recommended, unless ordered by a physician. Confirmation of positive newborn screening test results is always necessary. Additionally, newborn screening programs should not preclude the pediatrician's assessment of clinical symptoms at any age. Parents of affected children identified through a screening should be routinely offered counseling concerning the occurrence and reoccurrence of the disorder in existing or prospective siblings. These services are available at genetic centers at the University of Alabama in Birmingham and the University of South Alabama in Mobile. It should be noted physicians should not bill for the laboratory tests performed by the Alabama Newborn Screening Program. However, procedure codes 36415 and 36416 with modifier 90 may be billed for the specimen collection when referred to an outside laboratory.

Laboratory Test	***Description***
Sickle Cell Disease and Sickle Cell Trait Screening	State law requires sickle cell screening at birth on all children. An abnormal hemoglobin is performed as part of the Alabama Newborn Screening Program. Please note for recipients less than 6 months of age, sickle cell testing will be reimbursed when performed by electrophoresis. If verifiable results are unobtainable for children from birth to six months of age, a repeat sickle cell test should be performed. Children over age one who have never been tested need only be screened when ordered by a physician. Counseling should be provided, when appropriate, for those with abnormal results. It is recommended that children identified as having sickle cell disease be referred to Comprehensive Sickle Cell Centers at the University of Alabama in Birmingham or the University of South Alabama in Mobile.
Public Health: Alabama Voice Response System (AVRS):	The Alabama Voice Response System (AVRS) is a Newborn Screening Information System, offered by the Alabama Department of Public Health. The AVRS provides 24-hour, seven days a week telephone reporting of screening results in 30 seconds or less directly through a toll free number, (800) 566-1556. The AVRS was designed to allow physicians quick access to Newborn Screening results. The AVRS requires pre-registration with the screening program and positive identification of the caller through two security checks. Physicians are prompted by the system to enter their state license number (preceded by zeros, if needed, to make a seven digit number), in addition to the entry of a four-digit personal identification number or PIN. Physicians may register with the program by completing the **Alabama Voice Response System Registration Form**. This form may be requested by calling the Newborn Screening Program at 334-206-2971 or by accessing the Newborn Screening website at: www.adph.org/NEWBORNSCREENING/ . Applicants will be notified when their form has been processed. Each physician chooses his individual PIN and records the number on the pre-registration form. The PIN must be four numeric characters. Physicians must have available the specimen kit number found on the filter paper collection form preceded by the year of the infant's birth **or** the mother's social security number. Information is provided by recorded voice messages. The infant's name and date of birth are spelled and verified by user response before any test results are given. Along with the test result, information is provided concerning the need for repeat testing or medical follow-up. Additional information may also be obtained by contacting the Newborn Screening Program at (334) 206-2971, (334) 206-5955 or (800) 654-1385.
Iron Deficiency Anemia Screening	Hematocrit or hemoglobin values must be determined at a medical screening visit between 1-9 months of age. However, providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. Hematocrit or hemoglobin must be determined, between 11-20 years of age, and as deemed medically necessary based on physical examination and nutritional assessment.
Urine screening	Urine screening must be performed at the medical screening visit at five years of age and at each visit between 11 and 20 years of age depending on the success in obtaining a voided urine specimen. If specimen is unobtainable, SNA (Specimen Not Available) should be documented. The required screening procedure is a dipstick that shows the measurement of protein and glucose. Urine obtained from recipients between 11 and 20 years of age should be checked for leukocytes.

NOTE:

The hgb or hct and the urine dipstick for sugar and protein are included in the screening reimbursement and should not be billed separately.

Laboratory Test	*Description*
Lead toxicity screening	All children must have a blood lead toxicity screening at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at 9 or 12 months of age. A lead toxicity screening is also required for any child 36 to 72 months of age who has not previously received a blood lead toxicity screening or who presents with symptoms of possible lead poisoning. All children should receive lead toxicity screenings since all children are vulnerable to blood lead poisoning. Children's blood lead levels increase most rapidly at 9-12 months of age and peak at 18-24 months of age. The screening test of choice is blood lead measurement (replaces the erythrocyte protoporphyrin (EP) test.
Other lab tests	There are several other tests to consider in addition to those listed above. Their appropriateness is determined by an individual's age, sex, health history, clinical symptoms, and exposure to disease. These may include, for example, a pinworm slide, urine culture, VDRL, GC cultures and stool specimen for parasites, ova, and blood. **Note:** The test for VDRL, gonorrhea cultures, intestinal parasites, and pinworms may be done by the Alabama Department of Public Health clinical laboratory, at NO cost to the EPSDT screening provider. The State lab slip must have "EPSDT Program" documented across the top. Other Medicaid approved laboratories may be used to run sickle cell and lead screening tests.

Risk Questionnaire

Providers should assess a child's risk of blood lead poisoning beginning at 9 months of age. Children determined to be at high risk of blood lead poisoning should receive parental education and nutritional counseling. Administering the Risk Assessment Questionnaire instead of a blood lead toxicity screening does not meet Medicaid requirements.

Does child live in or visit a home built before 1950? Yes = High Risk

Does child live in or visit a home built before 1978 under-

going renovation? Yes = High Risk

Does child have a sibling/playmate diagnosed with lead

poisoning? Yes = High Risk

Does child have household members who participate in a lead-

related occupation or hobby? Yes = High Risk

Does child live near lead smelters, battery recycling plants

or other industries likely to release atmospheric lead? Yes = High Risk

Interpretation of Lead Toxicity Screening Results

Interpretation of blood results and follow-up activities based on blood lead concentration are described below and has been adapted from Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention.

Capillary Sample Blood Lead Concentration (μg/dL)	Comments
< 10	Is not indicative of lead poisoning.
	Refer to Risk Questionnaire
	If low risk: perform a blood lead toxicity screening at 9-12 months and 24 months of age
	If high risk: Retest in 3 months. If 2nd test <10 μg/dL. Perform a blood lead toxicity screening at 9-12 months and 24 months of age.
10-14	Confirm with venous sample within 3 months
15-19	Confirm with venous sample within 1 month
20-44	Confirm with venous sample within 5 days.
45-59	Confirm with venous sample within 48 hours
60-69	Confirm with venous sample within 24 hours
>70	Confirm with venous sample immediately.

NOTE:

All capillary results that are > 10μg/dL, should be confirmed with a venous blood lead test.

Venous Sample Blood Lead Concentration	***Comments***
<10	Is not indicative of lead poisoning. Refer to Risk Questionnaire: **Low risk:** Perform a blood lead toxicity screening at 9-12 months and 24 months of age. **High risk:** Retest in 3 months. If 2nd test < 10 μg/dL, Perform a blood lead toxicity screening at 9-12 months and 24 months of age.
10-14	Refer for EPSDT care coordination via mailing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to the address on the bottom of the form within **5 days** of notification of results. Retest within 3 months with venous sample. Schedule retest and provide parental education and nutritional counseling.
15-19	Refer for EPSDT care coordination and environmental investigation via mailing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to the address on the bottom of the form within **5 days** of notification of results.

Venous Sample Blood Lead Concentration	***Comments***
	Retest within 3 months with venous sample. Schedule retest and provide parental education and nutritional counseling.
20-44	Refer for EPSDT care coordination and environmental investigation via mailing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to the address on the bottom of the form within **3 days** of notification of results. Retest within 3 months with venous sample or more often as determined by MD. Schedule retests and provide parental education and nutritional counseling.
45-59	Refer for medical treatment (chelation therapy) to MD within **24 hours** if asymptomatic; otherwise, refer for medical treatment immediately. Child should only return to a lead-safe environment after chelation therapy. Refer for EPSDT care coordination and environmental investigation via faxing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to (334) 206-2983 **immediately** upon notification of results. Retest within **1 month** with venous sample or more often as determined by MD. Schedule retest and provide parental education and nutritional counseling.
60-69	Refer for medical treatment (chelation therapy) to MD within **24 hours** if asymptomatic; otherwise, refer for medical treatment immediately. Child should only return to a lead-safe environment after chelation therapy. Refer for EPSDT care coordination and environmental investigation via faxing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to (334) 206-2983 **immediately** upon notification of results. Retest within **2 weeks** with venous sample or more often as determined by MD. Schedule retest and provide parental education and nutritional counseling.
>70 µg/dL	Refer for medical treatment (chelation therapy) to MD within **24 hours** if asymptomatic; otherwise, refer for medical treatment immediately. Child should only return to a lead-safe environment after chelation therapy. Refer for EPSDT care coordination and environmental investigation via faxing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to (334)206-2983 **immediately** upon notification of results. Retest **weekly** with venous sample or more often as determined by MD. Schedule retest and provide parental education and nutritional counseling.

NOTE:

The State Laboratory will supply microvettes, mailing containers and forms for obtaining blood lead levels at no cost to providers upon request. Please contact (334) 260-3400 to obtain additional information.

Public Health Department Services

EPSDT care coordination is initiated for children with a confirmed blood lead level of > 10 μg/dL. EPSDT care coordinators assess the family's social and environmental needs, develop case plan with goal of reducing blood lead levels, educate family regarding lead risk behaviors, schedule blood lead level retest, and refer to appropriate resources regarding lead screening guidelines. An environmental investigation is initiated for children with a confirmed venous blood lead level of ≥ 15 ug/dL. Environmentalists perform an environmental investigation on a residence to identify lead hazards and recommend interim control or abatement measure if necessary.

For clinical consultation contact: Case Management Coordinator, Alabama Childhood Lead Poisoning Prevention Project (334) 206-2933 and/or Pediatric Lead Poisoning Consultant, University of Alabama at Birmingham (800) 292-6678.

Environmental Lead

Environmental Lead Investigations is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Please refer to Chapter 101, County Health Departments, for more information.

Normal and Abnormal Diagnoses

An abnormal diagnosis should only be billed when a health problem is identified and is referred for further diagnosis and treatment services. These services may be self-referrals.

A normal diagnosis should be billed when no health problem is identified or when identified health problems are treated immediately (acute or one time problem) during the screening (same day) and no referral is made for further diagnosis and treatment services. A normal diagnosis should also be billed when the only referrals are for *routine* vision, hearing or dental services. Diagnosis codes that may be utilized to indicate a "normal" screening are, but are not limited to: V20.0-V20.2 and V70.0.

Interperiodic Screenings

EPSDT-eligible children may receive medical, vision, hearing, and dental services that are medically necessary to determine the existence of a suspected physical or mental illness or condition, regardless of whether such services coincide with the periodicity schedule for these services. Screenings that are performed more frequently or at different intervals than the established periodicity schedules are called **interperiodic screenings**. An interperiodic screening may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings are performed for undiagnosed medically necessary conditions outside the established periodicity schedule. Interperiodic EPSDT screenings are problem-focused and abnormal.

Interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary.

By performing an interperiodic screening and issuing and EPSDT referral form, physician office and other benefits will be "saved" for acute illnesses or other sickness. An interperiodic screening should be performed (where a history and problem-focused physical exam occurs) for suspected medical, vision, hearing, psychological, or dental problems in order for an EPSDT referral to be issued for further diagnosis and/or treatment. In this manner, the recipient will be referred for consultation and/or to a specialist for medically necessary and appropriate diagnostic tests and/or treatment. Vision/hearing screenings are to be performed/billed on the same date of service as an initial or periodic screening only. Vision/hearing screenings are limited to one each annually, beginning at age 3 for vision and 5 for hearing. However if a suspected vision/hearing/ dental/medical problem should manifest itself, an interperiodic screening should be performed in order for an EPSDT referral to be issued to a specialist or consultant. For more information regarding vision and hearing screenings, please refer to section A.3.5. For more information regarding dental, please refer to Chapter 13 Dentist. For dental EPSDT referral requirements, please refer to Chapter 13, Section 13.3.3.

An interperiodic screening may be performed based upon a request by the parent(s) or guardian(s), or based on the provider's professional judgment relative to medical necessity. The Alabama Medicaid Agency considers **any** encounter with a health care professional who meets the qualifications for participation in the EPSDT program to be an interperiodic screen, regardless of whether the health care professional is enrolled as a provider with the Agency.

A health developmental or educational professional who comes in contact with the child outside the formal health care system may also determine whether an interperiodic screening is medically necessary. The screening provider must document the person referring the child, and a description of the suspected problem, in the record.

Documentation requirements for interperiodic screenings are:

- consent;
- medical-surgical history update;
- problem-focused physical examination;
- anticipatory guidance/counseling related to the diagnosis made.

Interperiodic screenings 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. This policy will be in effect through December 31, 2006.

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 filed to Medicaid, in order to bypass benefit limitations. This policy will be in effect through December 31, 2006.

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"

NOTE:

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.

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

99233 EP for Inpatient interperiodic screenings

The new interperiodic screening codes will count against office /hospital visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child's primary insurance must be billed first, and then Medicaid as the payor of last resort.

See page A-24 for a crosswalk of codes used for Interperiodic Screenings.

Intensive Developmental Diagnostic Assessment

An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants' age zero to under two years, and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

NOTE:

Medical necessity is subject to retrospective review by the Alabama Medicaid Agency. Please refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for more information.

Interagency Coordination

The State of Alabama, in conjunction with the Interagency Coordinating Council and the Alabama Department of Rehabilitation Services will implement a system of services to the eligible population (20 USC Section 1471 et seq, Part H), with the assistance of agencies, programs, providers, and the families of eligible infants and toddlers with special needs.

The Alabama Medicaid Agency is one of nine state agencies that hold positions on the Interagency Coordinating Council. The Early Intervention Law legislates a statewide system of early intervention services for eligible infants and toddlers that is comprehensive and coordinated among all disciplines and providers involved, and encourages the development of a system of service delivery that includes parents' participation and input. Services that provide early intervention are to be coordinated across agency and provider lines.

The definition of a child eligible for early intervention includes infants and toddlers under age three inclusive, who are either (1) experiencing developmental delay equal to or greater than 25 percent as measure by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development; or (2) they have a diagnosed physical or mental condition which has a high probability of resulting n developmental delay are eligible for early intervention services. Early intervention services can include the following:

Audiology	Service coordination
Family training/counseling & home visits	Occupational therapy
Health	Nursing
Medical services for diagnostic/evaluation	Vision services
Nutrition	Physical therapy
Psychological services	Social work
Special instruction	Speech/language pathology
Assistive technology devices & services	Transportation

The Early Intervention Service Coordinator who receives the Child Find referral will contact the EPSDT or Patient 1st provider to obtain the EPSDT screening information and any other pertinent information. In order to coordinate services, once a well child check-up (EPSDT) has been completed and a developmental delay has been indicated, contact Child Find, (**800) 543-3098**. Please refer to the Early Intervention Child Find Referral Form at the end of this Appendix or visit Medicaid's website at: www.medicaid.alabama.gov .

NOTE:

You may refer a family to Alabama's Early Intervention System (AEIS) in addition to referring the child and family to other appropriate services. AEIS staff is located in seven districts in the state. Please call the toll free number if you are interested in information about local EI resources.

Recommended Health Education Counseling Topics

2 weeks-3 months
Nutrition - Spitting up
Hiccoughs
Sneezing, etc.
Safety
Need for affection
Immunizations
Skin and scalp care
Bathing frequency
How to use a thermometer
When to call the doctor

4-6 months
Nutrition
Safety
Teething and drooling/dental hygiene
Fear of strangers
Lead poisoning
Immunizations

7-12 months
Nutrition
Immunizations
Safety
Dental hygiene
Night crying
Separation anxiety
Need for affection
Discipline
Lead poisoning

13-18 months
Nutrition
Safety
Immunizations
Dental hygiene
Temper tantrums
Obedience
Speech development
Lead poisoning

19-24 months
Nutrition
Safety
Need for peer relationship
Sharing
Toilet training
Dental hygiene
Need for attention and patience
Lead poisoning

3-5 years
Nutrition
Safety
Dental hygiene
Assertion of independence
Type of shoes
Need for attention
Manners
Lead poisoning

6-13 years	14-21 years
Nutrition	Nutrition
Safety	Dental
Dental care	Safety (automobile)
School readiness	Understanding body anatomy
Onset of sexual awareness	Male/female relationships
Peer relationship (male and female)	Contraceptive information
Preputertal body changes	Obedience and discipline
Substance abuse	Parent-child relationships
Contraceptive information (if sexually active)	Alcohol, drugs, and smoking
	Occupational guidance
	Substance abuse

Providers may use the PT+3 teaching method for anticipatory guidance counseling. Providers should document PT+3 counseling was utilized and list the three points emphasized.

Billing Requirements

The table below provides billing information for EPSDT screening claims:

Topic	***Explanation***
Copayment	EPSDT recipients, under 18 years of age, are not subject to co-payments.
Prior Authorization	Screenings are not subject to prior authorization.
Referral	Please refer to Section A.4, Providing and Obtaining Referrals, for more information.
Time Limit for Filing Claims	One year from the date of service
Visit Limitations	An office visit is not billable on the same day with an EPSDT screening by the same provider or provider group.
Diagnosis Codes	The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.
Procedure Codes and Modifiers	The following procedure codes should be used when billing comprehensive EPSDT screening services: 99381-99385 with modifier EP Initial EPSDT Screening 99391-99395 with modifier EP Periodic EPSDT Screening 99173 with modifier EP Vision Screening – Annual 92551 with modifier EP Hearing Screening – Annual The following procedure codes, without a modifier, are used to identify interperiodic screenings, through 12/31/06. Interperiodic screening procedure codes should have abnormal diagnosis codes. 99391 Interperiodic EPSDT Screening (under 1 year of age) Deleted effective 12/31/06 99392- Interperiodic EPSDT Screening (age 1-4 years) Deleted effective 12/31/06 99393- Interperiodic EPSDT Screening (age 5-11 years) Deleted effective 12/31/06 99394-Interperiodic EPSDT Screening (age 12-17 years) Deleted effective 12/31/06 99395-Interperiodic EPSDT Screening (age 18-20 years) Deleted effective 12/31/06 Effective January 1, 2007 the interperiodic screening codes have changed. The following procedure codes (in service locations other than inpatient hospital) must be used: 99211EP-99215EP You must use an EP modifier in order to bypass office visit benefit limits.

Topic	*Explanation*
	For interperiodic screenings performed in an inpatient hospital setting, the following procedure code must be used: 99233EP You must use an EP modifier in order to bypass hospital visit benefit limits. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.
Intensive Developmental Diagnostic Assessment	The following procedure codes should be used when billing for an intensive development diagnostic assessment (a multidisciplinary comprehensive screening) for children under two years of age (limited to two per recipient) 96110 - Intensive developmental diagnostic assessment, normal findings 96111 - Intensive developmental diagnostic assessment, abnormal findings
Third Party Coverage	Providers are required to file with available third party resources prior to filing Medicaid. Preventive pediatric services and prenatal care are excluded from this requirement unless the recipient has managed care coverage or Medicaid pays the provider a global fee.
Reimbursement	Governmental screening providers (including physicians) will be paid on a negotiated rate basis, which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge, which is not to exceed the maximum allowable rate established by Medicaid.
EPSDT Indicator Reference	The EPSDT Indicator will be either a “Y” or “N”, as applicable, when using electronic claims only.

NOTE:

Well child check-up visits (initial, periodic, and interperiodic screenings) do not count against recipient's benefit limits of 14 physician office visits per calendar year. There is no co-pay for recipients under 18 years of age.

A.3.7 Patient 1st, Primary Care Case Management (PCCM) Referral Services

To participate in the PCCM program, physicians are required to:

- Provide an ongoing physician/patient relationship
- Provide primary care services, including prevention, health maintenance and treatment of illness and injury
- Coordinate all patient referrals to specialists and other health services
- Offer 24-hour availability of primary care or referral for other necessary medical services
- Use a preferred drug list

- Follow program procedures
- Participate in the enrollee grievance process
- Meet other minimum program criteria

Physicians who agree to serve as primary medical providers are paid fee components to provide case management services for their patients.

Please refer to the Alabama Medicaid Provider Manual, Chapter 39 for more information regarding the Patient 1st program.

NOTE:

The Patient 1st program does not extend or supersede any existing program benefit or program requirement.

A.3.8 Billing for Patient 1st Referred Services

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing. If a service does not require a Patient 1st referral it is not necessary to get a referral from the PMP and it is not necessary to retain a referral form in the recipient's medical record. A list of the Patient 1st services "requiring" and "not requiring" a written signed referral are listed in the Alabama Medicaid Provider Manual in Chapter 39.

When billing for referred services the PMP name/nine digit Medicaid provider number, and indicator "4" must be reflected on either the CMS-1500 (blocks 17, 17a, and 24H) by the specialty physician or on the UB-92 (block 2 and the indicator "A1" in block 24) if a hospital or outpatient clinic is providing the specialty services. If all fields are not properly coded, Medicaid will reject the claim. (Refer to Chapters 5, Filing Claims, and 39, Patient 1st, of the Provider Manual for claim instructions).

If a service performed by the billing provider does not require a Patient 1st referral, do not enter the name of a referring physician and/or the nine digit PMP number on the CMS-1500 (blocks 17 and 17a) or on the UB-92 Claim Form (block 2).

Please refer to Chapter 5, Filing Claims, for information regarding filing claims from a Patient 1st referral.

A.4 Providing and Obtaining Referrals

One of the primary purposes of the EPSDT services is to ensure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. A Medicaid eligible child who has received an EPSDT screening (well child check-up) may receive additional medically necessary health care. These services are considered above the normal benefit limitations and require a referral from an EPSDT screening provider and Patient 1st PMP, if applicable. Some of these referred services require prior authorization from the Alabama Medicaid Agency.

If a child is admitted to the hospital as a result of an EPSDT screening, the days will not count against the yearly benefit limit. Facility fees for outpatient visits will not count against the yearly benefit limit if the visit is the result of an EPSDT screening and referral. Services rendered by speech and occupational therapists are covered **only** as the result of an EPSDT screening.

A.4.1 Vision, Hearing, and Dental Referrals

If the EPSDT screening provider chooses to refer a recipient for vision, hearing, and/or dental services, the recipient must be referred to the appropriate provider for diagnosis and/or treatment. After the recipient's vision, hearing, and/or dental service is initiated, the consultant's portion of the EPSDT referral form must be completed by the consultant and the appropriate copy must be returned to the screening provider. Referral forms should be returned in 30 days, from the date of the appointment, or (if no appointment was made) from the date of the screening examination.

NOTE:

If the recipient is three years of age or older and is not under the care of a dentist, the recipient must be referred to a dentist for diagnosis and/or treatment. Follow-up on dental referrals is not required.

A referral form is completed by the screening provider when an abnormality or condition is noted during the child's screening that requires further diagnosis and/or treatment. The referring provider must document the condition(s) within the medical record (either in the medical history or physical exam portion). Medicaid has the right to recoup the screening service fees from the referring provider when a referral is made for a condition not documented in the medical record (in medical history or physical exam portion).

A.4.2 Referrals Resulting from a Diagnosis

If, as a result of a medical, vision, hearing, or dental screening, it is suspected or confirmed that the child has a physical or mental problem, the screening provider and Patient 1st PMP, if applicable, must refer the child without delay for further evaluation of the child's health status. Follow-up is required to assure that the child receives a complete diagnostic evaluation. Diagnostic services may include but are not limited to physical examination, developmental assessments, psychological and mental health evaluation, laboratory tests and any x-rays. Diagnosis may be provided at the same time or it may be provided at a second appointment.

The time limit for completing the referral form (Form 362) requires the form to be completed within 364 days of the date of the screening. If an abnormality or condition is noted during an EPSDT screening and an EPSDT referral form is not issued at the time (for example, sickle cell remission), an EPDST referral may be issued at a later date for the same diagnosis only (for example, sickle cell remission changes to sickle cell crisis). In this instance, the date utilized on the referral form will be the same as the date of the EPSDT screening where the abnormality/condition was noted. If another abnormality or condition occurs that was not diagnosed during an EPSDT screening, or if a condition has changed sufficiently so that further examination is medically necessary, an interperiodic screening should be performed (or periodic screening if it is due) to identify the problem.

EPSDT referrals are valid for one year from the date of the EPSDT screening. Therefore the maximum time an EPSDT referral is valid is 12 months from the date of the well child check-up (EPSDT screening). The EPSDT screening date must be current to be valid. The EPSDT screening date may not be backdated or future dated. The date of the EPSDT screening should be documented under “Type of Referral” on form 362, the Alabama Medicaid Agency Referral Form. The EPSDT screening date documented on the Referral Form is the date used to determine the length of time an EPSDT referral is valid (regardless of a Patient 1st referral). The “Length of Referral” is used to determine the amount of time the referral is valid from the referral date and is inclusive of all types of referrals (e.g., Patient 1st referral, EPSDT referral, Targeted Case Management, etc). Please refer to Appendix E, Medicaid Forms, for additional information.

Diagnosis and treatment services may be provided by the screening provider (self referral) or may be obtained by referral to any other practitioner or facility qualified to evaluate, diagnose, or treat the child's health problem.

NOTE:

The number of visits or months must be documented on the EPSDT referral form to be considered a valid referral.

A.4.3 Treatment

Treatment may include but is not limited to physicians' or dentists' services, optometrists' services, podiatrists' services, hospital services (inpatient and outpatient), clinic services, laboratory and X-ray services, prescribed drugs, eyeglasses, hearing aids, prostheses, physical therapy, rehabilitation services, psychological services, and other types of health care and mental health services.

If a condition requires a referral, it is the responsibility of the screening provider and Patient 1st PMP, if applicable, to:

- Document the abnormality discovered during the EPSDT screening in the record
- Determine what resources a child needs and to which provider he/she wishes to be referred (the recipient's freedom of choice of providers must be ensured)
- Make the appropriate referral in a timely manner

- Offer and provide assistance in scheduling the appointment

- Verify whether the child received the service. Referrals must be followed up within 30 days (excluding dental) from the date of the appointment with the consultant.

A.4.4 Completing the Referral Form

The Referral for Services Form 362 must be completed after a screening if further diagnosis and/or treatment are required for a child not assigned to a PMP. The referral form is completed when referring the recipient to other providers for services that were identified during the screening as medically necessary.

Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form.

Screening providers must include their nine-digit provider number, name, and address for those recipients who do not participate in managed care (i.e., Patient 1st).

PMPs must include their nine-digit provider number, name, and address for those recipients who participate in Patient 1st.

- The **screening provider** must document the time span in which the referral is valid. The maximum time span is 12 months from the date of the screening.

- The **consulting provider** must follow the appropriate billing instructions and guidelines for completion of the CMS 1500 claim form found in Chapter 5, Section 5.2.2 of the Alabama Medicaid Provider Manual.

NOTE:

Once benefit limitations have been exceeded, Medicaid will not pay for services without the EPSDT referral. This is important for patients with chronic conditions or a problem that will require numerous visits to treat. Providers should write the referral as soon as the condition is noted so that the regular benefits are not exhausted.

The referral form should follow the recipient for all services related to the condition noted on the form. If a child is screened with a particular condition noted and referred for further diagnosis, and another condition develops that is not noted on the referral form, the child must be re-screened in order to receive expanded benefits for the second condition noted. If not re-screened, the services rendered would count against the child's routine benefit limits.

NOTE:

If the screening provider refers a child to a consultant, it is the screening provider’s responsibility to follow up. However, if the managed care provider refers the child to a consultant, it is the managed care provider’s responsibility to follow up.

A.4.5 EPSDT Referrals for Patient 1st Recipients

Scenario: A child is referred by the PMP to be screened by a county health department and appears to have a foot deformity.

Procedure: The child **must** be sent to their assigned Primary Medical Provider (PMP) to obtain the PMP referral form. The PMP may choose to

- Provide the necessary treatment
- Refer the child to an orthopedic specialist
- Instruct the screening provider to complete the referral form

The PMP must complete the Alabama Medicaid Agency Referral Form (Form 362) if referring the child to a specialist. The name and address of the screening provider should be entered to reflect, in this scenario, the county health department. The screening provider number and signature will reflect the county health department number and the signature of the health department employee who performed the screening.

The referring/PMP number reflects the Alabama Medicaid provider number of the PMP. The consulting provider must use the PMP's number as the referring physician on the claim form.

In this scenario, the specialist may suggest surgery, braces, and/or therapy. All services approved by and referred by the PMP would then be covered by an EPSDT screening referral.

NOTE:
The PMP must be contacted and approve any and all referrals made by the specialist.

A.4.6 EPSDT Referrals for Non-Patient 1st Recipients

Scenario: A child is screened by a county health department and appears to have a foot deformity.

Procedure: This child is referred to a pediatrician. The pediatrician may then refer the child to an orthopedic specialist. The specialist may suggest surgery, braces, and/or therapy.

All services in this scenario are covered by the original EPSDT screening referral, which must follow the child from visit to visit. Each provider treating the condition diagnosed during the screening, and documented in the referral, must include the referring provider's number on the claim form. Please refer to Chapter 5, Filing Claims, for instructions on including the referring provider number on the claim form.

A.4.7 Billing Instructions for Referred Services

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.

NOTE:

Each line item on the CMS-1500 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.

Coordinating Care

The Alabama Medicaid Agency establishes the service standards and requirements that the providers must meet.

Providers of medical screening services are responsible for overall care coordination for those recipients that are not enrolled in a managed care system. For those recipients who are enrolled in a Managed Care system, it is the managed care provider’s responsibility for overall care coordination. These ongoing activities include scheduling, coordinating, follow-up, and monitoring necessary EPSDT screening and other health services.

Care coordination enhances EPSDT Program efficiency and effectiveness by assuring that needed services are provided in a timely and efficient manner and that duplicated and unnecessary services are avoided.

A.4.8 Consent Forms

Since EPSDT screenings are voluntary services, some parents of children may decline a screening. This does not preclude the child from receiving a screening at a later date or receiving medically necessary diagnosis, treatment or other health services separate from the screening, providing such services do not exceed normal benefit limitations.

A “Consent for Services” form must be signed at each visit by the responsible adult. The consent could be a permission form to treat or a signature reflecting the date the service is rendered (e.g., a sign-in sheet). The consent for services should be filed in the patient's permanent medical record. If a sign-in logbook is used, the provider will need to keep this record for a minimum of three years plus the current year. The responsible adult must be present at the time of the screening to give pertinent history and developmental status and to receive counseling as indicated. The absence of a responsible adult as defined above would invalidate the screening. When off-site screenings are performed, the parent may complete the history form prior to the screening in compliance with Off-Site Screening Protocol. Recipients 14 years of age or older may sign for themselves.

A.4.9 Medical Records

All screening providers must maintain complete records for three years plus the current year on all children who have received services or screened. Records of all EPSDT-eligible children must be made available to Medicaid upon request. Medicaid will monitor EPSDT services provided by screening physicians or agencies on a periodic basis. If Medicaid identifies claims paid where any three findings listed as critical components of the screening process are omitted, the claim may be adjusted.

Medical records must include the following documentation. The critical components of a well child check-up (comprehensive screening) are denoted with an asterisk.

- Consent signature
- * Family history of diseases and annual updates
- * Medical history and updates at each screening
- Mental health assessment
- * History of immunizations and administration as indicated
- * Age-appropriate developmental assessment
- * Age-appropriate anticipatory guidance
- * Nutritional assessment to include recorded results of hemoglobin/hematocrit and plotted height/weight
- * Documentation of sickle cell test results
- * Recorded results of hemoglobin/hematocrit
- * Urine test for protein and sugar
- * Lead testing/results (according to age)
- Tb skin test
- Height, weight, temperature, pulse, and blood pressure
- * Vision and hearing assessment/testing (Considered as two critical components)
- * Documentation of the unclothed physical examination
- * Dental referral/status for recipients 1 year of age and above
- * Failure to make appropriate referral, when required (i.e., medical, vision, hearing)
- * Referral follow-up on conditions related to medical, vision, or hearing problems

A.5 Off-site Screenings

Children are our state's most important assets and yet many of them arrive at school generally in poor health. The healthier a child, the greater his or her learning potential. The Alabama Medicaid Agency is committed to helping ensure that children are healthy and ready to learn. To that end, the Alabama Medicaid Agency has developed protocols for off-site EPSDT screenings. These services must be accessible to all children, not just Medicaid-eligible children.

NOTE:

EPSDT screening providers must also contact the recipient's primary medical provider (Patient 1st) to receive prior authorizations to perform the screening.

Off-site screenings are defined as screenings that are provided off-site from a medical facility, which is limited to hospitals, physician offices, Department of Public Health (DPH) clinics, and Federal/State certified clinics. Off-site screenings occur in schools, day care centers, head start centers, and housing projects.

An off-site EPSDT screening provider must develop and adhere to confidentiality policies set out by the respective agencies and should be submitted to the agency. Information pertinent to the child's performance may be shared. Information pertinent to infectious disease shall be released only by the County Health Officer. Sharing information with others outside the local agency may take place only if parental consent has been given.

Provider is defined as and will include only a county health department clinic, hospital, FQHC, IRHC, PBRHC, or a physician's office. A provider must be located within the county or within 15 miles of the county in which the off-site screenings occur. Medical personnel performing the physical examination are limited to physicians, certified registered nurse practitioners (CRNP), certified nurse midwives (CNM), physician assistants (PA), and registered nurses (RN) employed by the facilities listed above.

Clinic is defined as a certified medical facility, under the supervision of a physician that provides a full range of medical services on a regular basis. A clinic must be equipped to handle acute care situations and provide treatment and/or management of chronic diseases. Licensed medical personnel must perform medical services.

Medical facility is defined as a Federal/State certified clinic, hospital, physician's office, or a DPH clinic where diagnosis of health problems are rendered and treatment of diseases occur. The medical facility must have a permanent location, regularly scheduled hours of operation, and a published telephone number. Medical services and supplies must also be available for treatment of abnormal conditions identified at the time of an EPSDT screening.

Physician's office is defined as a place staffed by physician(s) and other medical professionals where medical activities, such as the practice of medicine, is conducted. This office is specifically designed and set up to provide medical diagnosis and treatment of medical conditions. This office is open and operating on a published, regularly scheduled basis with a published telephone number and regularly scheduled appointments.

A.5.1 Enrollment for Off-site providers

To be considered as an EPSDT screening provider for off-site screenings, potential providers must submit the following criteria:

- A letter documenting the ability to complete all components of a screening. The physical exam portion of the screening must be completed by an approved EPSDT screening provider: physician, nurse practitioner, physician assistant, or a registered nurse. All registered nurses, except BSNs, must complete a Medicaid-approved Pediatric Assessment course or show proof of having completed a similar program of study in their professional training that prepared them to perform pediatric health assessments.

- A primary care referral list of medical providers in the county to whom you will refer to services. The referral list must include pediatricians, family and/or general practice physicians, internal medicine physicians, vision and hearing providers, and dentists. All providers must agree to be on your referral list, therefore, you must submit their written agreement with your referral list. The list must be sufficient in number to allow recipients/parents a choice in the selection of a provider.

- Documentation to demonstrate that services will be offered to all children enrolled at an off-site location, not just Medicaid-eligible children. A copy of your fee schedule must be attached to your documentation and must include fees for non-Medicaid enrollees.

- Child abuse and confidentiality policies

- A signed Matrix of Responsibilities form between the off-site location authority (school superintendent, principal, day care director, etc.) and the screening provider. Only one screening provider will be approved per location.

NOTE:

Only RNs that are employed by a FQHC, RHC, Health Department, Physicians office, and hospital may perform off-site EPSDT screenings.

- A signed agreement/letter from a local physician to serve as Medical Director. This physician may be a pediatrician, family practice physician, general practice physician, or an internal medicine physician. Proof of 6 pediatric focused credits (CME) from the previous year must be included with the signed agreement. EXCEPTION: A board-certified pediatrician should submit a copy of current certification only. **The medical director is responsible for resolving problems that the nurses encounter and rendering care for medical emergencies.**

- A monthly schedule shall be maintained designating the dates, times, and the local agency in which you will be offering the EPSDT services. The monthly schedule should be readily available and retained in either the local agency/medical facility (i.e., the facility that has been approved as an off-site EPSDT screening provider) or the recipient's medical record. Failure to maintain schedules one week in advance of Off-site EPSDT screenings may result in termination and loss of revenue.

- A document, listing members of the Peer Review Coalition of community members to serve in an advisory capacity. The committee must have the opportunity to participate in policy development and program administration of the provider's off-site program and to advise the director about health and medical service needs within the community. The committee must be comprised of parents, school personnel, public health personnel and local physicians within the local community. Members must be familiar with the medical needs of low-income population groups and with the resources available in the community.

- Information packet materials, including letters, forms, and examples of anticipatory guidance information sheets to be used. These materials must be prior approved by Medicaid.

- A copy of the waiver certificate and/or CLIA number, issued by the Division of Health Care Facility, Bureau of Health Provider Standards for the State of Alabama Department of Public Health.

- A list of all physical locations at which EPSDT screenings will be provided. A separate provider number will be assigned to each off-site location and will be distinct from any other provider number. A separate application and contract is required for each off-site location.

A.5.2 Space for Screenings

The room in which screenings are done may vary according to the availability of space. Space to perform the screening assessment must include a well-lighted private room in close proximity to hot and cold running water, a bathroom, and a nearby waiting area.

A.5.3 Parent/Guardian Consent and Follow-up

Children under 14 years of age must have written consent from their parent/guardian before participating in the screening program. Children age 14 and above may consent for themselves. The parent/guardian should be encouraged to be present during the screening.

Once the health screening is complete, the parent/guardian must be informed of the results of the screening by mail or in a one-on-one meeting. The anticipatory guidance materials must be age appropriate and the material may be given to children 14 years of age and above. Documentation must reflect that anticipatory guidance materials were mailed to parent/guardian for recipients under 14 years of age.

NOTE:
The potential provider cannot begin well child check-ups (screenings) until approval has been authorized in writing and Medicaid has assigned off-site provider numbers.

A.6 Vaccines for Children

In an effort to increase the immunization levels of Alabama's children by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program on October 1, 1994,

This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled and eligible, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations ("underinsured"), if they obtain those vaccines from a Federally Qualified Health Center or Rural Health Clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 400,000 of Alabama's children are Medicaid enrolled.

A.6.1 Fees

Medicaid has taken the past vaccine and administration fee costs and calculated an equivalent reimbursement fee of $8.00 per dose. When multiple doses are given on the same visit, Medicaid will reimburse for each dose. When doses are given in conjunction with an EPSDT screening visit, an administration fee of $8.00 per dose will also be paid. When doses are given in conjunction with an office visit, an administration fee of $8.00 per dose will also be paid.

Providers should use the immunization(s) procedure code designated by the VFC Program when billing for the administration of an immunization. Please refer to section A.6.3 for the list of designated VFC procedure codes.

Medicaid VFC providers may give VFC vaccines to children who are Medicaid enrolled, non-Medicaid, uninsured, American Indian, or Alaskan Native. If a VFC vaccine is given to any of the above patients, with the exception of Medicaid enrolled, an administration fee not to exceed $14.26 for each vaccine administered may be charged. Underinsured patients must go to an FQHC, RHC, or county health department to receive VFC vaccines. An administration fee not to exceed $14.26 for each vaccine administered may be charged. No VFC-eligible patient should be denied immunizations because of an inability to pay the administration fee.

Physicians and health departments are not required to file recipient health insurance prior to filing Medicaid for preventive pediatric services, including administration fees for VFC. Exceptions to this rule require that all providers must file with a recipient's health plan when the plan is an HMO or other managed care plan. In addition, FQHCs and RHCs are required to file other insurance prior to filing Medicaid as are any providers receiving a lump sum payment for bundled services or a capitation payment from Medicaid.

A.6.2 Enrollment

The Department of Public Health is the lead agency in administering the VFC Program. Enrollment and vaccine order forms are available through the Immunization Division. Questions regarding enrollment should be directed to the VFC Coordinator at (800) 469-4599.

Participation in Medicaid is not required for VFC enrollment. Participation in the VFC Program is not required for Medicaid enrollment.

A.6.3 Vaccines for Children Billing Instructions

Providers must use an appropriate CPT-4 code on a CMS-1500 claim form in order to receive reimbursement for the administration of each immunization given from VFC stock.

When immunizations are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8.00 per injection will be paid for recipients 18 years or younger. The statewide fee-for-service rate will be paid for recipients 19 and 20 years old.

NOTE:

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

The following CPT-4 codes must be used when billing Medicaid for immunizations for any recipient under age 21:

CPT-4 Procedure Code	*Immunization*
90633	Hepatitis A, 2-dose pediatric formulation (12months-18years of age) – Eff. 2/1/06
90636	Hepatitis A & B, 3-dose adult formulation (18 years of age only) – Eff. 2/1/06
90645	Hemophilus influenza type b (Hibtiter)
90647	Hemophilus influenza type b (Pedvax)
90648	Hemophilus influenza type b (ActHib)
90649	Human Papilloma Virus (HPV) Vaccine, Types 6,11,16,18 (Quadrivalent), 3-dose schedule-Eff. 11/1/06 (9-18 years)
90655	Influenza, preservative-free (6-35 months) – Eff. 1-1-05
90656	Hemophilus influenza split virus, preservative free (3 years and older)
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90660	Influenza Virus Vaccine, Live, For Intranasal Use (LAIV) eff. 10/1/06 (5 years and older)
90669	Pneumococcal Conjugate vaccine 7 valent (Pnu 7)
90680	Rotavirus Vaccine, Pentavalent, 3 dose schedule, live, for oral use (6-32 weeks of age only) eff. 2/3/06
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR))
90708	Measles and Rubella Virus Vaccine, Live, for subcutaneous use (0-18 years of age)
90710	Measles, Mumps, Rubella, and Varicella (MMRV) vaccine, Live, for subcutaneous use (1-12 years of age) – Eff. 9/6/05

Added: 90708

CPT-4 Procedure Code	*Immunization*
90713	Poliomyelitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05
90716	Varicella (Chicken pox) vaccine *(for selected recipients)*
90718	Tetanus and Diptheria (Td) (*for adult use*)
90721	Diphtheria, Tetanus, Acellular Pertussis and *Hemophilus influenza type b,(DTaP-HIB) (1-5 yrs. of age)*
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Memingococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and *Hemophilus influenza b* (Hep B-Hib) (0-18 yrs of age)

A.6.4 ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us/ for more information.

A.6.5 Recommended Immunization Schedule

The chart on the next page provides the recommended immunization schedule or you may access the schedule at www.cdc.gov/nip.

The schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

A.6.6 Synagis

The drug Synagis must be prior authorized through Health Information Designs (HID) at 1-800-748-0130. The new form for prior authorization is available on our website at www.mediaid.alabama.gov under Programs: Pharmacy: Prior Authorizations/Override Criteria and Forms: Instruction Booklet for Form 369 and Form 351. The appropriate administration fee may be billed in addition to Synagis.

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Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

Vaccine ▼ / Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	HepB				HepB Series		
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP		DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib		Hib			
Pneumococcal[5]			PCV	PCV	PCV	PCV				PCV PPV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MPSV4	

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 0–6 years. Additional information is available at http://www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at **http://www.vaers, hhs.gov** or by telephone, **800-822-7967**.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:
- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg-negative, the birth dose can only be delayed with physician's order and mother's negative HBsAg laboratory report documented in the infant's medical record.

After the birth dose:
- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered at age ≥24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of ≥3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:
- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*
- Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*
- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*
- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHiBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged ≥12 months.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])*
- Administer PCV at ages 24–59 months in certain high-risk groups. Administer PPV to children aged ≥2 years in certain high-risk groups. See *MMWR* 2000;49(No. RR-9):1–35.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*
- All children aged 6–59 months and close contacts of all children aged 0–59 months are recommended to receive influenza vaccine.
- Influenza vaccine is recommended annually for children aged ≥59 months with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55(No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children receiving TIV should receive 0.25 mL if aged 6–35 months or 0.5 mL if aged ≥3 years.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*
- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.

8. Varicella vaccine. *(Minimum age: 12 months)*
- Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided that ≥3 months have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*
- HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Meningococcal polysaccharide vaccine (MPSV4). *(Minimum age: 2 years)*
- Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2007

Vaccine ▼ / Age ▶	7–10 years	11–12 YEARS	13–14 years	15 years	16–18 years
Tetanus, Diphtheria, Pertussis[1]	see footnote 1	Tdap	Tdap		
Human Papillomavirus[2]	see footnote 2	HPV (3 doses)	HPV Series		
Meningococcal[3]	MPSV4	MCV4	MCV4	MCV4[3]	MCV4
Pneumococcal[4]	PPV				
Influenza[5]	Influenza (Yearly)				
Hepatitis A[6]	HepA Series				
Hepatitis B[7]	HepB Series				
Inactivated Poliovirus[8]	IPV Series				
Measles, Mumps, Rubella[9]	MMR Series				
Varicella[10]	Varicella Series				

Range of recommended ages

Catch-up immunization

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at http://www.cdc.gov/nip/recs/child-schedule.htm. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). *(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)*

- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
- Adolescents aged 13–18 years who missed the 11–12 year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*

- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. *(Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])*

- Administer MCV4 at age 11–12 years and to previously unvaccinated adolescents at high school entry (at approximately age 15 years).
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
- Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7):1–21. Use MPSV4 for children aged 2–10 years and MCV4 or MPSV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). *(Minimum age: 2 years)*

- Administer for certain high-risk groups. See *MMWR* 1997;46(No. RR-8):1–24, and *MMWR* 2000;49(No. RR-9):1–35.

5. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 5 years for live, attenuated influenza vaccine [LAIV])*

- Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at high risk. See *MMWR* 2006;55 (No. RR-10):1–41.
- For healthy persons aged 5–49 years, LAIV may be used as an alternative to TIV.
- Children aged <9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for TIV and ≥6 weeks for LAIV).

6. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- The 2 doses in the series should be administered at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55 (No. RR-7):1–23.

7. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). *(Minimum age: 6 weeks)*

- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥4 weeks between the doses.

10. Varicella vaccine. *(Minimum age: 12 months)*

- Administer 2 doses of varicella vaccine to persons without evidence of immunity.
- Administer 2 doses of varicella vaccine to persons aged <13 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
- Administer 2 doses of varicella vaccine to persons aged ≥13 years at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

CS100131

Catch-up Immunization Schedule

UNITED STATES • 2007

for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Hepatitis B[1]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Rotavirus[2]	6 wks	4 weeks	4 weeks		
Diphtheria, Tetanus, Pertussis[3]	6 wks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 wks	4 weeks if first dose administered at age <12 months 8 weeks (as final dose) if first dose administered at age 12-14 months No further doses needed if first dose administered at age ≥15 months	4 weeks[4] if current age <12 months 8 weeks (as final dose)[4] if current age ≥12 months and second dose administered at age <15 months No further doses needed if previous dose administered at age ≥15 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	4 weeks if first dose administered at age <12 months and current age <24 months 8 weeks (as final dose) if first dose administered at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose administered at age ≥24 months	4 weeks if current age <12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose administered at age ≥24 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months			
Hepatitis A[9]	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	4 weeks	8 weeks if first dose administered at age <12 months 6 months if first dose administered at age ≥12 months	6 months if first dose administered at age <12 months	
Human Papillomavirus[11]	9 yrs	4 weeks	12 weeks		
Hepatitis A[9]	12 mos	6 months			
Hepatitis B[1]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	4 weeks if first dose administered at age ≥13 years 3 months if first dose administered at age <13 years			

1. **Hepatitis B vaccine (HepB).** *(Minimum age: birth)*
   - Administer the 3-dose series to those who were not previously vaccinated.
   - A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.
2. **Rotavirus vaccine (Rota).** *(Minimum age: 6 weeks)*
   - Do not start the series later than age 12 weeks.
   - Administer the final dose in the series by age 32 weeks. Do not administer a dose later than age 32 weeks.
   - Data on safety and efficacy outside of these age ranges are insufficient.
3. **Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).** *(Minimum age: 6 weeks)*
   - The fifth dose is not necessary if the fourth dose was administered at age ≥4 years.
   - DTaP is not indicated for persons aged ≥7 years.
4. ***Haemophilus influenzae* type b conjugate vaccine (Hib).** *(Minimum age: 6 weeks)*
   - Vaccine is not generally recommended for children aged ≥5 years.
   - If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12– 15 months and at least 8 weeks after the second dose.
   - If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.
5. **Pneumococcal conjugate vaccine (PCV).** *(Minimum age: 6 weeks)*
   - Vaccine is not generally recommended for children aged ≥5 years.
6. **Inactivated poliovirus vaccine (IPV).** *(Minimum age: 6 weeks)*
   - For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
7. **Measles, mumps, and rubella vaccine (MMR).** *(Minimum age: 12 months)*
   - The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
   - If not previously vaccinated, administer 2 doses of MMR during any visit with ≥4 weeks between the doses.
8. **Varicella vaccine.** *(Minimum age: 12 months)*
   - The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
   - Do not repeat the second dose in persons aged <13 years if administered ≥28 days after the first dose.
9. **Hepatitis A vaccine (HepA).** *(Minimum age: 12 months)*
   - HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.
10. **Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).** *(Minimum ages: 7 years for Td, 10 years for BOOSTRIX®, and 11 years for ADACEL™)*
    - Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
    - A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at age <12 months. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).
11. **Human papillomavirus vaccine (HPV).** *(Minimum age: 9 years)*
    - Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at **http://www.vaers.hhs.gov** or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at **http://www.cdc.gov/nip/default.htm** or telephone, **800-CDC-INFO (800-232-4636)**.

A.7 Required Screening Protocols

The following table lists medical, vision, hearing, and dental screening protocols for infants and children by recipient age. **Refer to the following page for adolescents.**

	Infancy						**Early Childhood**					**Middle Childhood**					
Age By	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	Mo	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**
Medical Screening [1]	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Initial/Interval History	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Measurements																	
Height and Weight	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Head Circumference	X	X	X	X	X	X	X	X	X								
Body-mass index (BMI) [8] – If clinically indicated									X	X		X	X	X	X	X	X
Blood Pressure/Pulse										<----------Annually---------->							
Developmental Assessment	S	S	S	S	S	S	S	S	S	<----------Annually---------->							
Physical Exam/Assessment [2]	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Procedures																	
Immunization	X	X	X	X		<-------X------->						<----X---->					
Metabolic Screening 9																	
Sickle Cell Screening 9																	
Anemia Screening	X----------					X											
Urine Screening [3]												X					
Lead Screening [4]					X+	**X**	X+	X+	**X**	X+		X+	X+	X+			
Nutritional Assessment	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X		S/X	<--------Annually-->				
Health Education [5]	X	X	X	X	X	X	X	X	X	X		X	<--------Annually-->				
Vision Screening [6]	S	S	S	S	S	S	S	S	S	O		O	O	O	O	O	O
Hearing Screening [6]	S	S	S	S	S	S	S	S	S	S		O	O	O	O	O	O
Dental Screening [7]						<----------Annually---------->											
TB Skin Test [8] **(TST)**	The decision to place a TST should be made after completing a risk assessment using A.3.5 and determining the tuberculosis prevalence in the community by contacting the local health officials.																

Key

X	Required at the visit for this age
X+	Perform blood lead level if unknown
S	Subjective by history and observation
O	Objective by standard testing methods
<----->	Annually
X-------X	One test must be administered during this time frame. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age.
<---X--->	Range in which a service may be provided, where X indicates the preferred age
1	If a child comes under care for the first time at any point of the schedule, or if any components are not accomplished at the recommended age, the schedule should be brought up to date at the earliest possible time.
2	The physical examination/assessment must include an oral/dental inspection.
3	Urine screening (dipstick) is done if clinically indicated and must be done at 5 years and 11-21 years of age.
4	All children are considered at risk and must be screened for lead poisoning. A blood lead test is required at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. **X** indicated lead screening is required. X+ indicates a screening blood lead test also is required for any Medicaid-eligible child 36 to 72 months of age who has not previously been screened for lead poisoning.
5	Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 to 20, must receive more intensive health education that addresses physiological, emotional, substance usage and reproductive health issues at each screening visit.
6	These screenings must be performed annually. Patient should be rescreened within 30-45 days if he/she is uncooperative.
7	A child must be referred for an annual complete dental screening beginning at age three to age 21 unless the child is under care. Anticipatory guidance should begin with age one.
8	Please refer to Section A.3.5, Critical Components of Screenings, for detailed information.
9	These laboratory tests **do not** need to be performed again if you have obtainable, verifiable results. Screen for PKU and other disorders prior to discharge or 24 hours after birth, according to state law. A single PKU is adequate when performed at least 24 hours after birth in a well infant or when performed at 6 to 7 days of age in a premature or ill infant. The newborn screening Program tests results satisfies this requirement. For more information, please refer to Newborn Screening Program.

Adolescent Screening Protocols

For adolescents 11-20 years of age the following are performed annually:

- History
- Height/Weight
- Blood Pressure/Pulse
- Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
- Developmental Assessment
- Physical Exam
- Urine Screening

- Nutritional Assessment
- Health Education
- Vision Screening
- Hearing Screening
- Dental Screening

An anemia screening should be performed once for adolescents 11-20 years of age.

A urine screening should be performed annually for adolescents 11-20 years of age.

Immunizations are performed for adolescents 11-16 years of age according to AICP guidelines. Refer to Section A.7.4, Recommended Immunization Schedule, for the recommended ages for vaccines.

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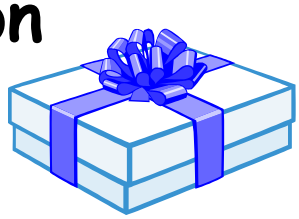
Alabama Early Intervention

Child Find Referral Form



1-800-543-3098/VOICE/TDD

En Español: 1-866-450-2838

INFANT/TODDLER INFORMATION

1. SSN#: _____ 2. Date of Birth: _____

3. Last Name: _____ First Name: _____ MI: _____

4. Sex: _____ 5. Ethnic Origin: _____ 6. Home Language: _____

CHILD RELATION INFORMATION

7. First Name: _____ Last Name: _____ MI: _____

8. Relation Type: _____ **9. Is this Primary relation? Y or N** **10. Is address same as child's? Y or N**

11. Mailing Address: _____

City/State/Zip: _____ 12. County: _____

13. Physical Address: _____

City/State/Zip: _____ 14. County: _____

15. Home Phone: ( ) _____ 16. Alternate Phone: ( ) _____ Ext #: _____

REFERRAL SOURCE INFORMATION

17. Person making referral: _____ 18. Referral Source: _____

19. County: _____ 20. Phone: ( ) _____ 21. Fax: ( ) _____

22. Reason for referral: _____

23. How family became aware of Child Find: _____ Additional Information: _____

Refer to Service Coordinator/Caseload ID: _____

Date Mailed/Faxed to Child Find: _____ Sender: _____

Mail to: ADRS/EI, 2129 E. South Blvd., Montgomery, AL 36111 Fax Number: 334-613-3494

REFERRALS NOT ACCEPTED UNLESS ALL BLANKS ARE COMPLETED

(STATE OFFICE USE ONLY)

Processed by: _____ **Official referral/entry date:** _____

REVISED 02/04

Question #5: - Ethnic Origin

1. **Black or African American (not Hispanic)** – A person having origins in any of the Black racial groups of Africa.
2. **White (not Hispanic)** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
3. **American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
4. **Asian or Pacific Islander** – A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including, the Philippine Islands, Thailand, and Vietnam. The Pacific Islands include Hawaii, Guam, and Samoa.
5. **Hispanic or Latino** – A person Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Question #6 – Child's Home Language

1 – American Sign Language
2 – Spanish
3 – Asian
4 – English
5 – Other

Question #23 – How Family Became Aware of Child Find

1 – Agency
2 – APC Parenting Kit
3 – Child Care
4 – Therapist
5 – Doctor
6 – EI Programs
7 – Web Site
8 – Relative/Friend
9 – High Risk
10 – PA Materials
11 – Media
12 – Healthy Child Care AL
13 – Hospital
14 – SSA
15 – EI in Other State
16 – Parent(Child in EI before)
17 – EI Recipient's Family
18 – Dev. Follow-Up Clinic
19 - Other

Question #12, #14, and #19 – County Code

01	**Autauga**	**24**	**Dallas**	**47**	**Marion**
02	**Baldwin**	**25**	**DeKalb**	**48**	**Marshall**
03	**Barbour**	**26**	**Elmore**	**49**	**Mobile**
04	**Bibb**	**27**	**Escambia**	**50**	**Monroe**
05	**Blount**	**28**	**Etowah**	**51**	**Montgomery**
06	**Bullock**	**29**	**Fayette**	**52**	**Morgan**
07	**Butler**	**30**	**Franklin**	**53**	**Perry**
08	**Calhoun**	**31**	**Geneva**	**54**	**Pickens**
09	**Chambers**	**32**	**Greene**	**55**	**Pike**
10	**Cherokee**	**33**	**Hale**	**56**	**Randolph**
11	**Chilton**	**34**	**Henry**	**57**	**Russell**
12	**Choctaw**	**35**	**Houston**	**58**	**Saint Clair**
13	**Clarke**	**36**	**Jackson**	**59**	**Shelby**
14	**Clay**	**37**	**Jefferson**	**60**	**Sumter**
15	**Cleburne**	**38**	**Lamar**	**61**	**Talladega**
16	**Coffee**	**39**	**Lauderdale**	**62**	**Tallapoosa**
17	**Colbert**	**40**	**Lawrence**	**63**	**Tuscaloosa**
18	**Conecuh**	**41**	**Lee**	**64**	**Walker**
19	**Coosa**	**42**	**Limestone**	**65**	**Washington**
20	**Covington**	**43**	**Lowndes**	**66**	**Wilcox**
21	**Crenshaw**	**44**	**Macon**	**67**	**Winston**
22	**Cullman**	**45**	**Madison**		
23	**Dale**	**46**	**Marengo**		

B Electronic Media Claims (EMC) Guidelines

This appendix contains information about electronic submission of claims and the software that providers use to transmit claims to EDS. It contains the following sections:

- General Information
- Provider Electronic Solutions
- Vendor Software

Technical support is available through the EDS Electronic Claims Submission Help Desk. Providers in Alabama call 1(800) 456-1242. (Out of state providers call (334) 215-0111.)

B.1 General Information

Electronic Claim Submission (ECS) offers many benefits to all participants in the claims submission process. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.

Electronic claim submission reduces claims processing time from start to finish. Rather than mailing paper claims, providers use PCs to submit claims to a central location via a web interface. The web interface then sends the claims to the system for processing.

With ECS, electronic claims avoid the sorting and keying process. The claim data is immediately available to the system. However, it is not only at the start of the claims cycle that electronic submission can save providers time.

Providers who submit claims electronically can check their claims to ensure that the data has passed basic edits, or can determine claim data that prevents the claim from paying. Providers can determine how much payment they will receive from each submission, in a fraction of the time it took when submitting claims on paper.

Electronic claim submission assists providers in receiving quick payment. Just as ECS can greatly reduce claims processing time, it can also help providers receive payment faster than with paper submission. As providers track submissions, make corrections, and resubmit claims online, they receive payment much quicker than paper filing.

Electronic claims submission provides an audit trail of claims that have failed preliminary edits. Providers can receive information about certain problems on submitted claims within a few hours instead of a few weeks. Providers can correct the problem or error and resubmit the claim before the next scheduled checkwriting date.

To submit claims electronically, providers use software designed specifically for this purpose. Providers may use software created by EDS, called Provider Electronic Solutions software, or software developed by outside vendors. The following two sections provide general information about each electronic option.

B.2 Provider Electronic Solutions

Provider Electronic Solutions software is data entry software used to verify eligibility and transmit claims in the proper format to the web so that they may be processed by the system.

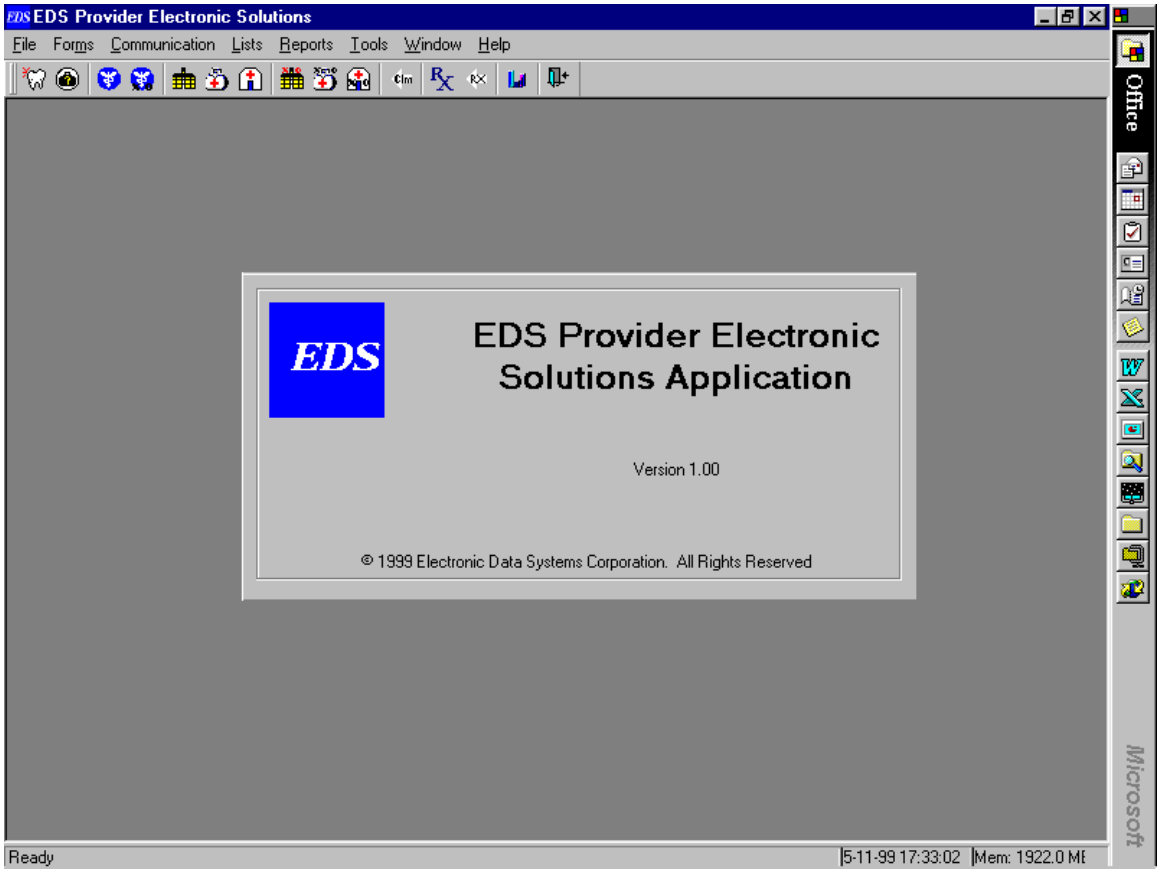
Provider Electronic Solutions software is available free of charge to any provider. EDS will mail the software to the provider at no cost, or the provider may download the software from the Internet. The Alabama Medicaid web address is http://www.medicaid.alabama.gov.

With Provider Electronic Solutions, providers can verify eligibility and transmit claims from the same program. The software allows providers to submit eligibility requests and claims in batch or interactive mode. In batch mode providers transmit groups of information. Interactive mode permits providers to submit information one transaction at a time.

Providers use Provider Electronic Solutions software to submit the following claim types:

- Dental – 837 Dental
- CMS 1500 – 837 Professional
- CMS 1500 Crossover (Medicare-related claims) – 837 Professional
- UB92 - Inpatient, Outpatient, and Long Term Care – 837 Institutional
- UB92 Crossover - Inpatient, Outpatient, and Long Term Care (Medicare-related claims) – 837 Institutional
- Pharmacy

The software also allows providers to perform eligibility verification, claim reversal, pharmacy reversal, and long-term care (LTC) census transactions.



B.2.1 Verifying Eligibility

Providers have access to all available eligibility information on a recipient including but not limited to the following:

- Recipient name on file
- Full recipient number including the check digit (13th digit)
- Managed care status – Patient 1st or Maternity Care
- Aid category – indicating benefit limitations, for example, SOBRA
- Name and phone number of assigned Primary Medical Provider
- Benefit limits to date, for services such as physician visits, inpatient/outpatient visits, EPSDT screenings, and vision services
- Third party insurance information

NOTE:

The Provider Electronic Solutions (PES) software offers the feature of verifying recipient's eye care benefit limits. Select the eligibility icon and enter the requested information in all of the fields. When inquiring about a recipient's eligibility for eye care services, be sure to check the current year and previous year. For example, if inquiring about 1998 eye care benefits, enter the current date with 1998 year.

B.2.2 Viewing Submission Information: Understanding your Data

Providers have access to the following information about their submissions.

- **Communication Log** - displays information about communication during submissions
- **Up-front Rejection Codes** - allow the user to view rejection codes immediately. Claims that are rejected will not be entered into the system. For an explanation of rejection codes, see Section J.3, Electronic Up-Front Rejections, in Appendix J of this manual.
- **View Batch Response** - allows the user to view the response file that is downloaded from the web. This file indicates the status of the claims submitted within a batch.
- **View Electronic Remittance Advice (ERA)** - allows the user to view Electronic Explanation of Payments.

B.2.3 Using Report and List Features: Managing your Data

Providers use the Lists feature to store frequently submitted values. These values can then be reused in later claims submissions, shortening data entry time. Provider Electronic Solution software stores lists of data about the following topics:

- Attending/Operating Provider
- Prescriber
- Provider
- Recipient
- Admission Type
- Carrier
- Modifier
- NDC
- Other Insurance Reason
- Policy Holder
- Taxonomy
- Condition Code
- Diagnosis
- Occurrence
- Patient Status
- Place of Service
- Procedure/HCPCS
- Revenue
- Type of Bill

Providers can generate reports about these lists, as well as detail and summary reports about the claims they have submitted.

B.2.4 Archive and Connection Tools: Protecting your Data

Providers use the Get Upgrades option to upgrade their software from any downloaded update through the web. Options allow users to set up their modems, batch and interactive submitter IDs, carrier information (for example, phone number to dial), and to establish their retention settings (sets the number of files to keep before archiving).

The Archive tool allows users to create archives and restore archives. This feature is very useful for space conservation on the provider's computer system. The Database Recovery tool allows users to compact, repair, and unlock their databases. These tools are very useful in correcting database problems, allowing users to correct the problem without EDS sending new software.

B.2.5 Additional Information about Provider Electronic Solutions

Provider Electronic Solutions software does not interface with accounting systems or other databases. It requires claim data to be keyed twice, once when submitting the claim, and again when office staff enter it into the provider's database.

However, this software is perfect for providers who do not submit a large number of Medicaid claims, and for providers who want to save the vendor fee.

Provider Electronic Solutions software comes with full installation instructions, a user's guide, and full technical support.

For more information on obtaining Provider Electronic Solutions software, contact the EDS Electronic Claims Submission Help Desk at 1(800) 456-1242 (Out of state providers call (334) 215-0111).

B.3 Vendor Software

Providers may prefer to submit claims using vendor software. Providers are recommended to contact EDS to determine if their vendor's software is approved for claims submission.

C Family Planning

Family planning services are services provided to prevent or delay pregnancy.

C.1 Eligible Individuals

Eligible individuals are those females of childbearing age between 10 and 55 years of age and males of any age who may be sexually active and meet the criteria for Medicaid eligibility. Family planning services **do not require a referral** for recipients in Medicaid's managed care programs.

Reimbursement will be made only for eligible Medicaid recipients. Eligibility should be verified **prior to rendering** services to **ANY** Medicaid recipient.

SOBRA-eligible Medicaid women are covered for family planning services through the end of the month in which the 60th postpartum day falls.

Plan First

The Plan First program is an 1115 Research and Demonstration waiver approved by the Centers for Medicare and Medicaid Services that extends family planning coverage for women ages 19-44. Please refer to the section, Plan First, for additional information.

C.1.1 Authorization for Recipient Services

The recipient must have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary on the part of the recipient and without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. **A recipient consent for services must be obtained at each Family Planning visit. A sign-in logbook may be used after the initial consent form has been signed.**

Age of Consent

Family planning services are available to:

- Females, any age, after onset of menses. If age 14 or over, no parental or other consent is required.
- Males, any age. If age 14 or over, no parental or other consent is required.
- If a child is under the age of 14, whether they are sexually active or not, parental consent is required.

C.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

C.2.1 Family Planning Visits

The following services are covered services when provided by Family Planning providers.

Initial Visit (99205-FP)

The initial visit is the first time a recipient receives family planning services. An initial visit is limited to one per provider per recipient per lifetime.

The initial visit requires the establishment of medical records, an in-depth evaluation of an individual including a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, and issuance of supplies or prescription. Counseling in the family planning setting is interactive and includes education. Counseling/education topics must be based on patient need and on protocol requirements.

PT+3 Teaching Method

All family planning counseling must utilize the **PT+3 teaching method**, after the provider has received training. The acronym, PT+3, means:

P = Personalize the PROBLEM,
T = "TAKLE" the problem
- T = set a Therapeutic Tone,
- A = Assess the knowledge level of the patient,
- K = provide Knowledge
- L = Listen for feedback,
- E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

NOTE:

Questions about PT+3? Call the Outreach and Education Unit at (334) 353-5203.

At all points during the counseling and education process, the patient must be given the information in such a way as to encourage and support the exercise of choice. In order to support informed choice, certain informational elements should be offered. Due to the constraint of time, the topics are listed in order of priority. Priority One includes those topics that MUST be DISCUSSED with the patient. Priority Two includes those topics that can be presented to the patient in a written document, with verbal follow-up. Priority Three includes those topics that can be presented in written format only, with follow-up occurring should the patient need/desire further clarification.

At all times, the PT+3 method of teaching/counseling should be used so that time is targeted toward individual patient need.

Priority One Topics:

1. Patient expressed needs or problems
2. Contraception:
    a. Listing of the various options
    b. How to use
    c. Side effect management
3. Prevention of STDs including HIV
4. Breast self-exam or testicular self-exam

Priority Two Topics

1. Explanation of any screening or lab testing done
2. Services offered
3. Telephone number of office or instructions about accessing emergency care
4. Folic Acid

Priority Three Topics

1. Need for Mammogram
2. Anatomy and physiology

Billable laboratory services **for the initial and annual visits include:**

- Hemoglobin or hematocrit,
- Urinalysis,
- PAP smear,
- STD/HIV test, and
- Pregnancy testing.

Since a family planning visit may be the only medical encounter a female has, **performing the listed laboratory tests is encouraged at the initial and annual visits.** Pregnancy testing is covered during any visit where clinical indication is present and evaluation is needed. Any laboratory procedure performed within the past 30 days with available results need not be repeated. A pap smear may be accepted if done within the past 6 months and is considered normal.

The **physical assessment** is another integral part of the initial family planning visit. The following services, at a minimum, must be provided during the initial visit:

- Height, blood pressure, and weight check
- Thyroid palpation

- Breast and axilla examination accompanied by instruction for self-breast examination
- Abdominal examination and liver palpation
- Auscultation of heart and lungs
- Pelvic evaluation to include bimanual and recto-vaginal examination with cervical visualization
- Examination of extremities for edema and varicosity
- Testicular, genital, and rectal examination for males.

Annual Visit (99214-FP)

The annual visit is the re-evaluation of an established patient requiring an update to medical records, interim history, complete physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling using PT+3 teaching method, and adjustment of contraceptive management as indicated. An annual visit is **limited to one per calendar year**.

The services listed below must be provided during the annual visit:

- Updating of entire history and screening, noting any changes
- Counseling and education, as necessary, using the PT+3 teaching method
- Complete physical assessment as outlined in the “Initial Visit” requirements
- Laboratory tests as outlined under “Initial Visit”
- Issuance of supplies or prescription.

Periodic Revisit (99213-FP)

The periodic revisit is a follow-up evaluation of an established patient with a new or existing family planning condition. Four periodic visits are available per calendar year. These visits are available for multiple reasons such as contraceptive changes, issuance of supplies, or contraceptive problems (e.g. breakthrough bleeding or the need for additional guidance). Providers may utilize the appropriate **V254** diagnosis code, “Surveillance of previously prescribed contraceptive methods,” for a visit related to a contraceptive problem.

The following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure
- Interim history
- Symptom appraisal as needed

Documentation of any treatment/counseling including administration/issuance of contraceptive supplies.

NOTE:

Family Planning visits are not payable after a sterilization.

Home Visit (99347-FP)

The home visit is a brief evaluation by a medical professional in the home of an established patient and is for the purpose of providing contraceptive counseling (using the PT+3 teaching method) and administration/**issuance of supplies** as indicated. The home visit is for postpartum women during the 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is limited to one per 60-day postpartum period.

To qualify for reimbursement for the home visit:

- Medical professionals who are licensed to administer medications such as oral contraceptives or to give injections must provide the home visit.
- The home visit must include: brief medical histories: family, medical, contraceptive, and OB/GYN, blood pressure and weight check, contraceptive education and counseling using the PT+3 teaching method assuring that the patient:
  - understands how to use the method selected,
  - how to manage side effects/adverse reactions,
  - when/whom to contact in case of adverse reactions, and the importance of follow-up.
  - scheduling of a follow-up visit in the clinic if needed
  - issuance or prescription of contraceptive supplies as appropriate.

The patient must give her signed consent for this visit.

Extended Family Planning Counseling Visit (99212-FP)

The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The extended family planning counseling visit is performed in conjunction with the 6-week postpartum visit in the office/clinic setting. The counseling services are those provided **above and beyond the routine contraceptive counseling that is included in the postpartum visit.** The purpose of this additional counseling time is to take full advantage of the window of opportunity that occurs just after delivery when the physical need for pregnancy delay is at a peak. Extended family planning counseling is limited to once during the 60-day post-partum period, and is not available for women who have undergone a sterilization procedure.

Services required:

- Contraceptive counseling and education
- STD/HIV risk screening and counseling
- Issuance of contraceptive supplies.

NOTE:

In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP.

Deleted: ~~NOTE~~

STD/HIV Risk Screening and (Pre-HIV test) Counseling (99401, Diagnosis Code V259)

STD/HIV screening, counseling, and testing is necessary to identify infected persons who will benefit from medical treatment and to support and encourage all persons to practice responsible sex. Patients who contract ANY type of STD are at greater risk of contracting HIV and those who are HIV+ and contract any type of STD have a much greater chance of transmitting HIV. The best way to prevent HIV is to prevent an STD. For this reason, emphasis is being placed on STD/HIV screening and counseling in lieu of HIV testing only**.** The HIV pre-test counseling code will be used even though this activity is performed in conjunction with STD risk counseling. Document on the form provided in the Attachment section.

Basic requirements of STD/HIV screening and counseling are:

1. Determine degree of risk
2. Intervene with confrontation and counseling
3. Test for STDs and HIV as clinically indicated
4. Document using the form provided
5. Screen for risk at the initial and annual visit or as clinically indicated.

Requirements Detailed:

- Determine degree of risk.
- Screen for STD/HIV risk using the screening tool provided. See Attachments for a reproducible copy.
- Intervene with confrontation and counseling.
    a. Risk Level I - No risk factors identified. Minimal counseling required.
    b. Risk Level II - At Risk – Due to exposure to blood or blood products only. limited counseling required.
    c. Risk Level III - One or more risk factors present: Prevention Counseling required using the PT+3 method.

- Test for STDs and HIV as indicated by screening results and clinical symptoms.
- Document using the form provided.
- Screen for risk at the initial and annual visit or as clinically indicated.

At a minimum, screening for STD/HIV risk is to be done at these visits, however screening and offering STD and HIV testing should be done as necessary or appropriate.

Please note that the pre-test counseling may be billed regardless of whether the counseling session results in the drawing of blood or of STD testing.

STD/HIV Post-Test Counseling (99402, Diagnosis Code V259)

Post-test counseling is performed to provide the patient with test results. When STD testing results in a positive finding, the patient should be called in and told of test results and treated immediately. A plan of notification of partners with treatment should be developed. Counseling should focus on immediate treatment and future prevention efforts.

Post-test counseling for HIV testing, if negative, should emphasize and reinforce the HIV prevention message imparted during the pre-test counseling session. If positive results are obtained, this counseling visit should focus on

- the meaning of the test result,
- assisting with the emotional consequences of learning the result,
- providing a referral for and stressing the importance of getting into medical care as soon as possible,
- developing a plan to prevent transmission of HIV,
- developing a plan for notification of partners, and
- justification, if needed, for a second post-test counseling visit.

Should a second post-test visit be necessary, requirements for this second session are the same as those above. Forms for documentation of HIV testing and post-test counseling are available in reproducible form in the Attachment section.

NOTE:

Each procedure code is limited to two counseling services per patient per calendar year, and must be performed in conjunction with a family planning visit.

C.2.2 Family Planning Protocols-Clinical

Visits	*INIT*	*AN*	*PER*	*IMP/PE*	*EXT/C*	*HOME*
Consent For Services	*X*	*X*	*X*	*X*	*X*	*X*
History						
Family	X	X		X		X
Med/Surg/OB-GYN	X	X		X		X
Contraceptive	X	X		X		X
STD/HIV screening	X	X		X		X
Interim		X	X			
Blood Pressure	**X**	**X**	**X**	**X**		**X**
Weight	**X**	**X**	**X**	**X**		**X**
Physical Exam						
Skin/General appearance	X	X	CI	X		
Eyes/ENT	X	X	CI	X		
Head/Neck/Thyroid	X	X	CI	X		
Nodes	X	X	CI	X		
Heart/Lungs	X	X	CI	X		
Breast/SBE	X	X	CI	X		
Abdomen	X	X	CI	X		
Extremities/Back	X	X	CI	X		
External genitalia	X	X	CI	X		
Glands	X	X	CI	X		
Vagina	X	X	CI	X		
Cervix	X	X	CI	X		
Uterus size/shape	X	X	CI	X		
Adnexa	X	X	CI	X		
Recto-vaginal	X	X	CI	X		
Rectum	X	X	CI	X		
Laboratory						
HGB or HCT	CI	CI	CI	CI		
Urinalysis	CI	CI	CI	CI		
Pap smear	X	X		CI		
STD tests including HIV	CI	CI	CI	CI		
Pregnancy testing	CI	CI	CI	CI		

➢ ***Table Legend***

X	Perform at this visit
CI	Do if clinically indicated
INIT	Initial
AN	Annual
PER	Periodic
IMP/PE	Implant physical exam
EXT/C	Extended family planning counseling
HOME	Home visit

C.2.3 Family Planning Protocols – Educational

		INIT	AN	Per	IMP/P	EXT/C	Home
Counseling Using PT + 3 Teaching Method							
Priority One	*Patient expressed needs or problems*	X	X	X	X	X	X
	Contraceptives: **** Listing of the various options* ****How to use* **** Side effect management*	CI	CI	CI	CI	CI	CI
	Prevention of STDs including HIV	X	X	CI	CI	CI	CI
	Breast self-exam or testicular self-exam	X	X	X	X	X	X
Priority Two	*Explanation of any screening or lab testing done*	X	X	X	X	X	X
	Services offered	X	X				
	Telephone number of office or instructions regarding the accessing of emergency care	X	X	X	X	X	X
	Folic Acid	X	X				
Priority Three	*Need for Mammogram*	X	X				
Optional	Anatomy and physiology	CI	CI	CI	CI	CI	CI

***Topic priority explanations:** **Priority One** includes those topics that MUST be discussed with the patient. All patient concerns fall in this area. **Priority Two** includes those topics that can be presented to the patient in a written document, with verbal follow-up. **Priority Three** includes those topics that can be presented in written format only, with verbal clarification done if needed or desired by the patient. At all times, if the patient wants to discuss a topic, the opportunity should be provided.

C.3 Sterilization

Counseling services involving complete information regarding male/female sterilization procedures shall be provided for the individual or couple requesting such services. These counseling services may be provided during any contraceptive visit to the office/clinic. Counseling and education should use the PT+ 3 teaching method. Full information concerning alternative methods of contraception will be discussed with the recipient.

NOTE:

The recipient is to be made aware that sterilization is considered permanent and irreversible and Medicaid does not cover the reversal of a voluntary sterilization. A "Consent to Sterilization" is a **required form**. The sterilization consent form is included with a sterilization booklet given to the recipient.

Counseling related to sterilization must include:

- Assessment of base knowledge level of the reproductive process/sterilization procedure.
- Instruction as needed.
- Listing and discussion of all reversible contraceptive methods.
- Information stressing that the sterilization procedure is considered irreversible.
- Complete explanation of the sterilization procedures using charts or body models.
- Complete information concerning possible complications and failure rates.
- Information regarding the relative merits of male versus female sterilization given to both partners, if possible.
- Information explaining that sterilization does not interfere with sexual function or pleasure.

The counselor shall in no way coerce or “talk the patient into being” sterilized.

C.3.1 Contraindications to Sterilization

The following conditions shall be considered contraindications for voluntary sterilization:

- The recipient has physical, mental, or emotional conditions that could be improved by other treatment.
- The recipient is mentally incompetent or institutionalized, regardless of age.
- The recipient is suffering from temporary economic difficulties that may improve.

- The recipient or couple feels that they are not yet ready to assume the responsibilities of parenthood.
- The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

NOTE:

If sterilization is not desired, alternate methods of contraception must be discussed.

C.3.2 General Rules

Surgical procedures for male and female recipients as a method of birth control are covered services under the rules and regulations as stated in the *Alabama Medicaid Agency Administrative Code,* Chapter 14, Rule No. 560-X-14-.04, and as set forth below.

a. The recipient must be eligible for Medicaid at the time the procedure is performed.

b. The recipient is at least 21 years old at the time informed consent is obtained.

c. The recipient is mentally competent.

d. The recipient has voluntarily given informed consent in accordance with all requirements.

e. At least 30 days, but not more than 180 days, have passed between the date of signed informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

f. A recipient may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days prior to EDC (expected date of delivery). If the recipient decides to be sterilized, the provider must be responsible for referring the recipient to the proper medical source and for ensuring that the recipient is accepted by that resource. In addition, the provider shall:

g. Inform the recipient that, in accordance with federal regulations, a 30-day waiting period is required between the time the consent form is signed and the procedure is performed.

h. Provide information and instructions concerning the need for follow-up, particularly for male recipients.

i. Provide appropriate post-operative semen analysis for vasectomy recipients.

NOTE:

Payment is not available for the sterilization of a mentally incompetent or institutionalized individual. Federal regulations prohibit Medicaid coverage of sterilization for anyone less than 21 years of age.

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.

NOTE:

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.

The sterilization consent forms shall be completed as follows.

a. The counselor must thoroughly explain the sterilization procedure to the recipient:

b. The "Consent to Sterilization" must be signed by the person to be sterilized at least 30 days prior to the procedure date. The birth date must indicate the person to be at least 21 years of age on the date the signature was obtained.

c. The person obtaining consent (counselor) and the title for that person (e.g., M.D., D.O., R.N., L.P.N., C.R.N.P., C.N.M.W.), if applicable, must be indicated on the consent form.

d. The counselor's original signature with date, as well as the recipient's signature with date, shall reflect that at least 30 days, but not more than 180 days, have passed prior to the procedure being performed. The counselor signs and dates the consent form after the recipient signs the consent form and prior to the procedure. The counselor may sign the consent form on the same date as the recipient if the counselor signs after the recipient.

e. If no interpreter is used, this section of the form must be marked as "Not Applicable" (N/A). If the "Interpreter's Statement" is signed and dated, please complete the "in_____ language" line also. The recipient and interpreter must sign and date the consent form on the same date.

f. Procedure recorded in the "Physician's Statement": It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure. However, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form. Example: "Bilateral tubal ligation" listed in the recipient's section and "postpartum tubal ligation" listed under the physician's section is acceptable.

NOTE:

The physician's statement must be signed or initialed by an individual clearly identified as a physician. The signature or initials are not acceptable if they are rubber stamped, unless the physician has initialed the stamp. The physician must date the certification on the same date he or she signs it.

g. Each copy of the consent form (Form 193) is used in the correct manner. Upon completion, the forms should be dispensed according to the following procedure:

    a. Original – Patient

    b. Copy 2 – EDS

    c. Copy 3 - Patient's permanent record

C.3.3 Referrals

Family planning providers shall be responsible for referring the recipient to the proper resource, and for ensuring that the recipient is accepted by the resource to which they are referred, in the following circumstances:

a. Medical/GYN problems indicated by history, physical examination, or laboratory and clinical tests, including the removal of Norplant capsules

b. Pregnancy related services.

C.3.4 Family Planning Drugs

Medically approved pharmaceutical supplies and devices, such as oral contraceptive pills, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

C.4 Plan First

Plan First operates under an 1115 Research and Demonstration waiver granted by the Centers for Medicare and Medicaid Services (CMS). The Alabama Medicaid Agency initiated this program to extend family planning and birth control services to an expanded eligibility group in Alabama who qualify for prenatal care through Medicaid's SOBRA program.

Under Plan First, eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera shot, vaginal ring and contraceptive patch doctor/clinic visits (for family planning only), and tubal ligations. Plan First does not cover any other medical services, and women who have been previously sterilized are not eligible for participation in this program.

NOTE:

Pain medication prescribed after a tubal ligation **is not** covered for a Plan First recipient.

NOTE:

If for medical reasons, a **Plan First recipient** requires an **inpatient stay** for sterilization, **prior approval** must be requested by the physician and approved by Medicaid prior to performing the sterilization. Please contact the Plan First Program Manager at (334) 353-5263 for prior approval of an inpatient stay.

C.5 Eligible Individuals

Eligible individuals are females of childbearing age between 19 and 44 years of age who meet the eligibility criteria described below. These women are identified on the Eligibility Master File with an aid category of 50.

As always, providers are responsible for verifying eligibility and coverage via PES or AVRS systems.

Eligible recipients fall into three categories; however, there is no difference in benefits. The income limit for each of these groups must not exceed 133% of the federal poverty level. The three groups are described below:

Group 1

Women 19 through 44 years of age who have SOBRA-eligible children (poverty level), and who meet citizenship and alienage requirements, are automatically eligible for family planning without a separate eligibility determination. These women are automatically eligible and are not required to complete an application.

Group 2

SOBRA poverty level pregnant women 19 through 44 years of age, who meet citizenship and alienage requirements, are automatically eligible for family planning services after 60 days postpartum without a separate eligibility determination. These women are automatically eligible and are not required to complete an application.

Group 3

Women 19 through 44 years of age who are not postpartum or who are not applying for a child may apply using a simplified shortened application. An eligibility determination is completed using poverty level eligibility rules and standards. These women must also meet citizenship and alienage requirements.

C.6 Plan First Provider Enrollment

Participation in Plan First is open to any provider who wishes to be Medicaid enrolled and executes a Plan First agreement. Only those Plan First enrolled providers are able to service Plan First eligibles. Providers can be clinics, private physicians, nurse midwives, nurse practitioners, or physician assistants. Providers are bound by the requirements in the Appendix C of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology, 1996; and the approved 1115 Research and Demonstration Waiver.

In addition to enrolling as a Medicaid provider through EDS, the provider must complete a Plan First agreement.

Clinics and clinic-based providers (Health Departments, FQHCs, and RHCs) are enrolled as one group. Individual providers within these groups are not required to individually enroll. Plan First recipients have the option of using any provider within these groups. Once a provider has enrolled as a Plan First provider, a specialty code of F7 will be added to the provider file. In order for claims to process for Plan First recipients, this specialty code must be present on the provider file.

Providers that perform only tubal ligations do not have to enroll as a Plan First provider. This includes surgeons and anesthesiologists as well as outpatient surgery centers.

If you have further questions regarding this program or if you wish to enroll, please call the Plan First Program Manager at (334) 353-5263. Recipients may call the Plan First hotline toll-free at 1 (888) 737-2083 for more information.

C.6.1 Network List

The Alabama Medicaid Agency maintains a listing of all providers who have enrolled to provide services to Plan First eligibles. The list contains the provider's address and phone number and is sorted by the provider's county of practice. The list is made available to all Plan First care coordinators and staff of the Plan First toll free hotline, and will also be available to any other party who may be assisting women in locating a Plan First provider. The list is available online at the Alabama Medicaid web site (www.medicaid.alabama.gov) as well as in printed form.

Confidentiality

Providers agree that any information obtained through this program is confidential and will not be disclosed directly or indirectly except for purposes directly connected with the conduct of this program. The informed, written consent of the individual must be obtained for any disclosure.

Availability of Records

The provider shall make available for review and audit by authorized representatives of the Alabama Medicaid Agency at all reasonable times, the medical records pertaining to the services rendered to program recipients.

C.7 Plan First Benefits and Limitations

Services covered are the same as current Medicaid family planning services unless otherwise noted. See Section C.2 for a listing of these. Please note; however, that **Plan First is for women only ages 19 to 44,** services for male family planners are not a part of the Plan First program.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring will obtain these supplies from the county health department while maintaining a medical home with their chosen Plan First service provider. **Prescriptions for these supplies will not be honored at a pharmacy for Plan First patients.**

NOTE:
Plan First recipients seeing providers at a Federally Qualified Health Center (FQHC) will receive the oral contraceptives, contraceptive patch or vaginal ring from the FQHC provider.

Plan First Providers are to submit an order per patient for the contraceptive method utilizing the **Plan First Patient Contraceptive Order Form.** This order will be in effect for one year from the time of the initial/annual family planning visit as dated on the order form. If changes in the contraceptive method are indicated due to patient need or preference, the patient will be required to obtain a new Plan First Patient Contraceptive Order Form from her provider.

The health department will provide oral contraceptives, the contraceptive patch and the vaginal ring as follows:

- First time users will initially receive a 3-month supply. If no problems exist upon return, the remainder of the year's supply will be issued.
- Current/Previous users will receive a 1-year supply.
- All contraceptive patch and vaginal ring users will receive a 3-month supply on a quarterly basis.

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

Providers with questions may contact the Bureau of Family Health Services Plan First Manager at (334) 206-2959.

C.7.1 Care Coordination

Medicaid will reimburse for care coordination services provided to a Plan First recipient. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allow for enhanced contraceptive education, encouragement to continue with pregnancy spacing plans and assistance with the mitigation or removal of barriers to successful pregnancy planning. These services must be provided by licensed social workers or registered nurses associated with the Department of Public Health. Services are available to all Plan First recipients, regardless of the service provider. Should care coordination services be needed, a referral can be made by calling the local health department and asking for the Plan First Care Coordinator.

As mentioned above, the goal of care coordination is to form a partnership with the patient to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A bio-psychosocial assessment and development of case plan for all patients who accept care coordination.
- Counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified in the assessment, such as substance abuse or domestic violence.
- Referrals and follow up to ensure appointments are kept, including subsequent family planning visits.
- Answers to general questions about family planning.
- Low-literacy family planning education based on the PT+3 model.
- Consultation with providers regarding problems with the selected family planning method.

The care coordinator will work diligently with family planning providers to ensure that patients receive care coordination services in a timely manner. All Plan First patients are eligible to receive an initial risk assessment to determine if and what type of care coordination services is needed.

C.7.2 Patient Choice/Consent for Service

As with any family planning visit, the recipient must have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. **Recipients are required to give written consent prior to receiving family planning services.**

C.8 Cost Sharing (Co-payment)

Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services.

There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

Plan First Claims Information

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Claims for family planning services - See sections C.10, Completing the Claim form and C.10.2 and C.10.3 for diagnosis and procedure codes. Service requirements per visit are detailed in Section C.2.2, Family Planning Protocol - Clinical.

Non-enrolled providers who are billing for a tubal ligation or a tubal ligation with a family planning visit must submit a **hard copy** claim to EDS in order to receive reimbursement. The approved Plan First tubal codes are 58600, 58615, 58670, and 58671. The Plan First family planning visit codes are 99205-FP(initial), 99214-FP (annual), or 99213-FP (periodic). In addition to these codes, the diagnosis code V25.9 must be used.

If the sterilization is **not** performed, the non-enrolled provider must use the V25.9 diagnosis code with procedure code 99205-FP, 99214-FP or 99213-FP.

For information about Third Party Liability, please refer to Section 3.3.6, Third Party Liability.

Quality Assurance Overview

As with any waiver, there is a requirement for Quality Assurance monitoring and complaint/grievance resolution.

The Waiver has four major goals:

- To assure accessibility of family planning services to eligible clients,
- To assure that client assessments include the assessment and care plan appropriate for the risk level,
- To assure that the family planning encounters provided through enrolled providers follows the guidelines in the Appendix C, Plan First, of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology, 1996; and
- To ensure that an effective complaint and grievance system is in place for both providers and recipients.

The Waiver has provisions for UAB to assist in providing outcome and summary reports to support effectiveness of the Program. This will enable comparisons between different sectors of populations and historical data.

Through referral from a Plan First Provider, the Waiver has approved Care Coordinators to assist patients who are assessed to be at high risk of an unintended pregnancy. The Care Coordinators will make and follow a plan to aid the high-risk patients in avoiding unintended pregnancies through improved compliance and informed decisions about Family Planning services.

The Alabama Medicaid Agency is responsible for Quality Assurance, Complaint and Grievance Resolution, and Utilization Monitoring. In order to accomplish these Waiver requirements, the Agency will implement several monitoring functions as outlined below:

- Utilization reports from claims data to monitor trends and utilization,
- Sample random review of Provider and Care Coordinator records for documentation standards,
  - Monitor Care Coordinator activity,
  - Review Summary Reports, (Care Coordinator and UAB)
- Request Plans of Correction for documentation not meeting standards (standards as outlined above), and
  - Coordinate complaints and grievances to acceptable resolution.

C.9 Services Other Than Family Planning

Services required to manage or treat medical conditions/diseases whether or not such procedures are also related to preventing or delaying pregnancy are not eligible as family planning. Many procedures that are done for “medical” reasons also have family planning implications.

- Sterilization by hysterectomy is not a family planning covered service.
- Abortions are not covered as a family planning service. Refer to Chapter 28, Physician's Program, for details about abortions.
- Hospital charges incurred when a recipient enters the hospital for sterilization purposes, but then opts out of the procedure cannot be reimbursed as a family planning service.

- Removal of an IUD due to a uterine or pelvic infection is not considered a family planning service, and is not reimbursable as such.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions are not considered family planning services.
- Diagnostic or screening mammograms are not considered family planning services.
- Medical complications requiring treatment (for example, perforated bowel) caused by or following a family planning procedure are not a covered family planning service.
- Any procedure or service provided to a woman who is known to be pregnant is not considered a family planning service.
- Removal of contraceptive implants due to medical complications are not family planning services.

C.10 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

- Providers who bill Medicaid claims electronically receive the following benefits:
- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

C.10.1 Time Limit for Filing Claims

Medicaid requires all claims for family planning to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

C.10.2 Diagnosis Codes

V2501	Prescription of Oral Contraceptives
V2502	Initiation of other contraceptive measures – fitting of diaphragm, prescriptions of foams, creams, or other agents
V2509	Other – Family planning advice
V251	Insertion of intrauterine contraceptive device
V252	Sterilization- Admission for interruption of fallopian tubes or vas deferens
V2540	Contraceptive surveillance, unspecified
V2541	Contraceptive Pill
V2542	Intrauterine contraceptive device – Checking, reinsertion, or removal of intrauterine device
V2543	Implantable subdermal contraceptive
V2549	Other contraceptive method
V255	Insertion of implantable subdermal contraceptive (Norplant)
V258	Other specified contraceptive - management post vasectomy sperm count
V259	Unspecified contraceptive management

NOTE:

All claims filed for Plan First recipients must utilize one of the family planning diagnosis codes noted above. This includes claims filed for lab services. Diagnosis codes that are used and not listed above will cause the claim for a Plan First recipient to deny.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4 or 5 digits). Do not use decimal points in the diagnosis code field.

C.10.3 Family Planning Indicator References

Providers must complete the Family Planning Indicator, as applicable. “Y or “N” are the only valid indicators, when filing electronic claims.

C.10.4 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

NOTE:

Family planning visits do not count against the recipient's office visits when the procedure codes listed below and the appropriate family planning indicator are used.

Code	Procedure Description
99420	Low Risk assessment; use with modifier 22 for high-risk assessment. *For Plan First patients only – to be billed only by health departments.*
99403	Care coordination. *For Plan first patients only – to be billed by health departments only.*
99402	STD/HIV Post-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code V259)
99401	STD/HIV Risk Screening and HIV Pre-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. (Must use diagnosis code V259)
88305	Level IV Surgical Pathology, gross and microscopic examination
88304	Level III Surgical Pathology, gross and microscopic examination
88302	Surgical pathology, gross and microscopic examination
88300	Level I Surgical Pathology, gross examination only
89300	Semen analysis; presence and/or motility of sperm *(not applicable for Plan First)*
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision.
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal
88162	Cytopathology, any other source
88161	Cytopathology, any other source
88160	Cytopathology, smears, any other source
88155	Cytopathology, slides, cervical or vaginal
88154	Cytopathology, slides, computer assisted
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)
88152	Cytopathology, slides, cervical or vaginal
88150	Cytopathology, manual screening under physician supervision
88148	Cytopathology, screening by automated system with manual rescreening
88147	Cytopathology smears, screening by automated system under physician supervision

Code	Procedure Description
88143	Cytopathology, manual screening & rescreening under physician supervision
88142	Cytopathology, cervical or vaginal, automated thin layer preparation
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88108	Cytopathology, concentration technique, smears and interpretation
87850	Neisseria gonorrhea
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique
87660	Trichomonas vaginalis, direct probe technique
87622	Papillomavirus, human, quantification
87621	Papillomavirus, human, amplified probe technique
87620	Papillomavirus, human, direct probe technique
87592	Neisseria gonorrhea, quantification
87591	Neisseria gonorrhea, amplified probe technique
87590	Neisseria gonorrhea, direct probe technique
87539	HIV-2, quantification
87538	HIV-2, amplified probe technique
87537	HIV-2, direct probe technique
87536	HIV-1, quantification
87535	HIV-1, amplified probe technique
87534	HIV-1, direct probe technique
87533	Herpes virus-6, quantification
87532	Herpes virus-6, amplified probe technique
87531	Herpes virus-6, direct probe technique
87530	Herpes simplex virus, quantification
87529	Herpes simplex virus, amplified probe technique
87528	Herpes simplex virus, direct probe technique
87512	Gardnerella vaginalis, quantification
87511	Gardnerella vaginalis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique.
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain for bacteria, fungi, or cell types
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
87177	Smear, primary source, with interpretation, wet and dry mount for ova and parasites, concentration and identification
87164	Dark field examination, any source; includes specimen collection
87110	Culture, chlamydia
87081	Culture, bacterial, screening only, for single organisms
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86689	HTLV or HIV antibody

Code	Procedure Description
86593	Syphilis
86592	Syphilis
85032	Manual cell count (erythrocyte, leukocyte or platelet) each
85027	Blood count; RBC only
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85018	Blood count; hemoglobin
85014	Blood count; other than spun hematocrit
85013	Blood count; spun microhematocrit
85009	Blood count; differential WBC count, buffy coat
85008	Blood count; manual blood smear examination without differential parameters
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
84703	HCG qualitative
84702	HCG quantitative
81025	Urine pregnancy test
81020	Urinalysis; two or three glass test
81015	Urinalysis microscopic only
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81003	Urinalysis; automated without microscopy
81002	Urinalysis; non-automated without microscopy
81001	Urinalysis; automated with microscopy
81000	Urinalysis by dip stick or tablet reagent
74740	Hysterosalpingography, radiological supervision and interpretation
58671	Tubal ligation by laparoscopic surgery
58670	Tubal ligation by laparoscopic surgery
58615	Tubal ligation by suprapubic approach
58611	Tubal ligation done in conjunction with a c-section (*Not applicable for Plan first)*
58605	Tubal ligation by abdominal approach (postpartum) (*Not applicable for Plan first)*
58600	Tubal ligation by abdominal incision
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (by Prior Approval only; **See note box below procedures)
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58301	IUD removal
58300	IUD insertion
57170	Diaphragm – fitting with instructions
55450	Vasectomy (*Not applicable for Plan first)*
55250	Vasectomy (*Not applicable for Plan first)*
11980	Subcutaneous hormone pellet implantation(implantation of estradiol and/or testosterone beneath the skin)
11977	Removal with reinsertion, implantable contraceptive capsules (Implanon)
11976	Implanon– implant removal
11975	Insertion, implantable contraceptive capsules (Implanon)
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.
J1056	Lunelle
J1055	Depo-Provera – 150mg/ml – Limited to one injection *every 70 days*
J3490	Depo – Subq Provera 104 – Limited to one injection *every 70 days*
J7302	Mirena IUD
J7304	Ortho Evra Patch (To be used for billing by Plan First Private Providers) TPL exempt applicable until current office supplies exhausted
J7304-FP	Ortho Evra Patch (For Health Department Billing Only) TPL exempt
J7304-SE	Ortho Evra Patch (For FQHCs, PRHCs, IRHCs Billing only) applicable until current office supplies exhausted
J7303	Vaginal Ring (This code is Not applicable for Plan First billing)
J7303-FP	Vaginal Ring (For Health Department billing only and is covered for Plan First)
99205-FP	Initial visit

Added to 11977:
(Implanon)
Deleted from 11976:
~~Norplant~~
Added to 11976:
Implanon
Added to 11975:
Implanon

Code	Procedure Description
99214-FP	Annual visit
99213-FP	Periodic visit
99347-FP	Home visit – Limited to one per 60 day post-partum period. (Not applicable for Plan First)
S4993-FP	Birth control pills (For Health Department billing only)
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
99212-FP	Extended contraceptive counseling visit (May be billed alone or in conjunction with the postpartum visit – Limited to one service during the 60 day postpartum period.) (Not applicable for Plan First.)
S4993	Birth control pills (To be used for billing by Plan First Private Providers) applicable until current office supplies exhausted (Refer to ALERT dated 8/21/2006).
S4993-SE	Birth Control Pills (For FQHCs, PRHCs, IRHCs Billing only) applicable until current office supplies exhausted
S0180	Etonogestrel (contraceptive) implant system, including implants and supplies also known as Implanon
J7300	Mechanical (Paragard) IUD
S4989	Hormonal (Progestasert) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
36415-90	Routine venipuncture for collection
36416-90	Collection of capillary blood specimen (eg, finger, heel, ear stick)

NOTE:

The **Essure** method of sterilization is **restricted to Prior Approval.** The limitations 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); or

Abdominal mesh that mechanically interferes with laparoscopic tubal ligation sterilization procedures; or

Permanent colostomy with documented adhesions; or

Multiple abdominal/pelvic surgeries with documented severe adhesions; or

Artificial heart valve requiring continuous anticoagulation; or

Other severe medical problems that would be a contraindication to laparoscopic tubal ligation procedures based on medical documentation submitted.

C.11 Attachments

- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form
- Plan First Patient Contraceptive Order Form

These handouts are available through Outreach and Education (334-353-5203)

- How to do a Breast Self-Exam (Handout)
- Folic Acid for Women for healthy babies (Handout)
- Birth Control Method Sheets (Handout)
- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form

NOTE:

Please go to the Alabama Medicaid Agency web site to access the Alabama Medicaid Product Catalog for any forms that you may need to order. The web address is www.medicaid.alabama.gov.

Patient Name_____ Sex: M F Today's Date _____

STD/HIV Risk Screening and Intervention Tool

Questions/Risk Factors	YES	NO
1. Have you had a blood transfusion or received any blood products prior to 1985? ***Blood exposure?***		
2. Have you ever had a job that exposed you to blood or other body fluids? Like a nursing Home or a day care or hospital? Doctor's office? Funeral Home? ***Occupational exposure?***		
3. Your medical history tells me that you (do or do not have) the free bleeding disease called Hemophilia. Is that correct? ***Has Hemophilia?***		
4. Has the use of alcohol or any other drug ever caused you to do things sexually that you Normally would not do? ***Risky use of alcohol or non-IV drugs****?*		
5. Have you **ever** put drugs of any type into your veins? ***Ever an IV drug user?***		
6. Have you ever had any type of infection of the sex organs*?* ***History of STDs?***		
7. Think about the first time you had sex. (Since your last HIV test?) Have you had sex With more than one partner since then? What about your current partner? ***Multiple Sex Partners***?		
8. Some women and some men use sex to get things they need. Have you ever had to do this?		
9. Have you ever been hit, kicked, slapped, pushed or shoved by your partner? ***History of Abuse?***		
10. Some women/men prefer sex with men, some with women and some with both. What type of partner do you prefer? **Circle One: Man Woman Both**		
11. **As far as you know,** have you ever had sex with someone who		
a. was a free bleeder or Hemophiliac?		
b. had HIV or AIDS or an STD?		
c. was a man who had sex with men?		
d. used IV drugs or put drugs into their veins?		
e. was a prostitute - either male or female?		
NOTE: For screening after a previous negative HIV test, ask, "Since your last HIV test ..."		

Documentation instructions and explanations:

1. **Yes or No.** Blood transfusion prior to 1985 places the person at risk for HIV/AIDS.
2. **Yes or No**. Any profession that exposes the patient to body fluids creates a risk for HIV/AIDS.
3. **Yes or No**. Yes, if the patient has Hemophilia; No, if does not have the disease. Hemophilia itself does not create risk for HIV, but the use of blood and blood products by the patient does create risk for HIV/AIDS.
4. **Yes or No.** Use of alcohol or non-IV drugs in a setting/manner that results in sexual risk taking places a person at risk for both STDs and HIV.
5. **Yes or No.** IV drug use is a risk factor for HIV specifically.
6. **Yes or No**. A history of any STD places the patient at risk for another STD including HIV/AIDS.
7. **Yes or No.** Having more than one partner places a patient at risk for both STDs and HIV, unless the partners were prior to 1978.
8. **Yes or No**. Exchanging sex for anything places a person at risk for both HIV and STDs.
9. **Yes or No.** Any type of abuse or coerciveness that the patient has experienced places the patient at risk for both HIV and STDs
10. **Circle** the appropriate choice. Male homosexuality and/or male bisexuality are risk factors for HIV/AIDS.
11. **a-e. Yes or No.** Any Yes answer is considered a risk factor for both STDs and HIV/AIDS.

Intervention Documentation: Circle the intervention taken

Level I: - No risk factors identified – No counseling required. Offer "STDs – Don't…" Handout – because "sometimes we change". HIV testing w/counseling is optional – at patient request.

Level II: Risks are related to blood products exposure ONLY – Recommend HIV test. Inform of need for and explain universal precautions. Use "STDs – Don't… " handout.

Level III: Any other risk factor present - significant risk exists. Recommend strongly the HIV test. Test for other STDs as CI. Provide prevention counseling about need for change in (specifically identified) habits and importance of protected sex. Use "STDs – Don't…" handout. Provide skill training in use of condom and in negotiation skills.

Remember: All patients should be given information the handout, "Facts about HIV and HIV testing."

Documentation of HIV testing:

❑ ***HIV Testing Done*** ❑ ***NO HIV Test drawn***

IF Patient declined, why? Circle One

* I am not at risk,
* Do not want to know,
* Other

Follow-up Notes:

Signature/title of counselor _____ **Date** _____

HIV Post Test Counseling

HIV Test Results: Date _____

❑ **HIV positive**

- ○ Test results explained
- ○ Provided emotional assistance related to test result
- ○ Explained need to notify partners/contacts
- ○ Offered options for partner notification
- ○ Stressed need for transmission prevention
- ○ Explained need for early medical evaluation & treatment

❑ **HIV Negative**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

❑ **Indeterminate**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

Referrals made:

- ❑ Mental Health_____
- ❑ Partner notification services _____
- ❑ Other Health Care Provider_____
- ❑ Social Services_____
- ❑ Retesting
- ❑ Other_____

Retest Results (Date) _____

Positive Negative Indeterminate

Follow-up Notes:

Additional Post- test counseling

Reason:

Points covered:

Signature/title of counselor _____ **Date** _____

Form 189 Alabama Medicaid Agency

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (Doctor/Clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Month/Day/Year) _____. I, _____, hereby consent of my own free will to be sterilized by (Doctor) _____, by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to: Representative of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) _____ (Date) _____

(Typed/Printed Name) _____

Recipient's Medicaid Number) _____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

_____ American Indian or Alaska Native
_____ Hispanic
_____ Asian or Pacific Islander
_____ Black (not of Hispanic origin)
_____ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized) I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ Language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) _____ (Date) _____

Original – Patient
Copy 2 – EDS
Copy 3 – Patient's Permanent Record

Form 193 (Revised 8-30-02)

STATEMENT OF PERSON OBTAINING CONSENT

Before (Patient's Name) _____ signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Signature) _____ (Date) _____

(Title of Person Obtaining Consent) _____

(Typed/Printed Name) _____

(Facility) _____

(Address) _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (Patient's Name) _____ on (Date) _____, I explained to him/her the nature of the sterilization operation (Specify Type of Operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):
   (1) _____ Premature delivery:
   Individual's expected date of delivery: _____
   (2) _____ Emergency abdominal surgery:
   (Describe circumstances using an attachment)

(Signature) _____ (Date) _____

(Typed/Printed Name of Physician) _____

(Medicaid Provider Number) _____

Alabama Medicaid Agency

Checklist for Consent Form Completion

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

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):

a) All blanks on the consent form must be appropriately completed before the State may pay the provider for sterilization procedure. The only exception is the Race, Ethnicity, and Title of person obtaining consent, which is optional.

b) The "Consent to Sterilization" must be signed by the person to be sterilized at least thirty days prior to the procedure date. The birth date must indicate the person to be at least twenty-one (21) years of age on the date the signature was obtained.

c) The interpreter, if one is used, must sign and date the consent the same day the recipient signs. In instances where the interpreter signs any date other than the date recorded by the recipient, the claim will be denied. If no interpreter is used, this section of the form must be marked as "not applicable" (N/A). If the Interpreter's Statement is signed and dated, please complete the "form of language" line also.

d) When it is not known in advance which specific physician will perform the procedure, it is acceptable to list a generic description of the physician, i.e. "staff physician, on-call physician, OB/GYN physician". When using a generic description and not a specific physician's name, the patient is to be informed that the physician on call or on duty will perform the procedure. The name of the provider facility (hospital, surgical center, etc.) or provider physician's group must also be entered in the same blank containing the generic physician description when the generic physician description is used. The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery and signs the "Physician's Statement".

e) Signature of person obtaining consent: The individual obtaining consent must sign after the recipient (may sign the same day as the recipient, as long as the recipient signs first) but prior to the procedure in order to properly document informed consent. In instances where the person obtaining consent does not sign prior to the procedure date, (date-wise – not time) the claim will be denied. In other words, denial will occur if the date of the signature of the person obtaining consent and the procedure date is the same or any date after the procedure date.

f) Procedure recorded in physician's statement: It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure; however, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form.

Most frequent causes of claims having to be returned for correction:	**Reasons consent forms and associated claims will be denied:**
1. Patient's date of birth not the same on the claim and consent form.	1. Missing recipient signature
2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.	2. Missing or invalid date of recipient signature, including less than 30 days prior to procedure
3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.	3. Recipient under age 21 on date consent form was signed
4. All blanks not appropriately completed.	4. Missing signature of person obtaining consent
5. Physician's stamp signature not initialed by physician.	5. Missing or invalid date of person obtaining consent, including date of procedure, or any later date
6. Date of sterilization not the same on the claim and on the consent form	6. Missing interpreter signature (if one was used)
7. Legibility of dates and signatures.	7. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used)
8. Facility name not on the consent form.	

*** As a reminder if these guidelines are not followed, EDS will deny the consent form. ***

PLAN FIRST
PATIENT CONTRACEPTIVE ORDER FORM

This form is to be used to enable the Health Department to provide certain pharmaceuticals to women who are receiving Family Planning services from enrolled Plan First Service Providers. The Plan First provider remains to be the patient's medical home. The Health Department will provide contraceptive counseling to all patients. A new form is required if the provider makes any changes based on patient need/preference.

PATIENT INFORMATION:
Patient Name _____ Medicaid # _____
DOB _____ Date of Initial/Annual Family Planning Visit _____

PROVIDER INFORMATION:
I have completed the above mentioned patient's medical history and physical exam and request the following type of contraceptive be provided to my patient. I understand that the Health Department has a limited formulary and that a comparable, alternative oral contraceptive may be used. Please provide the following contraceptive to my patient:

- ☐ Low Dose Monophasic Combined OC (Preferred Pill): _____
- ☐ Low Dose Triphasic Combined OC (Preferred Pill): _____
- ☐ Monophasic 50 mcg OC
- ☐ Progestin-Only OC
- ☐ Contraceptive Patch
- ☐ Vaginal Ring

COMMENTS: _____

PROVIDER SIGNATURE_____
Original Signature Required

PROVIDER NAME (PLEASE PRINT) _____

DATE_____ PROVIDER PHONE NUMBER (___)_____

Patient must return this completed form to the County Health Department in order to receive her contraceptive method. This order will expire one year from the date of the Initial/Annual Family Planning Visit noted above.

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D Reserved for Future Use

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E Medicaid Forms

This section contains examples of various Alabama Medicaid forms used in documenting medical necessity and claims processing.

The following forms may be obtained by contacting the following:

Form Name	***Contact***	***Phone***
Certification and Documentation of Abortion	Communication and Health Promotion	(334) 353-4099
Check Refund Form	EDS Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	Dental Program	(334) 353-5533
Hysterectomy Consent Form	Communication and Health Promotion	(334) 353-4099
Medicaid Adjustment Request Form	EDS Provider Assistance Center	(800) 688-7989
Patient Status Notification (Form 199)	Long Term Care Division	(334) 242-5684
Prior Authorization Form	EDS Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Communication and Health Promotion	(334) 353-4099
Family Planning Services Consent Form	Communication and Health Promotion	(334) 353-4099
Prior Authorization Request	Pharmacy Management	(334) 242-5050
Early Refill DUR Override	Pharmacy Management	(334) 242-5050
Growth Hormone For AIDS Wasting	Pharmacy Management	(334) 242-5050
Growth Hormone For Children	Pharmacy Management	(334) 242-5050
Adult Growth Hormone	Pharmacy Management	(334) 242-5050
Maximum Unit Override	Pharmacy Management	(334) 242-5050
Miscellaneous Medicaid Pharmacy PA Request Form	Pharmacy Management	(334) 242-5050
EPSDT Child Health Medical Record	Communication and Health Promotion	(334) 353-4099
Alabama Medicaid Agency Referral Form	Communication and Health Promotion	(334) 353-4099
Residential Treatment Facility Model Attestation Letter	Institutional Services Unit	(334) 353-4945
Certification of Need for Services: Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-4945
Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-4945
Patient 1st Medical Exemption Request Form	Patient 1st Program	(334) 353-5907
Patient 1st Complaint/Grievance Form	Patient 1st Program	(334) 353-5907
Patient 1st Override Request Form	Patient 1st Program	(334) 353-5907
Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5501

Deleted from Certification and Documentation of Abortion, Hysterectomy Consent Form, Sterilization Consent Form, Family Planning Services Consent Form, EPSDT Child Health Medical Record and Alabama Medicaid Agency Form: ~~Community Outreach and Education, (334) 353-5203~~

Added to Certification and Documentation of Abortion, Hysterectomy Consent Form, Sterilization Consent Form, Family Planning Services Consent Form, EPSDT Child Health Medical Record and Alabama Medicaid Agency Form: Communication and Health Promotion, (334) 353-4099

Deleted: ~~EDS Provider Assistance Center, (800) 688-7989~~

Added: Long Term Care Division (334) 242-5684

E.1 Certification and Documentation of Abortion

ALABAMA MEDICAID AGENCY

Certification and Documentation

For Abortion

I,_____, certify that the woman, _____

_____, suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Name of Patient	*Patient's Medicaid Number*		
Patient's Street Address	*City*	*State*	*Zip*
Printed Name of Physician	*Physician's Provider Number*		
Signature of Physician	*Date Physician Signed*		
Date of Surgery			

INSTRUCTIONS: The physician must send this form with the medical records and claim to:

EDS
P.O. Box 244032
Montgomery, AL 36124-4032

PHY-96-2 (Revised 10/01/99) Alabama Medicaid Agency
Formerly MSA-PP-81-1 Revised 10/11/96

E.2 Check Refund Form

Mail To: EDS
Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Check Refund Form (REF-02)

Provider Name _____ Provider Number _____

Check Number _____ Check Date _____ Check Amount _____

Information needed on each claim being refunded	**Claim 1**	**Claim 2**	**Claim 3**
13-digit Claim Number (from EOP)			
Recipient's ID Number (from EOP)			
Recipient's name (Last, First)			
Date(s) of service on claims			
Date of Medicaid payment			
Date(s) of service being refunded			
Service being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made
2. DUP: A payment was made by Alabama Medicaid more than once for the same service(s)
3. INS: A payment was received by a third party source other than Medicare
4. MC ADJ: An over application of deductible or coinsurance by Med
5. PNO: A payment was made on a recipient who is not a client in your office
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

10/99

E.3 Alabama Prior Review and Authorization Dental Request

Section I – Must be completed by a Medicaid provider.	**Section II**
Requesting Provider License No. _____	Medicaid Recipient Identification Number _____ (13-digit RID number is required.)
Phone( ) _____	Name as shown in Medicaid system _____
Name_____	Address _____
Address_____	City/State/Zip _____
City/State/Zip_____	Telephone Number _____
Provider Medicaid Number _____	

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

3. Brief Dental/Medical History:_____

_____

_____

NOTE :When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential." Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343 05/05

Alabama Medicaid Agency

E.4 Hysterectomy Consent Form

ALABAMA MEDICAID AGENCY

HYSTERECTOMY CONSENT FORM

PART I. **P H Y S I C I A N**

Certification by Physician Regarding Hysterectomy

I hereby certify that I have advised **Field 1** Medicaid Number **Field 2** _____to
Typed or Printed Name of Patient
undergo a hysterectomy because of the diagnosis of **Field 3** ,**Field 4** .
diagnosis code
Further, I have explained orally and in writing to this patient and/or her representative (**Field 5**) that she will be
Name of Representative, if any
permanently incapable of reproducing as a result of this operation which is medically necessary. This explanation was given before the operation was performed.

Field 6
Typed or Printed Name of Physician

Field 7
Medicaid Provider Number

Field 8
Signature of Physician

Field 9
Date of Signature

PART II. **P A T I E N T**

Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information

I, **Field 10** and/or **Field 11** hereby acknowledge that
Name of Patient *Date of Birth* *Name of Representative, if any*

I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation. This oral and written explanation that the hysterectomy would make me sterile was given to me before the operation.

Field 12
Signature of Patient

Field 13
Date

Field 14
Signature of Representative, if any

Field 15
Date

PART III. **P H Y S I C I A N**

Date of Surgery _____**Field 16**_____

PART IV. **U N U S U A L C I R C U M S T A N C E S**

Recipient Name: _____ Recipient ID: _____

I _____ certify
Printed name of physician

☐ patient was already sterile when the hysterectomy was performed. Cause of sterility _____.
Medical records are attached.

☐ hysterectomy was performed under a life threatening situation. Medical records are attached.

☐ hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.

Before the operation was performed, I informed the recipient that she would be permanently incapable of reproducing as a result of this operation. ☐ Yes ☐ No

Signature: _____ Date: _____

PART V. **S T A T E R E V I E W D E C I S I O N**

Signature of Reviewer: _____ Date of Review: _____ ☐ Pay ☐ Deny

Reason for denial: _____

INSTRUCTIONS: Before payment can be made for any services (physicians, hospitals, etc.) a copy of this consent form must be on file at EDS. Therefore, send this completed from to:

EDS
P.O. Box 244032
Montgomery, AL 36124-4032*y*

PART I.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- Record the diagnosis requiring hysterectomy
- Record the diagnosis code
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Type or print the name of the physician who will perform the hysterectomy
- Record the provider number of the physician who will perform the hysterectomy
- Physician must sign and record the date of signature. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART II.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient and the patient's date of birth including the day/month/year
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Patient must sign and record the date of signature unless a representative is being used to complete the form. Date must be the date of surgery or a prior date. If any date after surgery is recorded, the form will be denied.
- Representative must sign and record the date of signature, if the recipient is unable to sign the consent form. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART III.

This section is required for all hysterectomies.

- Record the date of surgery once the surgery has been performed

PART IV

This section is for use when a hysterectomy was performed on a patient who was already sterile, under a life-threatening emergency in which prior acknowledgement was not possible or during a period of retroactive Medicaid eligibility. Medical records must be submitted for any hysterectomy recorded under this section. In lieu of this form, a properly executed informed consent and medical records may be submitted for these three circumstances.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- The physician who performed the surgery must record their name
- Check the appropriate box to indicate the specific unusual circumstance
- Check the appropriate box regarding whether or not the patient was informed she would be permanently incapable of reproducing as a result of the operation.
- Attach medical records including Medical History; Operative Records; Discharge Summary and a Hospital Consent Form for the Hysterectomy.

PART V

The reviewer at the State completes this section whenever unusual circumstances are identified. EDS will send a copy of the consent form containing the State payment decision to the surgeon following State review.

E.5 Medicaid Adjustment Request Form

Mail to: Adjustments
P. O. Box 241684
Montgomery, AL 36124-1684

Section I: Provider Pay-To Information

Provider Number: _____
Provider Name: _____
Address: _____
_____

Section II: Paid Claims Information
(Please enter data from your remittance advice)

ICN Number: _____
Recipient Number:_____
Recipient Name:_____
Date(s) of Service:_____
Billed Amount:_____
Paid Amount:_____

Section III:

Reason for Recoupment

_____Duplicate payment.
_____Claim billed in error.
_____Recoup/delete line item____.
_____Billed under wrong Recipient.
_____Primary insurance payment received
_____Provider to rebill.
_____Medicare paid primary.
Other_____
_____

-or-

Reason for Adjustment

_____Change the number of units from ____ to ____ for procedure code_____.
_____Change the procedure code from _____ to _____ on line item_____.
_____Change the submitted charge from _____ to _____.
_____Change_____(place/date) of service from _____ to _____ on line item _____.
_____Add/delete modifier on line item_____.
_____Add/adjust primary insurance payment to _____.
_____Adjust coinsurance/deductible from _____ to _____.
_____Change the performing/provider number from _____ to _____.
_____Correct the diagnosis code from _____ to _____.
_____Re-release claim to pay at correct liability/provider rate.
Other _____
_____

Signature_____ Date_____ Telephone#_____

E.6 Patient Status Notification (Form 199)

MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred or expires)

TO: Alabama Medicaid Agency Date: _____

P.O. Box 5624 - 36103
501 Dexter Avenue
Montgomery, Alabama 36104

FROM: _____ Provider Number: _____
(Name of Facility)

_____ Telephone Number: _____
(Address of Facility)

CURRENT PATIENT STATUS

Patient's First Name M.I. Patient's Last Name
_____ / / _____ Birthdate _____

Patient's Social Security No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Female ☐

Patient's Medicaid No: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Male ☐

Date admitted _____ / _____
(Medicare Admission) (Medicaid Admission)

Number of Medicare Days this Admission: _____

☐ New Admission ☐ Hospital ☐ Mental Institution _____

☐ Re-Admission From: ☐ Home

☐ Transferred Admission ☐ Other Home _____

For Medicaid Use Only
Over 60-days late _____

Medicare Denial

Reference Information: _____
Name of Sponsor

_____
Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled

☐ Convalescent Care ☐ Post Extended Care Days ☐ Swing Bed Approved By _____

☐ Dual Diagnosis ☐ Mental Retardation Date Approved: _____

PATIENT DISCHARGE STATUS

Discharged to: _____ Date: _____
Death (Date) _____

Signed _____

Title _____

Distribution:
White: Alabama Medicaid Agency

Blue: Office of determination for Medicaid Eligibility - Check One: ☐ SSI ☐ D.O.
Pink: Nursing Home File Copy

_____
District Office

Form 199 (Formerly XIX - LTC - 4)
Revised 7/01/94

E.7 Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )
Requesting Provider
License # or Provider # _____
Phone ( ) _____
Name _____

Recipient Medicaid # _____
Name _____
Address _____
City/State/Zip _____
EPSDT Screening Date _____ DOB _____
Prescription Date CCYYMMDD _____

Rendering Provider Medicaid # _____
Phone ( )_____
Fax ( )_____

Name _____

Address _____

City/State/Zip _____
Ambulance Transport Code_____
Ambulance Transport Reason Code _____
DME Equipment: _____ New _____Used

First Diagnosis _____._____ Second Diagnosis _____._____
Service Type _____ Patient Condition _____ Prognosis Code _____

(01) Medical Care	(48) Hospital Inpatient Stay*	(75) Prosthetic Device
(02) Surgical	(54) LTC Waiver	(A7) Psychiatric-Inpatient*
(12) DME-Purchase	(56) Ground Transportation	(AC) Targeted Case Management
(18) DME-Rental	(57) Air Transportation	(AD) Occupational Therapy
(35) Dental Care	(69) Maternity	(AE) Physical Therapy
(42) Home Health Care	(72) Inhalation Therapy	(AF) Speech Therapy
(44) Home Health Visits	(74) Private Duty Nursing	(AL) Vision-Optometry

DATES OF SERVICE							
Line Item	START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____
_____
_____
_____
_____
_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider_____ Date_____

FORWARD TO: EDS, P.O. Box 244032 Montgomery, Alabama 36124-4032

Form 342
Revised 08/30/05

Alabama Medicaid Agency

E.8 Sterilization Consent Form

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (Doctor/Clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Month/Day/Year) _____. I, _____, hereby consent of my own free will to be sterilized by (Doctor) _____, by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to: Representative of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) _____ (Date) _____

(Typed/Printed Name) _____

Recipient's Medicaid Number) _____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

_____ American Indian or Alaska Native
_____ Hispanic
_____ Asian or Pacific Islander
_____ Black (not of Hispanic origin)
_____ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized) I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ Language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) _____ (Date) _____

Original – Patient
Copy 2 –EDS
Copy 3 – Patient's Permanent Record
Form 193 (Revised 8-30-02)

STATEMENT OF PERSON OBTAINING CONSENT

Before (Patient's Name) _____ signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Signature) _____ (Date) _____

(Title of Person Obtaining Consent) _____

(Typed/Printed Name) _____

(Facility) _____

(Address) _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (Patient's Name) _____ on (Date) _____, I explained to him/her the nature of the sterilization operation (Specify Type of Operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

1. At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(1) _____ Premature Delivery:
Individual's expected date of delivery: _____

(2) _____ Emergency abdominal surgery:
(Describe circumstances using an attachment)

(Signature) _____ (Date) _____

(Typed/Printed Name of Physician) _____

(Medicaid Provider Number) _____

E.9 Family Planning Services Consent Form

Name: _____
Medicaid Number: _____
Date of Birth: _____

I give my permission to _____ to provide family planning services to me. I understand that I will be given a physical exam that will include a pelvic (female) exam, Pap smear, tests for sexually transmitted diseases (STDs), tests of my blood and urine and any other tests that I might need. I have been told that birth control methods that I can pick from may include oral contraceptives (pills), Depo-Provera shots, intrauterine devices (IUDs), Norplant implant, diaphragms, foams, jellies, condoms, natural family planning or sterilization.

Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

Form 138 (Formerly MED-FP9106)
Revised 2/99

E.10 Prior Authorization Request Form

NOTE:

Prior Authorization Form 369 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.11 Early Refill DUR Override Request Form

NOTE:

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.12 Growth Hormone for AIDS Wasting

NOTE:

PA Form- Growth Hormone-AIDS Wasting, may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.13 Growth Hormone for Children Request Form

NOTE:

PA Form – Growth Hormone- Child may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.14 Adult Growth Hormone Request Form

NOTE:
PA Form – Growth Hormone – Adult may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.15 Maximum Unit Override

NOTE:

The Pharmacy Override Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.16 Miscellaneous Medicaid Pharmacy PA Request Form

NOTE:

The PA Form for Miscellaneous Drugs may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.17 EPSDT Child Health Medical Record (4 pages)

EPSDT CHILD HEALTH MEDICAL RECORD

Name_____ Medicaid Number _____
Last First Middle

Sex Race
___M ____White ____Black ____Am. Indian Birth Date _____
___F ____Latino ____Asian ____Other

I give permission for the child whose name is on this record to receive services in the _____
I understand that he/she will receive tests, immunizations, and exams. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____

FAMILY HISTORY

(Code Member Having Disease)
(F-Father, M-Mother, S-Sibling, GP-Grandparent,O-Other)
If Negative, place an N in the blank

____ heart disease ____ high blood pressure ____ tuberculosis ____ cancer
____ stroke ____ blood problem/disease ____ birth defects ____ stroke
____ asthma ____ nerve/mental problem ____ mental retardation ____ diabetes
____ alcohol/drug abuse ____ foster care ____ Other

Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____

MEDICAL HISTORY

HISTORY	0-Neg +-Pos	DETAIL POSITIVES	HISTORY	0-Neg +-Pos	DETAIL POSITIVES
Childhood Diseases			Frequent Colds		
Diabetes Mellitus			Tonsilitis		
Epilepsy			Bronchitis		
Thyroid Dysfunction			Ear Infection		
Mental I Illness			Pneumonia		
Rheumatic Fever			Convulsions		
Heart Disease			Headache		
Hepatitis			Drug Sensitivity		
Blood Dyscrasia			Allergies		
Anemia			Medications		
Eczema			Operation, Accident		
Tuberculosis			Drug Abuse		
Asthma			Chronic Problems		

Hospitilizations (year & reason)_____

Updates (each screening)_____

Form 172
Revised 1/1/97 Alabama Medicaid Agency

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DEVELOPMENTAL ASSESSMENT

DATE	NORMAL	ABNORMAL (detail)	DATE	NORMAL	ABNORMAL (detail)

ANTICIPATORY GUIDANCE

(Should be done at each screening and documented with a date)

2 Weeks to 3 Months_____
Dates completed

_____Nutrition
_____Safety
_____Spitting up, hiccoughs, sneezing, etc.
_____Immunizations
_____Need for affection
_____Skin & scalp care, bathing frequency
_____Teach how to use the thermometer and when to call the doctor

4 to 6 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Teething & drooling/dental hygiene
_____Fear of strangers
_____Lead poisoning
_____

7 to 12 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Night crying
_____Separation anxiety
_____Need for affection
_____Discipline
_____Lead poisoning
_____

13 to 18 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygeine
_____Temper tantrums
_____Obedience
_____Speech development
_____Lead poisoning
_____Toilet training counseling begins

19 to 24 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Need for peer relationships
_____Sharing
_____Toilet training should be in progress
_____Dental hygeine
_____Need for affection and patience
_____Lead poisoning

3 to 5 Years_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Assertion of independence
_____Need for attention
_____Manners
_____Lead poisoning
_____Alcohol & drugs

6 to 13 Years_____
Dates completed

_____Nutrition
_____Safety (auto passenger safety)
_____Dental care
_____School readiness
_____Onset of sexual awareness
_____Peer relationships (male & female)
_____Parent-child relationships
_____Prepubertal body changes (menst.)
_____Alcohol, drugs and smoking
_____Contraceptive information if sexually active
_____
_____
_____

14 to 21 Years_____
Dates completed

_____Nutrition/dental
_____Safety (automobile)
_____Understanding body anatomy
_____Male-female relationships
_____Contraceptive information
_____Obedience and discipline
_____Parent-child relationships
_____Alcohol, drugs and smoking
_____Occupational guidance
_____Substance abuse
_____
_____
_____

NUTRITIONAL ASSESSMENT

DATE	ADEQUATE	INADEQUATE (detail)	DATE	ADEQUATE	INADEQUATE (detail)

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LABORATORY TESTING

	Hematocrit Hemoglobin	Urine Sugar/Albumin	Lead	Sickle Cell Screen	Other
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					

Date	PROGRESS NOTES	SIGNATURE

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PHYSICAL ASSESSMENT

(UC=Under the care)

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ *UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

PHYSICAL ASSESSMENT

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

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E.18 Alabama Medicaid Agency Referral Form

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date _____ Date Referral Begins _____

Important NPI Information
See Instructions

MEDICAID RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

PRIMARY PHYSICIAN (PMP)	SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)
Name	Name
Address	Address
Telephone # with Area Code _____	Telephone # with Area Code _____
Fax # with Area Code _____	Fax # with Area Code _____
Email _____	Email _____
Provider # _____	Provider # _____
Provider NPI # _____	Provider NPI # _____
Signature _____	Signature _____

TYPE OF REFERRAL

❑ Patient 1st ❑ EPSDT Screening Date _____ ❑ Case Management/Care Coordination	❑ Lock-in ❑ Patient 1st/EPSDT Screening Date _____ ❑ Other

LENGTH OF REFERRAL

Referral Valid for _____ month(s) or _____ visit(s) from date referral begins.

REFERRAL VALID FOR

❑ Evaluation Only ❑ Evaluation and Treatment ❑ Referral by consultant to other provider for identified condition (cascading referral) ❑ Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral)	❑ Treatment Only ❑ Hospital Care (Outpatient) ❑ Performance of Interperiodic Screening (if necessary)

Reason for Referral By Primary Physician (PMP)	Other Conditions/Diagnoses Identified by Primary Physician (PMP)

CONSULTANT INFORMATION

Consultant Name	
Address	Consultant Telephone # with Area Code

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).

Findings should be submitted to primary physician (PMP) by

❑ Mail ❑ E-mail ❑ Fax ❑ In addition, please telephone

Form 362
Rev. 10-23-06

Alabama Medicaid Agency
www.medicaid.alabama.gov

Please find below information regarding the Medicaid Referral Form that was revised on 10/23/06. This information is being provided so that providers have a reference tool when utilizing this form. Questions regarding policy should be referred to the Patient 1st program at (334) 242-5148. Should you need an inservice for your staff on the form, you may contact the Outreach and Education Unit at (334) 353-5203.

General Information

Maintenance of Original Documentation:

1. The PMP should maintain the "original" referral form. Therefore, it is ok for consulting providers to receive copies, faxes or e-mailed versions of the referral form.

2. If the PMP completes, it will have his original signature and the PMP will copy and forward as necessary.

3. If the PMP has an MOU or a contract with someone else to complete the referral form, the PMP will receive a copy of the form from that person and the PMP should initial approval and keep in his/her file and this will become the "original".

4. If the PMP has an outside person performing the screening - the screener will complete their part of the form, sign, and keep this original for their file and forward a copy to the PMP. The PMP will then sign the copy and keep as his original. Therefore, each provider (PMP and screener) will have an original. But, if the referral needs to be forwarded on, a copy with the PMP's signature should be the one to send.

Memorandum of Understanding (MOU)

1. If the PMP has another physician take call for him and they have the understanding that it is ok to use the PMP's referral number, then the covering physician will not have to obtain a written referral. However, if the recipient needs to receive other care from a different provider, the consulting provider will need a written referral from the PMP. If the covering physician has approval from the PMP, the covering physician can sign the referral form on behalf of the PMP.

2. When operating under an MOU, each party must clearly understand what the agreement is so there is not a misunderstanding when it comes time to bill for the services. These parties need to have an agreement/contract in writing.

Completion Instructions

Today's Date – the date the form is completed and signed.

Referral Date – the date the referral is effective. This **is not a required field** but is appropriate to be used when the referral is/was needed for date other than today's date.

Recipient Information – enter recipient demographic information.

Primary Physician – the PMP in most cases. If for a lock-in recipient, it will be for the physician they are assigned to. **Primary Physician Signature**: It is ok to have a stamped signature with initials. It is ok to have someone else sign on behalf of the PMP as long as they have the PMP permission/MOU (memorandum of understanding) and it is indicated on the referral form. If case managers/care coordinators have an agreement with the PMP and are filling out the form for the PMP they should indicate "Signature On File/MOU". On forms that are sent via e-mail the PMP will indicate signature on file. ***Note: The provider number is the number the recipient is assigned to (if a clinic, it will be the clinic number).***

Screening Provider – to be completed only if the person performing a screening is not the PMP or if it is for a child who **is not enrolled in** the Patient 1st program. ***Note: The provider number in this situation is the screening provider number.***

NPI Information –This will enable providers to have the necessary information to receive payment once NPI changes are implemented. Providers receiving referrals SHOULD NOT BEGIN TO USE THE NPI number until advised to do so by Medicaid and EDS.

Type of Referral

Patient 1st – is for a referral that is Patient 1st only (not an EPSDT).

Lock-in – is for a referral for a recipient that is locked into one physician/pharmacy and must have referral for other services.

EPSDT – is for a referral resulting from an EPSDT screening of a recipient who is not enrolled in the Patient 1st program. Date of screening (which is the date the actual screening was performed) needs to be written here. **This is a mandatory field.**

Note: The same screening date should be used for all services provided as the result of the screening – there cannot be retro dates. Also, the referral date may be different from the date of the screening.

Patient 1st/EPSDT – is for a referral resulting from an EPSDT screening of a recipient who is enrolled in the Pt.1st program. Indicate date of the screening **(this is a mandatory field)**.

Note: The same screening date should be used for all services provided as the result of the screening – there cannot be retro dates. Also, the referral date may be different from the date of the screening.

Case Management/Care Coordination – is for a referral to a case manager of the Targeted Case Management Program for the medically at risk. To be used in order for the recipient to receive case management services.

Note: It is possible for more than one referral to be checked - i.e. Patient 1st and Case Management/Care Coordination

Length of Referral – is the amount of time the referral is good for from the referral date. ***This is a mandatory field and must be completed in order for the referral to be valid***. How this section is completed is up to the physician completing the form. In some situations it may be more appropriate to utilize a specific number of visits if the physician knows how many it would take to resolve the problem or if it is for a one-time consultation he/she would indicate one visit. If it is for a condition that may take several months to resolve and it is not known how many visits are needed, then the PMP may prefer to indicate months.

Note: If the referral is to be used for more than one type of referral and the physician wishes the number of visits to be different, then a separate form should be filled out for each type of referral.

Referral Valid For (Check all that apply):

Evaluation only – this would be used in a situation where the physician is sending the recipient for a consultation and wants an evaluation or input on how to formulate the treatment plan. *Example*: A physician who has a recipient with diabetes who is not responding to treatment would be referred to an endocrinologist to determine the best type of Insulin to use.

Evaluation and Treatment – this would be used in a situation where the physician determines the recipient's condition could be better treated by another physician. *Example*: A recipient with cancer would be referred to an oncologist for evaluation and chemotherapy.

Referral by consultant to other provider for identified condition – this would be used in a situation where the physician thinks more than one consultant may be needed to provide treatment for the identified condition. It gives permission to the consultant to refer on to another consultant for the identified diagnosis listed on the referral form without having to call the PMP for another referral. *Example*: Recipient who has been involved in a car wreck and may need care by a cardiologist, an orthopedic, a plastic surgeon, etc.

Referral by consultant to other provider for additional conditions diagnosed by consultant (Cascading Referral) – this would be used in the situation where the physician thinks that there may be more than one problem and would like for the consultant to refer the recipient as necessary without having to contact the PMP for permission. *Example*: A recipient who is referred to a cardiologist for chest pain and it is discovered that the recipient has gallstones.

Treatment Only – this is to be used in a situation where the physician has made the diagnosis but needs treatment to be provided elsewhere. *Example*: A recipient with a back injury who needs physical therapy.

Hospital Care (outpatient) – this would be used in a situation where the recipient needs care provided in the outpatient setting. *Example*: Non-emergency care provided in the emergency room, therapies performed as an outpatient, or care provided through ambulatory surgical centers.

Performance of Interperiodic screening (for children under age 21) if necessary – to be used in the situation where the physician thinks the recipient may have a condition that has not previously been identified or a condition that has changed significantly that may require continued care or follow-up. *Example*: a recipient who is referred to a pulmonologist for respiratory problems and is suspected to have asthma.

Note: Do not perform a screening unless this checked.

Note: If a recipient is in the hospital and you know that care will be needed outside the hospital please obtain a referral for any follow-up services that will be needed.

Reason for referral by Primary Physician/Other Conditions and Diagnoses Identified by Primary Physician– the physician should indicate the reason the recipient is being referred. The physician should also list any other conditions that the recipient currently has that might affect or be affected by treatment. *Example*: A recipient who is being referred for treatment of asthma also has diabetes. It is very important to know that because some of the drugs used for treating asthma can affect blood sugars significantly and if it is not known that the recipient has diabetes, the recipient could have severe adverse reactions.

Consultant information – indicate the name of the provider the recipient is being referred to. If the recipient is to be referred to more than one consultant, they may be listed in other available spaces on the form or listed on another page. The consultant may also indicate in his findings that the recipient is being referred on to another consultant.

Written report – findings of the consultation should be sent to the primary physician unless the physician has an agreement with the EPSDT screener to do the follow-up. The findings should be reported within 30 days.

Submit findings by – the primary physician should indicate whether he wants to be called with the findings, have them mailed, emailed or faxed.

E.19 Residential Treatment Facility Model Attestation Letter

Residential Treatment Facility
Model Attestation Letter

(RTF LETTERHEAD)
NAME OF THE RTF
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER
PROVIDER NUMBER (IF APPLICABLE)

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the (NAME OF FACILITY) hereby complies with all of the requirements set forth in the interim final rule governing use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), the Alabama Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 42 CFR, Section 431.610, have the right to validate that (NAME OF FACILITY) is in compliance with the requirements set forth in the Psych Under 21 rule, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the Alabama Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the Alabama Medicaid Agency if it is my belief that (NAME OF FACILITY) is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature,

Printed Name
Title
Date

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Revised 10/01/01
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov.

E.20 Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 who are admitted to an Alabama residential treatment facility (RTF) on an emergency basis or for individuals who become eligible for Medicaid after admission to the RTF. The interdisciplinary team shall complete and sign this form within 14 days of the emergency admission. This form shall be completed on or before the date of the application for Medicaid coverage for individuals who become eligible after admission. This form shall be filed in the recipient's medical record upon completion to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Admission Date**

INTERDISCIPLINARY TEAM CERTIFICATION:

1. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
2. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
3. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician Team Member **Signature** **Date**

Printed Name of Other Team Member **Signature** **Date**

Printed Name of Other Team Member **Signature** **Date**

Form 371 ***Revised 10/01/01***

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.21 Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility

Certification of Need for Services:
Non-Emergency Admission to a
Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Planned Admission Date**

PHYSICIAN CERTIFICATION:

1. **I am not employed or reimbursed by the facility.**
2. **I have competence in diagnosis and treatment of mental illness.**
3. **I have knowledge of the patient's situation.**
4. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
5. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
6. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician **Physician Signature** **Phone Number** **Date**

Physician Address **License Number**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Form 370 ***Revised 10/01/01***

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.22 Patient 1st Medical Exemption Request Form

The Patient 1st Program is based on the premise that patient care is best served by a medical home where a Primary Medical Provider (PMP) may coordinate care. The purpose of this form is for the provider to list the reasons why a patient would not benefit from this system of care.

_____ _____ _____
(Recipient's Name) (Medicaid Number) (Date of Birth)

Attention Physician: This section is to be completed only by the physician. Please check all blocks that apply regarding the patient's medical condition, and mail to the address below. (**Note:** At least one block should be checked, and the physician information requested below completed.

☐ **Terminal Illness** (**Note:** The enrollee has a six month or less life expectancy and/or is currently a hospice patient.)

☐ **Impaired Mental Condition** which makes it impossible for the adult enrollee to understand and participate in Patient 1st. (**Note:** This statement is not a determination of the patient's legal mental competence.

☐ Currently undergoing **Chemotherapy** or **Radiation treatments.** (**Note:** Exemption for this is temporary and will end with the completion of the therapy).

☐ **Diagnosis/Other information**: (Specify reasons why this recipient would not benefit from having a medical home with a local PMP who would coordinate his/her care.)

_____

_____

_____

_____
Print Physician's Name (Medicaid Provider/NPI Number) Telephone Number

Return Mailing Address City State Zip

_____
Physician's Signature Date

If you have any questions or would like to apply to become a Patient 1st provider, please contact the Patient 1st Program at (334) 242-5148. Send this completed and signed form via Fax to (334)353-3856 or mail to:

Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Form 392
Revised 2/13/07

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.23 PATIENT 1st Complaint/Grievance Form

**Note: for reporting complaints regarding Patient 1st Providers Only*

Mail the completed, ***signed*** form to: Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Name of Person Completing this Form: _____
(May be the recipient, designated friend/family member, medical provider, hospital, community member, etc.)

Date Form Completed: _____ Relationship to Recipient: _____

Recipient Name: _____ DOB: _____

Medicaid Number: _____ County of Residence: _____

Address: _____

Telephone Number:_____

Name of Doctor: _____ Practice: _____

Please describe your complaint in detail including dates/names: (please attach any additional documentation)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Over (See Consent Statement and Signature)

Form 393 Alabama Medicaid Agency

PATIENT 1ST COMPLAINT/GRIEVANCE FORM

Patient 1st staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **PLEASE DO NOT SIGN BOTH STATEMENTS.**

1. If you agree to allow us to use your name in investigating this complaint, please sign the following:

I give the Patient 1st staff permission to use my name when sharing my complaint with the Primary Medical Provider (PMP) named in my complaint. The PMP has my permission to respond to the Patient 1st staff concerning my complaint and release medical records regarding the patient when necessary.

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Complainant's Date of Birth

OR

2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Complainant's Date of Birth

If you have any questions regarding the use of this form or the Patient 1st complaint process, please contact the Patient 1st Program in Montgomery at 334-353-5907. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

Patient 1st PMP Name: _____ PMP# _____

Patient 1st Practice Name: _____

County Where Patient 1st Practice is Located: _____

Comments: _____

E.24 PATIENT 1ST Override Request Form

Complete this form to request a Patient 1st override when you have received a denial for referral services **or** the Primary Medical Provider (PMP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted to Medicaid's System Support Unit within 90 days of the date of service. Overrides will not be considered unless the PMP has been **contacted and refused** to authorize treatment. Attach a "clean claim" with any supporting documentation to this form and mail to System Support at the address below. System Support will process your request within 60 days of receipt. If your request is approved, the corrected claim will be sent to EDS and will be processed. If your request is denied, System Support will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at www.medicaid.alabama.gov.

Mail To:
Alabama Medicaid Agency
System Support
501 Dexter Avenue
Montgomery, AL 36103

Deleted: ~~45~~
Added: 90
Deleted: ~~30~~
Added: 60

Recipient's Name: _____ Medicaid Number: _____

Date(s) of Service: _____

Name of PMP: _____

Name of person contacted at PMP's office: _____Date contacted: _____

Reason PMP stated he would not authorize treatment:

I am requesting an override due to:

☐ Recipient assigned incorrectly to PMP. Please explain: _____

☐ This recipient has moved.

☐ Unable to contact PMP. Please explain: _____

_____

☐ Other. Please explain:_____

_____

Provider Name: _____ Provider Number: _____

Provider Contact: _____ Telephone :( ) _____ Fax:( ) _ _____

Form 391
Revised 8/7/07

Alabama Medicaid Agency

Added: Revised 8/7/07

E.25 Request for Administrative Review of Outdated Medicaid Claim

Alabama Medicaid Agency

REQUEST FOR ADMINISTRATIVE REVIEW OF OUTDATED MEDICAID CLAIM

This form is to be completed only if the claim is more than one year old as specified on the reverse side.

Section A

Print or Type

Provider's Name	Provider Number
Recipient 's Name	Recipient's Medicaid Number
Date of Service	ICN #

I do not agree with the determination you made on my claim as described on my Explanation of Payment dated:

Section B

My reasons are:

Section C

Signature of **either** the provider **or** his/her representative

Provider Signature	Representative Signature
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

Form # 402
Created 11/22/04

This form may be downloaded from the Medicaid website at: www.medicaid.alabama.gov

Alabama Medicaid Agency

7.2.1 - *Administrative Review and Fair Hearings*
Alabama Medicaid Provider Manual

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code.*

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated.** In addition to a clean claim, the provider should send all relevant EOPs and previous correspondence with EDS or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

Administrative Review
Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery AL 36103-5624

Include the program area in the address (for instance, write “Attn: System Support”).

NOTE:

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing.

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F Medicaid Internal Control Numbers (ICN)

EDS assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail.

Processing or returning the claim constitutes EDS' final action on that claim. A resubmission of the same service is considered a new claim.

Each claim sent to EDS is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when EDS actually received the claim.

Example:	98	99	001	200	001
	Region	Year	Julian Date	Batch Range	Sequence

Region

The first two digits in the ICN are the region code, which identifies the source of the claim. In this case, the term *region* refers to the claim's submission method. The following region codes define the claim's media as well.

Region Code	***Where the Claim Originated***
05	Provider submitted AEVCS
07	Managed Care claims (systematically created) (PHP)
10	Electronic claim submission (ECS) and tape billing
22	Managed Care cap claims
33	Paper special batch
50	Online adjustment or PES Pharmacy Recoupment or Adjustment
51	Mass adjustment
52	PES Recoupment or Adjustment
98	Paper submission

Year

The next two digits represent the year. For example, 01 is the year 2001.

Julian Date

The next three digits represent the Julian date. Use the table in this appendix to determine the Julian date.

Batch Range

The next three digits represent the batch range.

Batch Sequence

The last three digits of the ICN represent the sequence in the batch. The Batch sequence is used by Medicaid only.

Julian Date Reference Table - Regular Year

Use this table for years 1999, 2001, 2002, 2003, 2005, 2006, 2007, 2009, 2010, and 2011.

1-Jan	1	1-Mar	60	1-May	121	1-Jul	182	1-Sep	244	1-Nov	305
2-Jan	2	2-Mar	61	2-May	122	2-Jul	183	2-Sep	245	2-Nov	306
3-Jan	3	3-Mar	62	3-May	123	3-Jul	184	3-Sep	246	3-Nov	307
4-Jan	4	4-Mar	63	4-May	124	4-Jul	185	4-Sep	247	4-Nov	308
5-Jan	5	5-Mar	64	5-May	125	5-Jul	186	5-Sep	248	5-Nov	309
6-Jan	6	6-Mar	65	6-May	126	6-Jul	187	6-Sep	249	6-Nov	310
7-Jan	7	7-Mar	66	7-May	127	7-Jul	188	7-Sep	250	7-Nov	311
8-Jan	8	8-Mar	67	8-May	128	8-Jul	189	8-Sep	251	8-Nov	312
9-Jan	9	9-Mar	68	9-May	129	9-Jul	190	9-Sep	252	9-Nov	313
10-Jan	10	10-Mar	69	10-May	130	10-Jul	191	10-Sep	253	10-Nov	314
11-Jan	11	11-Mar	70	11-May	131	11-Jul	192	11-Sep	254	11-Nov	315
12-Jan	12	12-Mar	71	12-May	132	12-Jul	193	12-Sep	255	12-Nov	316
13-Jan	13	13-Mar	72	13-May	133	13-Jul	194	13-Sep	256	13-Nov	317
14-Jan	14	14-Mar	73	14-May	134	14-Jul	195	14-Sep	257	14-Nov	318
15-Jan	15	15-Mar	74	15-May	135	15-Jul	196	15-Sep	258	15-Nov	319
16-Jan	16	16-Mar	75	16-May	136	16-Jul	197	16-Sep	259	16-Nov	320
17-Jan	17	17-Mar	76	17-May	137	17-Jul	198	17-Sep	260	17-Nov	321
18-Jan	18	18-Mar	77	18-May	138	18-Jul	199	18-Sep	261	18-Nov	322
19-Jan	19	19-Mar	78	19-May	139	19-Jul	200	19-Sep	262	19-Nov	323
20-Jan	20	20-Mar	79	20-May	140	20-Jul	201	20-Sep	263	20-Nov	324
21-Jan	21	21-Mar	80	21-May	141	21-Jul	202	21-Sep	264	21-Nov	325
22-Jan	22	22-Mar	81	22-May	142	22-Jul	203	22-Sep	265	22-Nov	326
23-Jan	23	23-Mar	82	23-May	143	23-Jul	204	23-Sep	266	23-Nov	327
24-Jan	24	24-Mar	83	24-May	144	24-Jul	205	24-Sep	267	24-Nov	328
25-Jan	25	25-Mar	84	25-May	145	25-Jul	206	25-Sep	268	25-Nov	329
26-Jan	26	26-Mar	85	26-May	146	26-Jul	207	26-Sep	269	26-Nov	330
27-Jan	27	27-Mar	86	27-May	147	27-Jul	208	27-Sep	270	27-Nov	331
28-Jan	28	28-Mar	87	28-May	148	28-Jul	209	28-Sep	271	28-Nov	332
29-Jan	29	29-Mar	88	29-May	149	29-Jul	210	29-Sep	272	29-Nov	333
30-Jan	30	30-Mar	89	30-May	150	30-Jul	211	30-Sep	273	30-Nov	334
31-Jan	31	31-Mar	90	31-May	151	31-Jul	212				
1-Feb	32	1-Apr	91	1-Jun	152	1-Aug	213	1-Oct	274	1-Dec	335
2-Feb	33	2-Apr	92	2-Jun	153	2-Aug	214	2-Oct	275	2-Dec	336
3-Feb	34	3-Apr	93	3-Jun	154	3-Aug	215	3-Oct	276	3-Dec	337
4-Feb	35	4-Apr	94	4-Jun	155	4-Aug	216	4-Oct	277	4-Dec	338
5-Feb	36	5-Apr	95	5-Jun	156	5-Aug	217	5-Oct	278	5-Dec	339
6-Feb	37	6-Apr	96	6-Jun	157	6-Aug	218	6-Oct	279	6-Dec	340
7-Feb	38	7-Apr	97	7-Jun	158	7-Aug	219	7-Oct	280	7-Dec	341
8-Feb	39	8-Apr	98	8-Jun	159	8-Aug	220	8-Oct	281	8-Dec	342
9-Feb	40	9-Apr	99	9-Jun	160	9-Aug	221	9-Oct	282	9-Dec	343
10-Feb	41	10-Apr	100	10-Jun	161	10-Aug	222	10-Oct	283	10-Dec	344
11-Feb	42	11-Apr	101	11-Jun	162	11-Aug	223	11-Oct	284	11-Dec	345
12-Feb	43	12-Apr	102	12-Jun	163	12-Aug	224	12-Oct	285	12-Dec	346
13-Feb	44	13-Apr	103	13-Jun	164	13-Aug	225	13-Oct	286	13-Dec	347
14-Feb	45	14-Apr	104	14-Jun	165	14-Aug	226	14-Oct	287	14-Dec	348
15-Feb	46	15-Apr	105	15-Jun	166	15-Aug	227	15-Oct	288	15-Dec	349
16-Feb	47	16-Apr	106	16-Jun	167	16-Aug	228	16-Oct	289	16-Dec	350
17-Feb	48	17-Apr	107	17-Jun	168	17-Aug	229	17-Oct	290	17-Dec	351
18-Feb	49	18-Apr	108	18-Jun	169	18-Aug	230	18-Oct	291	18-Dec	352
19-Feb	50	19-Apr	109	19-Jun	170	19-Aug	231	19-Oct	292	19-Dec	353
20-Feb	51	20-Apr	110	20-Jun	171	20-Aug	232	20-Oct	293	20-Dec	354
21-Feb	52	21-Apr	111	21-Jun	172	21-Aug	233	21-Oct	294	21-Dec	355
22-Feb	53	22-Apr	112	22-Jun	173	22-Aug	234	22-Oct	295	22-Dec	356
23-Feb	54	23-Apr	113	23-Jun	174	23-Aug	235	23-Oct	296	23-Dec	357
24-Feb	55	24-Apr	114	24-Jun	175	24-Aug	236	24-Oct	297	24-Dec	358
25-Feb	56	25-Apr	115	25-Jun	176	25-Aug	237	25-Oct	298	25-Dec	359
26-Feb	57	26-Apr	116	26-Jun	177	26-Aug	238	26-Oct	299	26-Dec	360
27-Feb	58	27-Apr	117	27-Jun	178	27-Aug	239	27-Oct	300	27-Dec	361
28-Feb	59	28-Apr	118	28-Jun	179	28-Aug	240	28-Oct	301	28-Dec	362
		29-Apr	119	29-Jun	180	29-Aug	241	29-Oct	302	29-Dec	363
		30-Apr	120	30-Jun	181	30-Aug	242	30-Oct	303	30-Dec	364
						31-Aug	243	31-Oct	304	31-Dec	365

Julian Date Reference Table - Leap Year

Use this table for years 2000, 2004, 2008, and 2012.

1-Jan	1	1-Mar	61	1-May	122	1-Jul	183	1-Sep	245	1-Nov	306
2-Jan	2	2-Mar	62	2-May	123	2-Jul	184	2-Sep	246	2-Nov	307
3-Jan	3	3-Mar	63	3-May	124	3-Jul	185	3-Sep	247	3-Nov	308
4-Jan	4	4-Mar	64	4-May	125	4-Jul	186	4-Sep	248	4-Nov	309
5-Jan	5	5-Mar	65	5-May	126	5-Jul	187	5-Sep	249	5-Nov	310
6-Jan	6	6-Mar	66	6-May	127	6-Jul	188	6-Sep	250	6-Nov	311
7-Jan	7	7-Mar	67	7-May	128	7-Jul	189	7-Sep	251	7-Nov	312
8-Jan	8	8-Mar	68	8-May	129	8-Jul	190	8-Sep	252	8-Nov	313
9-Jan	9	9-Mar	69	9-May	130	9-Jul	191	9-Sep	253	9-Nov	314
10-Jan	10	10-Mar	70	10-May	131	10-Jul	192	10-Sep	254	10-Nov	315
11-Jan	11	11-Mar	71	11-May	132	11-Jul	193	11-Sep	255	11-Nov	316
12-Jan	12	12-Mar	72	12-May	133	12-Jul	194	12-Sep	256	12-Nov	317
13-Jan	13	13-Mar	73	13-May	134	13-Jul	195	13-Sep	257	13-Nov	318
14-Jan	14	14-Mar	74	14-May	135	14-Jul	196	14-Sep	258	14-Nov	319
15-Jan	15	15-Mar	75	15-May	136	15-Jul	197	15-Sep	259	15-Nov	320
16-Jan	16	16-Mar	76	16-May	137	16-Jul	198	16-Sep	260	16-Nov	321
17-Jan	17	17-Mar	77	17-May	138	17-Jul	199	17-Sep	261	17-Nov	322
18-Jan	18	18-Mar	78	18-May	139	18-Jul	200	18-Sep	262	18-Nov	323
19-Jan	19	19-Mar	79	19-May	140	19-Jul	201	19-Sep	263	19-Nov	324
20-Jan	20	20-Mar	80	20-May	141	20-Jul	202	20-Sep	264	20-Nov	325
21-Jan	21	21-Mar	81	21-May	142	21-Jul	203	21-Sep	265	21-Nov	326
22-Jan	22	22-Mar	82	22-May	143	22-Jul	204	22-Sep	266	22-Nov	327
23-Jan	23	23-Mar	83	23-May	144	23-Jul	205	23-Sep	267	23-Nov	328
24-Jan	24	24-Mar	84	24-May	145	24-Jul	206	24-Sep	268	24-Nov	329
25-Jan	25	25-Mar	85	25-May	146	25-Jul	207	25-Sep	269	25-Nov	330
26-Jan	26	26-Mar	86	26-May	147	26-Jul	208	26-Sep	270	26-Nov	331
27-Jan	27	27-Mar	87	27-May	148	27-Jul	209	27-Sep	271	27-Nov	332
28-Jan	28	28-Mar	88	28-May	149	28-Jul	210	28-Sep	272	28-Nov	333
29-Jan	29	29-Mar	89	29-May	150	29-Jul	211	29-Sep	273	29-Nov	334
30-Jan	30	30-Mar	90	30-May	151	30-Jul	212	30-Sep	274	30-Nov	335
31-Jan	31	31-Mar	91	31-May	152	31-Jul	213				
1-Feb	32	1-Apr	92	1-Jun	153	1-Aug	214	1-Oct	275	1-Dec	336
2-Feb	33	2-Apr	93	2-Jun	154	2-Aug	215	2-Oct	276	2-Dec	337
3-Feb	34	3-Apr	94	3-Jun	155	3-Aug	216	3-Oct	277	3-Dec	338
4-Feb	35	4-Apr	95	4-Jun	156	4-Aug	217	4-Oct	278	4-Dec	339
5-Feb	36	5-Apr	96	5-Jun	157	5-Aug	218	5-Oct	279	5-Dec	340
6-Feb	37	6-Apr	97	6-Jun	158	6-Aug	219	6-Oct	280	6-Dec	341
7-Feb	38	7-Apr	98	7-Jun	159	7-Aug	220	7-Oct	281	7-Dec	342
8-Feb	39	8-Apr	99	8-Jun	160	8-Aug	221	8-Oct	282	8-Dec	343
9-Feb	40	9-Apr	100	9-Jun	161	9-Aug	222	9-Oct	283	9-Dec	344
10-Feb	41	10-Apr	101	10-Jun	162	10-Aug	223	10-Oct	284	10-Dec	345
11-Feb	42	11-Apr	102	11-Jun	163	11-Aug	224	11-Oct	285	11-Dec	346
12-Feb	43	12-Apr	103	12-Jun	164	12-Aug	225	12-Oct	286	12-Dec	347
13-Feb	44	13-Apr	104	13-Jun	165	13-Aug	226	13-Oct	287	13-Dec	348
14-Feb	45	14-Apr	105	14-Jun	166	14-Aug	227	14-Oct	288	14-Dec	349
15-Feb	46	15-Apr	106	15-Jun	167	15-Aug	228	15-Oct	289	15-Dec	350
16-Feb	47	16-Apr	107	16-Jun	168	16-Aug	229	16-Oct	290	16-Dec	351
17-Feb	48	17-Apr	108	17-Jun	169	17-Aug	230	17-Oct	291	17-Dec	352
18-Feb	49	18-Apr	109	18-Jun	170	18-Aug	231	18-Oct	292	18-Dec	353
19-Feb	50	19-Apr	110	19-Jun	171	19-Aug	232	19-Oct	293	19-Dec	354
20-Feb	51	20-Apr	111	20-Jun	172	20-Aug	233	20-Oct	294	20-Dec	355
21-Feb	52	21-Apr	112	21-Jun	173	21-Aug	234	21-Oct	295	21-Dec	356
22-Feb	53	22-Apr	113	22-Jun	174	22-Aug	235	22-Oct	296	22-Dec	357
23-Feb	54	23-Apr	114	23-Jun	175	23-Aug	236	23-Oct	297	23-Dec	358
24-Feb	55	24-Apr	115	24-Jun	176	24-Aug	237	24-Oct	298	24-Dec	359
25-Feb	56	25-Apr	116	25-Jun	177	25-Aug	238	25-Oct	299	25-Dec	360
26-Feb	57	26-Apr	117	26-Jun	178	26-Aug	239	26-Oct	300	26-Dec	361
27-Feb	58	27-Apr	118	27-Jun	179	27-Aug	240	27-Oct	301	27-Dec	362
28-Feb	59	28-Apr	119	28-Jun	180	28-Aug	241	28-Oct	302	28-Dec	363
29-Feb	60	29-Apr	120	29-Jun	181	29-Aug	242	29-Oct	303	29-Dec	364
		30-Apr	121	30-Jun	182	30-Aug	243	30-Oct	304	30-Dec	365
						31-Aug	244	31-Oct	305	31-Dec	366

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G Non-Emergency Transportation (NET) Program

The Non-Emergency Transportation (NET) Program provides necessary non-ambulance transportation services to Medicaid recipients. Medicaid pays for rides to a doctor or clinic for medical care or treatment that is covered by Medicaid.

The NET Program has the responsibility to ensure that non-emergency transportation services are provided in the manner described below:

- Similar in scope and duration state-wide, although there will be some variation depending on resources available in a particular geographical location of the state
- Consistent with the best interest of recipients
- Appropriate to available services, geographic location and limitations of recipients
- Prompt, cost-effective, and efficient

Coordinators in the NET Program have the following responsibilities:

- Determine availability of free transportation, including recipient's vehicle, transportation by relative or friend, or volunteer services. Medicaid will not reimburse services if recipient has access to free transportation, except in the case of evident hardship (determined by Alabama Medicaid).
- Establish eligibility (Medicaid does not reimburse for non-eligible transportation services)
- Determine medical necessity for transportation services
- Determine the least costly means of transportation services
- Coordinate in-state and out-of-state commercial bus, train, or air transportation; Medicaid may approve the use of commercial buses, trains or airplanes for in-state and out-of-state use for Medicaid recipients in special circumstances.

Prior Authorization for NET Program

All payments for NET services require prior authorization with the exception of the services listed in Chapter 8, Ambulance, Section 8.2.2, Non-Emergency Ambulance Services, and those services requiring urgent care.

Urgent care is defined as medical care that is required after normal business hours. Requests for reimbursements for non-emergency transportation as a result of urgent care must be made the first business day after the need for transportation occurs.

Medicaid may issue a travel voucher for the cost of fare to recipients who are able to ride public transportation to medical services. Recipients should use public transportation whenever possible. Coordinators should determine that public transportation does not meet the recipient's needs before Medicaid authorizes other modes of transportation.

Recipients who request out-of-state transportation to medical facilities must have a physician send Medicaid a physician's statement that justifies the need for out-of-state services and assures that such services cannot be obtained in-state.

G.1 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

This section explains benefits the NET Program offers to eligible recipients and limitations of NET services.

Escorts

An escort is an individual who is not an employee of a NET transporter and whose presence is required to assist a recipient during transport while at the place of treatment. An escort is typically a relative, guardian, or volunteer. Only one escort is covered per recipient in need, and the recipient must prove an identifiable need for the escort.

Medicaid allows escorts for recipients under the age of 21. A recipient age 21 or older that requests an escort must submit a medical certification statement before Medicaid will reimburse the claim. The certification must document that the recipient has a physical or mental disability that would require assistance, such as the following:

- Blindness
- Deafness
- Mental retardation
- Mental illness
- Physical handicap to a degree that personal assistance is necessary

Covered Services

The NET Program may be used for the following medical services:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Inpatient hospital care
- Outpatient hospital care
- Physician services
- Diagnostic devices (for example, x-ray and laboratory)

- Clinic services (family planning, rural health, and community mental health)
- Dental services
- Orthotic and prosthetic services
- Eye care

NOTE:

Medicaid reimburses transportation service to a physician's office through the NET Program only when prior authorized.

NET Resources

NET services include the following resources when the recipient requires medical care and has no other transportation resources. Coordinators must use the most inexpensive mode of transportation that meets the recipient's needs.

- Automobile (volunteer driver) - Medicaid encourages multiple passenger transportation. Volunteer drivers can be reimbursed for transport from the recipient's home (or place of admission or discharge) and return, unless Medicaid determines paying for additional mileage is the most economical transportation.
- Minibus
- Wheelchair vans - Escorts are allowed for wheelchair vans when prior approved by Medicaid.
- Bus (commercial or city transit) – This service may be provided in-state or out-of-state.
- Airplane transportation
- Train service
- Escort services for minibus, automobile, commercial bus, train, and airplane transportation - Escort services for commercial bus, train, and airplane transportation are reimbursed for the actual cost of the bus, train, or plane ticket.
- Meals and lodging for the recipient and one escort, when required, during overnight travel

Meals and Lodging

When overnight travel is necessary, Medicaid pays for meals and lodging for the recipient and one escort (when authorized). Medicaid must receive receipts or confirmation of expenses before reimbursement can be made. Reimbursement will not exceed $50 per person, per day.

Non-Covered Services

The NET program does not cover the following services:

- Transportation provided by relatives or individuals living in the same household with the Medicaid recipient, except in the case of evident hardship
- Transportation provided in the Medicaid recipient's vehicle or relative's vehicle, except in the case of evident hardship
- Any travel when the Medicaid recipient is not an occupant of the vehicle, unless that would be the most economical transportation available
- Meals and lodging for volunteer drivers
- The use of supplies such as oxygen and intravenous fluids
- Transportation for any services other than those covered by Medicaid
- Transportation provided after the death of a Medicaid recipient
- Minibus or wheelchair van travel 30 miles outside the state line
- Services for which prior approval is required but is not obtained
- Services that are not medically necessary or that are not provided in compliance with the provision of this chapter

G.2 Frequently Asked Questions

This section is intended to help NET program providers answer questions frequently asked by Medicaid recipients.

What is non-emergency transportation?

Medicaid’s NET program is set up to help pay for rides to and from a doctor's office, clinic, or other place for medical care that can be planned ahead of time. This ride can be in a car, bus, or van and can be given by a friend, neighbor, or family member. You can also get a ride on a city bus or from a group in your town or area.

Who can get a ride?

For Medicaid to pay for a ride, the person who is going to the doctor or clinic must be covered by Medicaid for the visit they are going to make and should be approved for the ride ahead of time.

How does the program work?

For Medicaid to pay for a ride, you (or someone who is helping you) will need to call Medicaid's toll-free number at 1-800-362-1504. When you call, the operator will ask you for some information to make sure you are covered by Medicaid and also about your need for a ride. This information will be used to decide if Medicaid can pay for your ride. The NET hotline is open from 8:00 a.m. to 4:00 p.m., Monday through Friday, except on state holidays.

What do I do?

You must first try to get a ride on your own. If you are approved for a ride, you will be told about people or groups in your areas who can help you get a ride for little or no cost.

If the people or groups in your community who usually give you a ride cannot give you a ride, then call the toll-free hotline to speak to an operator. The operator will try to help you. In some cases, a special Medicaid worker may work with you if you have to go for a lot of medical care or treatment (like kidney dialysis or cancer treatments).

What if I have an emergency?

If you have an emergency, call 911 (or the emergency number in your town) to reach an ambulance or paramedics who can help you. Medicaid covers ambulance rides when there is an emergency, such as when someone stops breathing or has been badly hurt.

What do I do if I have a medical problem that can't wait?

A medical problem that must be treated right away, but does not cause your life to be in danger is called an "urgent" medical problem. Broken arms, a bad cut, a baby with a bad earache, or mild chest pains are examples of "urgent" problems.

If you have to pay someone to take you to the emergency room or doctor's office after hours because of an "urgent" problem, you need to call Medicaid's toll-free hotline as soon as possible after the visit to apply for payment. Medicaid pays for the ride to the emergency room only if the visit is for an "urgent" medical problem. Medicaid does not pay for a ride to the emergency room for a problem that can wait until the doctor's office or clinic is open.

How much will Medicaid pay for a ride?

Medicaid pays what is reasonable and necessary to make sure you get the medical care you need. If you have questions about this, ask your operator when you call the toll-free number.

What do I do if I have to pay for a ride to see the doctor on the weekend?

Call the toll-free number the next working day after the ride. Tell the operator where you went for care and why you need help in paying for your ride. Depending on what happened, you might be able to get payment for a ride you had to pay for.

Will Medicaid pay for someone to go with me?

Medicaid pays for an escort for a child or for an adult who is unable to go alone because of a physical or mental disability.

How many rides will Medicaid pay for?

Medicaid pays for rides only to a doctor or clinic for medical care or treatment that is covered by Medicaid. For example, once you use up all of your doctor visits for the year, Medicaid will not pay for rides to any doctor visits.

How will Medicaid pay for my ride?

If your ride is approved, Medicaid sends you a voucher you can use like a check. Once the doctor or clinic staff signs the voucher, you can cash it and use the money to pay for your ride. If you want, you can give the signed voucher to the person who gave you the ride. Once it has been signed, the voucher can be cashed by anyone at a bank or other place that cashes checks.

H Alabama Medicaid Physician Drug List

Effective for dates of service January 1, 2004 and thereafter, Medicaid will begin using only HCPCS codes.

H.1 Policy

H.1.1 Injections

Medicaid covers physician drugs when billed by a physician using the new list of approved HCPCS codes.

The HCPCs drug codes are intended for use in Physician office and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for compounded medications by the billing of NDC numbers through the Pharmacy Program directives.

Appropriate administration code(s) in the Current Procedural Terminology (CPT) may be billed in addition to the HCPCS drug codes and office visit codes for the same date of service. Please refer to the following section "Evaluation and Management Codes Billed in Conjuction With Drug Administration Codes" for details concerning office visits, chemotherapy administration, hydration therapy and chemotherapy, and date specific changes.

Medicare/Medicaid Drugs

Medicare Part B covers some drugs in a physician's office. If the recipient is dually eligible for Medicare and Medicaid, the HCPCS code should be billed first to Medicare.

Medicare Part D drugs are a pharmacy benefit and should not be billed to Medicaid by physicians or outpatient facilities. Part D drugs are billed to Medicare on a pharmacy claim with the NDC number.

Not all drugs listed in Appendix H are considered Part B drugs. Self Administered drugs are generally considered non-covered for Part B benefits. Coverage of Physician Drugs may be found on Medicaid's website at www.medicaid.alabama.gov or by AVRS or Provider Assistance Center at 1-800-688-7989.

Site-Specific Injections

Both the relevant CPT and J codes are billed. For example, a subconjunctival injection to the eye would be billed as 68200 (CPT) with a separate J code for the drug; thus, site specific injections are submitted as two lines.

EVALUATION AND MANAGEMENT CODES BILLED IN CONJUNCTION WITH DRUG ADMINISTRATION CODES

Effective for Dates of Service 01/01/2006 and Thereafter

When an Evaluation and Management Code (E & M) is billed, medical record documentation must support the medical necessity of the visit as well as the level of care provided. CPT Guidelines are utilized to determine if the key components of an Evaluation and Management Code are met. When an Evaluation and Management service is provided *and* a Drug Administration code (90772, 90773, 90774, and 90775) is provided at the same time, the E & M code, Drug Administration Code, and the HCPCs Code for the drug may be billed.

However, when no E & M service is actually provided at the time of a Drug Administration, an E & M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without an E & M service being provided.

There have been 2006 CPT Code changes to describe other Administration Codes for Hydration (90760, 90761), Therapeutic, Prophylactic, and Diagnostic Infusions (90765, 90766, 90767, 90768) and Chemotherapy Administration Codes (96401-96542). A Significant Separately Identifiable Service must be performed in conjunction with these administration codes for consideration of payment for an Evaluation and Management Code to occur. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Codes 99211 will not be allowed with Modifier 25 or in conjunction with the administration codes for the same date of service. Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.

Chemotherapy Injections

For Dates Of Service Prior To July 1, 2005

Medicaid will pay separately for cancer chemotherapy medications (e.g., J codes) and chemotherapy administration (e.g., 96400-96450). If an office visit occurs on the same day as chemotherapy, the office visit must be a significant, separately identifiable evaluation and management service by the same physician.

Physicians will also be paid separately for chemotherapy injections when provided with an infusion during an office visit. (Again, there must be a different diagnosis code than that of cancer.) Separate payments will be made for each chemotherapeutic agent furnished on the day of chemotherapy. This also includes chemotherapy injections when provided with an infusion during an office visit.

Medicaid will not pay for chemotherapy administration in a hospital setting, and claims for these codes with modifier 26 will not be recognized.

Hydration Therapy and Chemotherapy

For Dates Of Service July 1, 2005 Through December 31, 2005

Effective for Dates of Service July 1, 2005 and thereafter, the Alabama Medicaid Agency will adopt Medicare's Drug Pricing Methodology using the Average Sale Price (ASP) for HCPCS injectable drug codes. In keeping with Medicare guidelines, Alabama Medicaid will also adopt the temporary G codes designated for Chemotherapy and Non-Chemotherapy administration codes. These codes are effective for services provided on or after July 1, 2005 and before January 1, 2006. The crosswalk between the previous codes and the new codes is outlined on below.

The following CPT drug administration codes will remain in effect and covered for 2005.

- CPT code 90783 and 90788,
- CPT codes 96405 to 96406,
- CPT codes 96420 to 96520, and
- CPT codes 96530 to 96549.

The change to the G codes brings about an improvement in billing and reporting codes through the creation of new codes to identify initial infusions and additional sequential infusions. There are also new codes to identify additional non-chemotherapy sequential intravenous pushes and intravenous chemotherapy pushes for additional drugs.

Alabama Medicaid has established the following new guidelines that should be utilized by physicians when billing for administration codes.

- For non-chemotherapy injections, services described by codes G0351, G0353, G0354, and CPT codes 90783 and 90788, may be billed in addition to other physician fee schedule services billed by the same provider on the same day of service.

  For IV infusions and chemotherapy infusions, if a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25.

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.

- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are considered separately billable with a modifier 76.

Old Code	New Code	Descriptor	Add-On Code
90780	G0345	Intravenous infusion, hydration; initial, up to 1 hour	
90781	G0346	Intravenous infusion, hydration; each additional hour, up to 8 hours (List separately in addition to code for procedure)	Yes
90780	G0347	Intravenous infusion, for therapy/diagnosis; initial, up to 1 hour (Specify substance or drug)	
90781	G0348	Intravenous infusion, for therapy/diagnosis (Specify substance or drug); Each additional hour, up to 8 hours (List separately in addition to code for procedure)	Yes
90781	G0349	Intravenous infusion, for therapy/diagnosis (Specify substance or drug); Additional sequential infusion, up to 1 hour (List separately in addition to code for procedure)	Yes
NA	G0350	Intravenous infusion, for therapy/diagnosis (Specify substance or drug); Concurrent infusion (List separately in addition to code for procedure)	Yes
90782	G0351	Therapeutic or diagnostic injection (Specify substance or drug); Subcutaneous or Intramuscular	
90784	G0353	Therapeutic or diagnostic injection (Specify substance or drug); Intravenous push, single or initial substance/drug	
NA	G0354	Therapeutic or diagnostic injection (Specify substance or drug); Each additional sequential intravenous push (List separately in addition to code for primary procedure)	Yes
96400	G0355	Chemotherapy administration, subcutaneous or intramuscular; Non-hormonal antineoplastic	
96400	G0356	Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic	
96408	G0357	Chemotherapy administration, intravenous; push technique, Single of initial substance/drug	
96408	G0358	Chemotherapy administration, intravenous; push technique, Each additional substance/drug (List separately in addition to code for primary procedure)	Yes
96410	G0359	Chemotherapy administration, intravenous infusion technique; Up to 1 hour, single or initial substance/drug	
96412	G0360	Chemotherapy administration, intravenous infusion technique, Each additional hour, 1 to 8 hours (List separately in addition to code for primary procedure)	Yes
96414	G0361	Chemotherapy administration, intravenous initiation of prolonged Chemotherapy infusion (more than 8 hours), requiring use of a Portable or implantable pump	
96412	G0362	Chemotherapy administration, intravenous	Yes

Old Code	New Code	Descriptor	Add-On Code
		infusion technique; Each additional sequential infusion, (different substance/drug) Up to 1 hour (List separately in addition to code for primary procedure)	
NA	G0363	Irrigation of implanted venous access device for drug delivery system Reimbursable only when performed as a single service	

For Dates Of Service January 1, 2006 And Thereafter

Effective for Dates of Service January 1, 2006 and thereafter, the Alabama Medicaid Agency will adopt the new CPT's Chemotherapy and Non-Chemotherapy administration codes. Alabama Medicaid will also discontinue coverage of the temporary G codes designated for Chemotherapy and Non-Chemotherapy administration codes effective December 31, 2005. The temporary G codes are effective for services provided on or after July 1, 2005 and before January 1, 2006. The crosswalk between the previous codes and the new codes is outlined on page 2 of this Alert. The following CPT drug administration codes will remain in effect and covered for 2006. Please refer to the CPT 2006 guidelines for Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy) and Chemotherapy Administration codes. The following CPT code ranges are:

- CPT code ranges 90760 through 90775, and
- CPT codes ranges 96401 through 96542.

The change to the new codes brings about an improvement in billing and reporting codes through the creation of new codes to identify initial infusions and additional sequential infusions. There are also new codes to identify additional non-chemotherapy sequential intravenous pushes and intravenous chemotherapy pushes for additional drugs.

Alabama Medicaid has established the following new guidelines that should be utilized by physicians when billing for administration codes.

- For non-chemotherapy injections, services described by CPT codes 90772, 90774, and 90775 may be billed in addition to other physician fee schedule services billed by the same provider on the same day of service.

- For IV infusions and chemotherapy infusions, if a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25.

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.

- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are considered separately billable with a modifier 76.

Old Code	New Code	Descriptor	Add-On Code
G0345	90760	Intravenous infusion, hydration; initial, up to 1 hour	
G0346	90761	Intravenous infusion, hydration; each additional hour, up to 8 hours (List separately in addition to code for procedure)	Yes
G0347	90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour (Specify substance or drug)	
G0348	90766	Intravenous infusion, for therapy, prophylaxis, or diagnosis; (specify substance or drug) each additional hour, up to 8 hours (List separately in addition to code for procedure)	Yes
G0349	90767	Intravenous infusion, for therapy, prophylaxis, or diagnosis (Specify substance or drug); Additional sequential infusion, up to 1 hour (List separately in addition to code for procedure)	Yes
G0350	90768	Intravenous infusion, for therapy, prophylaxis, or diagnosis (Specify substance or drug); Concurrent infusion (List separately in addition to code for procedure)	Yes
G0351	90772	Therapeutic, prophylactic, or diagnostic injection (Specify substance or drug); Subcutaneous or Intramuscular	
90783	90773	Therapeutic, prophylactic or diagnostic injection (Specify substance or drug); intra-arterial	
G0353	90774	Therapeutic, prophylactic or diagnostic injection intravenous push, single or initial substance/	
G0354	90775	Therapeutic, prophylactic or diagnostic injection; each additional sequential intravenous push of a new substance/drug	Yes
G0355	96401	Chemotherapy administration, subcutaneous or intramuscular; Non-hormonal antineoplastic	
G0356	96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic	
G0357	96409	Chemotherapy administration, intravenous; push technique, single or initial substance/drug	
G0358	96411	Chemotherapy administration, intravenous push technique, each additional substance/drug (list separately in addition to code for primary procedure)	Yes
G0359	96413	Chemotherapy administration, intravenous infusion technique, up to 1 hour, single or initial substance/drug	
G0360	96415	Chemotherapy administration, intravenous infusion technique; each additional hour, 1 to 8 hours	Yes
G0361	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a Portable or implantable pump.	
G0362	96417	Chemotherapy administration, intravenous infusion	Yes

Old Code	New Code	Descriptor	Add-On Code
		technique; each additional sequential infusion (different substance/drug) up to 1 hour (List separately in addition to code for primary procedure)	
96520	96521	Refilling and maintenance of portable pump	
96530	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	
G0363	96523	Irrigation of implanted venous access device for drug delivery systems	

Please refer to Chapter 19 (Hospitals) for details on chemotherapy administration and infusion therapy.

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 1-800-688-7989 for reimbursement and guidelines.

Bevacizumab (Avastin)

There are two new procedure codes (PC) available to use for billing Bevacizumab. Both codes became available 1-1-05. The description for code S0116 is "bevacizumab, 100 mg". As a reminder, Avastin should be administered in combination with standard chemotherapy drugs for colon cancer, e.g., Fluorouracil, Leucovorin, Oxaliplatin, and Irinotecan, according to the FDA.

Prior Authorization Required for Orencia and Kineret

Effective September 1, 2006, injectable drugs Orencia (New Code in 2007 - J0129) and Kineret will require prior authorization as Biologicals through Health Information Designs (HID) prior to treatment. Although kineret has 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.

Immune Globulin Replacement Codes

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

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

Please refer to the Physicians' Drug Fee Schedule on Medicaid's website at www.medicaid.alabama.gov or call the EDS Provider Assistance Center 1-800-688-7989 for reimbursement and guidelines.

Effective for dates of service January 1, 2006 and thereafter, Intravenous Immune Globulin has new codes. The codes are listed below for reference and may be viewed on the Physician Drug Fee Schedule on our website at www.medicaid.alabama.gov.

HCPCs Code	Long Description	Max Units
J1566	Injection, Immune Globulin, Intravenous, Lyophilized, (e.g. powder), 500 mg.	140
J1567	Injection, Immune Globulin, Intravenous, Non-Lyophilized, (e.g. liquid), 500 mg	140

Previous HCPCs Codes: Q9941, Q9942, Q9943, and Q9944 have been discontinued effective December 31, 2005.

Allergy Treatments

Physicians may bill for antigen services using only the component codes (i.e., the injection only codes 95115 or 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Physicians providing only an injection service must bill for only code 95115 or code 95117. Professional services for allergen immunotherapy multiple injections (procedure codes 95117 and 95125) should be billed using only one unit. Effective April 1, 2003, the Agency will deny claims for these procedure codes when more than one unit is billed.

Physicians providing only the antigen/antigen preparation service would bill the appropriate code in the range of 95144 through 95170. Physicians providing both services would bill for both services. This includes allergists who provide both services through the use of treatment boards.

Physicians will no longer use the "complete" service codes, and instead must bill for both the injection and the antigen services separately, even though the current CPT definitions of the antigen codes refer to vials and the physicians using treatment boards do not create vials.

Procedure codes 95144 - 95170 are used for the provision of single or multi-dose vials of allergenic extract for single patient use only. These procedures should only be billed at the time that these vials are supplied to the patient.

In the November 2006 Insider, an article was published to announce a change in the maximum number of allowed units for allergen immunotherapy. Medicaid is providing clarification to guide physicians who bill for the provision of allergen immunotherapy. Medicaid allows billing for the allergen at the time an individual vial is first used for a patient, but not for the entire amount of allergen/dilution prepared for the patient at once as this would likely exceed the maximum number of allowed units.

Procedure Code 95165 represents the preparation of vials of non-venom antigens. The reimbursement for procedure code 95165 is based on preparing a vial containing a mixture of all the appropriate antigens plus diluents and calculating the number of 1/2cc billing units in the vial. Using this calculation, a 10cc vial would yield 20 billing units.

Therefore, one-half (1/2) cc equals one (1) billing unit. The actual number of doses received by a patient may differ significantly from the number of billing units. If a physician removes 1/2cc billing units from a 10cc multidose vial, and 20 billing units are obtained from one vial, he/she will still bill Medicaid for 20 billing units (aliquots). Billing for more than 20 billing units per 10cc 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 1/2cc billing units that may be removed from the vial. If a physician prepares two 10cc vials containing **different allergens**, he/she may bill Medicaid for a total of 40 billing units (20 billing units per vial).

The maximum number of billable units (two-10cc vials) for procedure code 95165 was set as “20” effective November 1, 2006. If multiple vials are prepared at one time, each vial should be billed when that vial is opened for use for the patient. Administration of vaccine may continue to be billed as each dose is given in the physician’s office. Medical record documentation must clearly support the treatment plan, each vial used, antigens, dosage, and changes in the treatment regime.

Claims exceeding 20 billing units (such as two 10cc vials containing different allergens) will require manual processing by sending a clean claim with medical justification, medical records, and supporting fact based documentation to:

Alabama Medicaid Agency
P.O. Box 5624
Montgomery, Alabama, 36104
Attention: Medical Support Programs

Botulinum Toxin Injections

HCPCS code for J0587 reads “per 100 units”. Therefore, 100 units of J0587 will equal one billing unit. However, because of the expense of the drug, physicians are encouraged to schedule patients in a manner that they can use botulinum toxin most efficiently. For example, a physician schedules three patients requiring botulinum toxin type A on the same day within the designated shelf life of the drug (shelf life is four hours). The physician administers 30 units to all three patients and bills 30 units for the first two patients and 40 units for the last patient. The physician would bill 40 units for the last patient because the patient received 30 units but the physician had to discard 10 units.

HCPCS code for J0585 reads “per unit”. Therefore this code requires the units of service on the claim to reflect the number of units used. However, if a physician must discard the remainder of a single does vial (sdv) after administering it to a patient, the Agency will cover the amount of the drug discarded along with the amount administered. For example, a physician administers 15 units of botulinum toxin type A and it is not practical to schedule another patient who requires botulinum toxin. Situations that are impractical to schedule another patient include (a) it is the first time the physician has seen the patient and did not know the patient’s condition or (b) the physician has no other patients who require botulinum toxin injections.

Documentation requirements must include the exact dosage of the drug given and the exact amount of the discarded portion in the patient’s medical record as well as the corresponding diagnosis. However, if no benefit is demonstrable by two sets of injections, further injections will not be considered medically necessary.

Units of Service

Physician drug maximum number of units allowed are calculated based on a “per dose” basis, and by the narrative description of the HCPCS code. Some dosages are inherent in the narrative description of the codes and will assist in determining the number of units to file. When administering a lesser or greater dosage than the narrative description providers should round the billing unit up to the closest amount charted. For example, J0290, Ampicillin, up to 500 mg:

If administering 1000mg, bill 2 units

750 mg, bill 2 units

500 mg, bill 1 unit

125 mg, bill 1 unit

The Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicare requests the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication. Medicaid accepts the use of modifier JW, but total units must not exceed maximum number of allowed units.

Added: Medicare requests the…of allowed units.

Flu Vaccination

Procedure code 90657 is covered for the administration fee under the Vaccine for Children (VFC) program for eligible children under three years of age. Procedure codes 90656 and 90658 are a covered service for the administration fee under the VFC program from age three through age eighteen. Code 90658 is covered fee-for-service (vaccine medication) from age nineteen and above.

Vaccines for Children (VFC)

The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children who are 18 years of age and under who are Medicaid eligible, uninsured, American Indian or Alaskan Native, or the under insured. Providers must be enrolled in the VFC Program to receive any reimbursement for the administration of immunizations provided to recipients 0-18 years of age. The Alabama Department of Public Health administers this program.

Medicaid tracks usage of the vaccine through billing of the administration fee using CPT codes. Refer to Section A.7, Vaccines for Children, in the EPSDT appendix in this manual, for covered CPT codes.

ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us for more information.

Adult Immunizations

Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service. Immunizations that are provided to Medicaid eligible recipients 19 years old and older must submit a claim for the appropriate CPT code. Vaccines are reimbursable on a fee-for-service basis. The administration fee may be billed separately if an office visit is not billed.

Unclassified Drugs

A provider who administers a physician drug not listed should use the following J codes:

- 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: EDS, Attn: Medical Policy, PO Box 244032, Montgomery, AL 36124-4032. EDS will determine the price of the drug.

Pricing of Physician Drugs

For Dates of Service prior to July 1, 2005, physician drug prices were updated semi-annually by EDS. Medicaid reimbursement was calculated by averaging the Average Wholesale Prices (AWP) from the *Red Book or 80-95% of DIMA (Drug, Improvement, and Modernization Act).*

Effective for Dates of Service July 1, 2005 and thereafter, the Alabama Medicaid Agency will adopt Medicare's Drug Pricing Methodology using the Average Sale Price (ASP) for HCPCS injectable drug codes.

H.2 Physician Drug List by Name

The following table provides a listing of valid physician drug codes sorted alphabetically by name. To view this list sorted numerically, refer to Section H.3, Physician Drug List by Procedure Code.

The inclusion or exclusion of a procedure code on this list does not imply Medicaid coverage, reimbursement, or lack thereof. To inquire regarding any restrictions/limits on these procedure codes, please consult the Provider Assistance Center at 1-800-688-7989. The pricing file must be verified to determine coverage and reimbursement amounts.

Deleted: ~~Effective for dates…X 1717 – J3301~~

The following drugs can be injected subcutaneously, intramuscularly, or intravenously.

Replaced table

Appendix H as of 08/28/07

Procedure Code	Procedure Code Description	Prior Authorization
J7042	5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)	NO
J7060	5% DEXTROSE/WATER (500 ML = 1 UNIT)	NO
J9015	ALDESLEUKIN, PER SINGLE USE VIAL	NO
J9010	ALEMTUZUMAB, 10 MG	NO
J9017	ARSENIC TRIOXIDE, 1MG	NO
J9020	ASPARAGINASE, 10,000 UNITS	NO
J7501	AZATHIOPRINE, PARENTERAL, 100 MG	NO
90586	BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR BLADDER CANCER, LIVE, FOR INTRAVESICAL USE	NO
90585	BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR TUBERCULOSIS, LIVE, FOR PERCUTANEOUS USE	NO
J9031	BCG (INTRAVESICAL) PER INSTILLATION	NO
J9040	BLEOMYCIN SULFATE, 15 UNITS	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0585	BOTULINUM TOXIN TYPE A, PER UNIT	NO
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS	NO
J9045	CARBOPLATIN, 50 MG	NO
J9050	CARMUSTINE, 100 MG	NO
96445	CHEMOTHERAPY ADMINISTRATION INTO PERITONEAL CAVITY, REQUIRING AND INCLUDING PERITONEOCENTESIS	NO
96440	CHEMOTHERAPY ADMINISTRATION INTO PLEURAL CAVITY, REQUIRING AND INCLUDING THORACENTESIS	NO
96450	CHEMOTHERAPY ADMINISTRATION, INTO CNS (EG, INTRATHECAL), REQUIRING AND INCLUDING SPINAL PUNCTURE	NO
96423	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
96425	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLE OR	NO
96422	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, UP TO ONE HOUR	NO
96420	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE	NO
96415	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
96417	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL SEQUENTIAL INFUSION (DIFFERENT SUBSTANCE/ DRUG), UP TO 1 HOUR (LIST SEPARATELY	NO
96416	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; INITIATION OF PROLONGED CHEMOTHERAPY INFUSION (MORE THAN 8 HOURS), REQUIRING USE OF A	NO
96413	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; UP TO 1 HOUR, SINGLE OR INITIAL SUBSTANCE/DRUG	NO
96402	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; HORMONAL ANTI-NEOPLASTIC	NO

Procedure Code	Procedure Code Description	Prior Authorization
96401	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; NON-HORMONAL ANTI-NEOPLASTIC	NO
96406	CHEMOTHERAPY ADMINISTRATION; INTRALESIONAL, MORE THAN 7 LESIONS	NO
96405	CHEMOTHERAPY ADMINISTRATION; INTRALESIONAL, UP TO AND INCLUDING 7 LESIONS	NO
96411	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, EACH ADDITIONAL SUBSTANCE/ DRUG (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
96409	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, SINGLE OR INITIAL SUBSTANCE/DRUG	NO
J9062	CISPLATIN, 50 MG	NO
J9060	CISPLATIN, POWDER OR S0LUTION, PER 10 MG	NO
J7304	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH	NO
J7303	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING VAGINAL RING, EACH	NO
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM	NO
J9070	CYCLOPHOSPHAMIDE, 100 MG	NO
J9092	CYCLOPHOSPHAMIDE, 2.0 GRAM	NO
J9080	CYCLOPHOSPHAMIDE, 200 MG	NO
J9090	CYCLOPHOSPHAMIDE, 500 MG	NO
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM	NO
J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM	NO
J9094	CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG	NO
J9095	CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG	NO
J7516	CYCLOSPORIN, PARENTERAL, 250 MG	NO
J9098	CYTARABINE LIPOSOME, 10 MG	NO
J9100	CYTARABINE, 100 MG	NO
J9110	CYTARABINE, 500 MG	NO
J9130	DACARBAZINE, 100 MG	NO
J9140	DACARBAZINE, 200 MG	NO
J9120	DACTINOMYCIN, 0.5 MG	NO
J9150	DAUNORUBICIN, 10 MG	NO
90702	DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	NO
90719	DIPHTHERIA TOXOID, FOR INTRAMUSCULAR USE	YES
90723	DIPHTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE, HEPATITIS B, AND POLIOVIRUS VACCINE,	NO
90700	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	NO
90721	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE AND HEMOPHILUS INFLUENZA B VACCINE (DTAP-HIB), FOR INTRAMUSCULAR USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9170	DOCETAXEL, 20 MG	NO
J9000	DOXORUBICIN HCL, 10 MG	NO
J9001	DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG	NO
S0180	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES	NO
J9181	ETOPOSIDE, 10 MG	NO
J9182	ETOPOSIDE, 100 MG	NO
J7189	FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PER 1 MICROGRAM	NO
J9200	FLOXURIDINE, 500 MG	NO
J9185	FLUDARABINE PHOSPHATE, 50 MG	NO
J9190	FLUOROURACIL, 500 MG	NO
J9201	GEMCITABINE HCL, 200 MG	NO
J9300	GEMTUZUMAB OZOGAMICIN, 5MG	NO
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG	NO
90645	HEMOPHILUS INFLUENZA B VACCINE (HIB), HBOC CONJUGATE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90647	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90648	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-T CONJUGATE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
90636	HEPATITIS A AND HEPATITIS B VACCINE (HEPA-HEPB), ADULT DOSAGE, FOR INTRAMUSCULAR USE	NO
90633	HEPATITIS A VACCINE, PEDIATRIC/ADOLESCENT DOSAGE-2 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	NO
90748	HEPATITIS B AND HEMOPHILUS INFLUENZA B VACCINE (HEPB-HIB), FOR INTRAMUSCULAR USE	NO
90371	HEPATITIS B IMMUNE GLOBULIN (HBIG), HUMAN, FOR INTRAMUSCULAR USE	NO
90746	HEPATITIS B VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE	NO
90740	HEPATITIS B VACCINE, DIALYSIS OR IMMUNOSUPPRESSED PATIENT DOSAGE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90747	HEPATITIS B VACCINE, DIALYSIS OR IMMUNOSUPPRESSED PATIENT DOSAGE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90744	HEPATITIS B VACCINE, PEDIATRIC/ADOLESCENT DOSAGE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
J9225	HISTRELIN IMPLANT, 50 MG	NO
90649	HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6, 11, 16, 18 (QUADRIVALENT), 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	NO
Q4085	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4083	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4086	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4084	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
J7130	HYPERTONIC SALINE SOLUTION, 50 OR 100 MEQ, 20 CC VIAL	NO
J9211	IDARUBICIN HYDROCHLORIDE, 5 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9208	IFOSFAMIDE, 1 GM	NO
90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	NO
90660	INFLUENZA VIRUS VACCINE, LIVE, FOR INTRANASAL USE	NO
90655	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	NO
90656	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO 3 YEARS AND OLDER, FOR INTRAMUSCULAR USE	NO
90658	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE	NO
90657	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	NO
J7070	INFUSION, D5W, 1000 CC	NO
J7100	INFUSION, DEXTRAN 40, 500 ML	NO
J7110	INFUSION, DEXTRAN 75, 500 ML	NO
J7030	INFUSION, NORMAL SALINE SOLUTION , 1000 CC	NO
J7050	INFUSION, NORMAL SALINE SOLUTION , 250 CC	NO
J7040	INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML=1 UNIT)	NO
Q4089	INJECTIN, RHO (D0 IMMUNE GLOBULIN (HUMAN) (RHOPHYLAC), INTRAVENOUS, 100 IU	NO
J1450	INJECTION FLUCONAZOLE, 200 MG	NO
J1745	INJECTION INFLIXIMAB, 10 MG	YES

Procedure Code	Procedure Code Description	Prior Authorization
J1830	INJECTION INTERFERON BETA-1B, 0.25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN	NO
J0128	INJECTION, ABARELIX, 10 MG	NO
J0129	INJECTION, ABATACEPT, 10 MG	YES
J0132	INJECTION, ACETYLCYSTEINE, 100 MG	NO
J0133	INJECTION, ACYCLOVIR, 5 MG	NO
J0135	INJECTION, ADALIMUMAB, 20 MG	YES
J0152	INJECTION, ADENOSINE FOR DIAGNOSTIC USE, 30 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS; INSTEAD USE A9270)	NO
J0150	INJECTION, ADENOSINE FOR THERAPEUTIC USE, 6 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)	NO
J0170	INJECTION, ADRENALIN, EPINEPHRINE, UP TO 1 ML AMPULE	NO
J0180	INJECTION, AGALSIDASE BETA, 1 MG	NO
J0215	INJECTION, ALEFACEPT, 0.5 MG	NO
J0205	INJECTION, ALGLUCERASE, PER 10 UNITS	NO
S0147	INJECTION, ALGLUCOSIDASE ALFA, 20 MG	NO
J0256	INJECTION, ALPHA 1 - PROTEINASE INHIBITOR - HUMAN, 10 MG	NO
J2997	INJECTION, ALTEPLASE RECOMBINANT, 1 MG	NO
J0207	INJECTION, AMIFOSTINE, 500 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0280	INJECTION, AMINOPHYLLIN, UP TO 250 MG	NO
J0282	INJECTION, AMIODARONE HYDROCHLORIDE, 30 MG	NO
J1320	INJECTION, AMITRIPTYLINE HCL, UP TO 20 MG	NO
J0300	INJECTION, AMOBARBITAL, UP TO 125 MG	NO
J0288	INJECTION, AMPHOTERICIN B CHOLESTERYL SULFATE COMPLEX, 10 MG	NO
J0287	INJECTION, AMPHOTERICIN B LIPID COMPLEX, 10 MG	NO
J0289	INJECTION, AMPHOTERICIN B LIPOSOME, 10 MG	NO
J0285	INJECTION, AMPHOTERICIN B, 50 MG	NO
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG	NO
J0295	INJECTION, AMPICILLIN SODIUM/SULBACTAM SODIUM, PER 1.5 GM	NO
J0348	INJECTION, ANADULAFUNGIN, 1 MG	NO
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG	NO
J0365	INJECTION, APROTONIN, 10,000 KIU	NO
J0460	INJECTION, ATROPINE SULFATE, UP TO 0.3 MG	NO
J9025	INJECTION, AZACITIDINE, 1 MG	NO
J0456	INJECTION, AZITHROMYCIN, 500 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
S0073	INJECTION, AZTREONAM, 500 MG	NO
J0475	INJECTION, BACLOFEN, 10 MG	NO
J0476	INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL	NO
J0515	INJECTION, BENZTROPINE MESYLATE, PER 1 MG	NO
J0702	INJECTION, BETAMETHASONE ACETATE AND BETAMETHASONE SODIUM PHOSPHATE, PER 3 MG	NO
J0704	INJECTION, BETAMETHASONE SODIUM PHOSPHATE, PER 4 MG	NO
J0520	INJECTION, BETHANECHOL CHLORIDE, MYOTONACHOL OR URECHOLINE, UP TO 5 MG	NO
J9035	INJECTION, BEVACIZUMAB, 10 MG	NO
J0583	INJECTION, BIVALIRUDIN, 1 MG	NO
J9041	INJECTION, BORTEZOMIB, 0.1 MG	NO
J0945	INJECTION, BROMPHENIRAMINE MALEATE, PER 10 MG	NO
S0171	INJECTION, BUMETANIDE, 0.5MG	NO
S0020	INJECTION, BUPIVICAINE HYDROCHLORIDE, 30 ML	NO
J0592	INJECTION, BUPRENORPHINE HYDROCHLORIDE, 0.1 MG	NO
J0595	INJECTION, BUTORPHANOL TARTRATE, 1 MG	NO
J0706	INJECTION, CAFFEINE CITRATE, 5MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0630	INJECTION, CALCITONIN SALMON, UP TO 400 UNITS	NO
J0636	INJECTION, CALCITRIOL, 0.1 MCG	NO
J0610	INJECTION, CALCIUM GLUCONATE, PER 10 ML	NO
J0620	INJECTION, CALCIUM GLYCEROPHOSPHATE AND CALCIUM LACTATE, PER 10 ML	NO
J0637	INJECTION, CASPOFUNGIN ACETATE, 5 MG	NO
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG	NO
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG	NO
J0698	INJECTION, CEFOTAXIME SODIUM, PER GM	NO
S0074	INJECTION, CEFOTETAN DISODIUM, 500 MG	NO
J0694	INJECTION, CEFOXITIN SODIUM, 1 GM	NO
J0713	INJECTION, CEFTAZIDIME, PER 500 MG	NO
J0715	INJECTION, CEFTIZOXIME SODIUM, PER 500 MG	NO
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG	NO
J9055	INJECTION, CETUXIMAB, 10 MG	NO
J0720	INJECTION, CHLORAMPHENICOL SODIUM SUCCINATE, UP TO 1 GM	NO
J1990	INJECTION, CHLORDIAZEPOXIDE HCL, UP TO 100 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2400	INJECTION, CHLOROPROCAINE HYDROCHLORIDE, PER 30 ML	NO
J1205	INJECTION, CHLOROTHIAZIDE SODIUM, PER 500 MG	NO
J0725	INJECTION, CHORIONIC GONADOTROPIN, PER 1,000 USP UNITS	NO
J0740	INJECTION, CIDOFOVIR, 375 MG	NO
J0743	INJECTION, CILASTATIN SODIUM; IMIPENEM, PER 250 MG	NO
S0023	INJECTION, CIMETIDINE HYDROCHLORIDE, 300 MG	NO
J0744	INJECTION, CIPROFLOXACIN FOR INTRAVENOUS INFUSION, 200 MG	NO
J9065	INJECTION, CLADRIBINE, PER 1 MG	NO
S0077	INJECTION, CLINDAMYCIN PHOSPHATE, 300 MG	NO
J0735	INJECTION, CLONIDINE HYDROCHLORIDE, 1 MG	NO
J0745	INJECTION, CODEINE PHOSPHATE, PER 30 MG	NO
J0760	INJECTION, COLCHICINE, PER 1MG	NO
J0770	INJECTION, COLISTIMETHATE SODIUM, UP TO 150 MG	NO
J0795	INJECTION, CORTICORELIN OVINE TRIFLUTATE, 1 MICROGRAM	NO
J0800	INJECTION, CORTICOTROPIN, UP TO 40 UNITS	NO
J0835	INJECTION, COSYNTROPIN, PER 0.25 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0850	INJECTION, CYTOMEGALOVIRUS IMMUNE GLOBULIN INTRAVENOUS (HUMAN), PER VIAL	NO
J1645	INJECTION, DALTEPARIN SODIUM, PER 2500 IU	NO
J0878	INJECTION, DAPTOMYCIN, 1 MG	NO
J0882	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS)	NO
J0881	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)	NO
J0895	INJECTION, DEFEROXAMINE MESYLATE, 500 MG	NO
J1000	INJECTION, DEPO-ESTRADIOL CYPIONATE, UP TO 5 MG	NO
J2597	INJECTION, DESMOPRESSIN ACETATE, PER 1 MCG	NO
J1094	INJECTION, DEXAMETHASONE ACETATE, 1 MG	NO
J1100	INJECTION, DEXAMETHASONE SODIUM PHOSPHATE, 1MG	NO
J1190	INJECTION, DEXRAZOXANE HYDROCHLORIDE, PER 250 MG	NO
J3360	INJECTION, DIAZEPAM, UP TO 5 MG	NO
J1730	INJECTION, DIAZOXIDE, UP TO 300 MG	NO
J0500	INJECTION, DICYCLOMINE HCL, UP TO 20 MG	NO
J1162	INJECTION, DIGOXIN IMMUNE FAB (OVINE), PER VIAL	NO
J1160	INJECTION, DIGOXIN, UP TO 0.5 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1110	INJECTION, DIHYDROERGOTAMINE MESYLATE, PER 1 MG	NO
J1240	INJECTION, DIMENHYDRINATE, UP TO 50 MG	NO
J0470	INJECTION, DIMERCAPROL, PER 100 MG	NO
J1200	INJECTION, DIPHENHYDRAMINE HCL, UP TO 50 MG	NO
J1245	INJECTION, DIPYRIDAMOLE, PER 10 MG	NO
J1212	INJECTION, DMSO, DIMETHYL SULFOXIDE, 50%, 50 ML	NO
J1250	INJECTION, DOBUTAMINE HYDROCHLORIDE, PER 250 MG	NO
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG	NO
J1265	INJECTION, DOPAMINE HCL, 40 MG	NO
J1270	INJECTION, DOXERCALCIFEROL, 1 MCG	NO
J1810	INJECTION, DROPERIDOL AND FENTANYL CITRATE, UP TO 2 ML AMPULE	NO
J1790	INJECTION, DROPERIDOL, UP TO 5 MG	NO
J1180	INJECTION, DYPHYLLINE, UP TO 500 MG	NO
J0600	INJECTION, EDETATE CALCIUM DISODIUM, UP TO 1000 MG	NO
S0162	INJECTION, EFALIZUMAB, 125 MG	YES
J9175	INJECTION, ELLIOTTS' B SOLUTION, 1 ML	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1650	INJECTION, ENOXAPARIN SODIUM, 10 MG	NO
J9178	INJECTION, EPIRUBICIN HCL, 2 MG	NO
J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS	NO
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)	NO
J0886	INJECTION, EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)	NO
J1327	INJECTION, EPTIFIBATIDE, 5 MG	NO
J1335	INJECTION, ERTAPENEM SODIUM, 500 MG	NO
J1364	INJECTION, ERYTHROMYCIN LACTOBIONATE, PER 500 MG	NO
J1380	INJECTION, ESTRADIOL VALERATE, UP TO 10 MG	NO
J1390	INJECTION, ESTRADIOL VALERATE, UP TO 20 MG	NO
J0970	INJECTION, ESTRADIOL VALERATE, UP TO 40 MG	NO
J1410	INJECTION, ESTROGEN CONJUGATED, PER 25 MG	NO
J1435	INJECTION, ESTRONE, PER 1 MG	NO
J1438	INJECTION, ETANERCEPT, 25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG	YES
J1430	INJECTION, ETHANOLAMINE OLEATE, 100 MG	NO
J1436	INJECTION, ETIDRONATE DISODIUM, PER 300 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
S0028	INJECTION, FAMOTIDINE, 20 MG	NO
J3010	INJECTION, FENTANYL CITRATE, 0.1 MG	NO
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG	NO
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG	NO
J2680	INJECTION, FLUPHENAZINE DECANOATE, UP TO 25 MG	NO
J1451	INJECTION, FOMEPIZOLE, 15 MG	NO
J1652	INJECTION, FONDAPARINUX SODIUM, 0.5 MG	NO
J1455	INJECTION, FOSCARNET SODIUM, PER 1000 MG	NO
Q2009	INJECTION, FOSPHENYTOIN, 50 MG	NO
J9395	INJECTION, FULVESTRANT, 25 MG	NO
J1940	INJECTION, FUROSEMIDE, UP TO 20 MG	NO
J1457	INJECTION, GALLIUM NITRATE, 1 MG	NO
J1458	INJECTION, GALSULFASE, 1 MG	NO
J1460	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 1 CC	NO
J1550	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 10 CC	NO
J1470	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 2 CC	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1480	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 3 CC	NO
J1490	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 4 CC	NO
J1500	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 5 CC	NO
J1510	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 6 CC	NO
J1520	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 7 CC	NO
J1530	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 8 CC	NO
J1540	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 9 CC	NO
J1560	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, OVER 10 CC	NO
J1570	INJECTION, GANCICLOVIR SODIUM, 500 MG	NO
J1580	INJECTION, GARAMYCIN, GENTAMICIN, UP TO 80 MG	NO
J1590	INJECTION, GATIFLOXACIN, 10MG	NO
J1595	INJECTION, GLATIRAMER ACETATE, 20 MG	NO
J1610	INJECTION, GLUCAGON HYDROCHLORIDE, PER 1 MG	NO
J1600	INJECTION, GOLD SODIUM THIOMALATE, UP TO 50 MG	NO
J1620	INJECTION, GONADORELIN HYDROCHLORIDE, PER 100 MCG	NO
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1631	INJECTION, HALOPERIDOL DECANOATE, PER 50 MG	NO
J1630	INJECTION, HALOPERIDOL, UP TO 5 MG	NO
J1640	INJECTION, HEMIN, 1 MG	NO
J1642	INJECTION, HEPARIN SODIUM, (HEPARIN LOCK FLUSH), PER 10 UNITS	NO
J1644	INJECTION, HEPARIN SODIUM, PER 1000 UNITS	NO
Q4090	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAOGAMB) INTRAMUSCULAR, 0.5 ML	NO
J0360	INJECTION, HYDRALAZINE HCL, UP TO 20 MG	NO
J1700	INJECTION, HYDROCORTISONE ACETATE, UP TO 25 MG	NO
J1720	INJECTION, HYDROCORTISONE SODIUM SUCCINATE, UP TO 100 MG	NO
J1170	INJECTION, HYDROMORPHONE, UP TO 4 MG	NO
J1980	INJECTION, HYOSCYAMINE SULFATE, UP TO 0.25 MG	NO
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG	NO
J1742	INJECTION, IBUTILIDE FUMARATE, 1 MG	NO
Q4091	INJECTION, IMMUNE GLOBULIN, (FLEBAGAMMA), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	NO
Q4088	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD), INTRAVENOUS, NON-LYOPHILIZED, (E.G LIQUID), 500 MG	NO
Q4092	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
Q4087	INJECTION, IMMUNE GLOBULIN, (OCTOGAM), INTRAVENOUS, NON-LYOPHILIZED, (E.G LIQUID), 500 MG	NO
J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG	NO
J1815	INJECTION, INSULIN, PER 5 UNITS	NO
J9212	INJECTION, INTERFERON ALFACON-1, RECOMBINANT, 1 MCG	NO
Q3025	INJECTION, INTERFERON BETA-1A, 11 MCG FOR INTRAMUSCULAR USE	NO
Q3026	INJECTION, INTERFERON BETA-1A, 11 MCG FOR SUBCUTANEOUS USE	NO
J1825	INJECTION, INTERFERON BETA-1A, 33 MCG	NO
J1751	INJECTION, IRON DEXTRAN 165, 50 MG	NO
J1752	INJECTION, IRON DEXTRAN 267, 50 MG	NO
J1756	INJECTION, IRON SUCROSE, 1 MG	NO
J3365	INJECTION, IV, UROKINASE, 250,000 I.U. VIAL	NO
J1840	INJECTION, KANAMYCIN SULFATE, UP TO 500 MG	NO
J1850	INJECTION, KANAMYCIN SULFATE, UP TO 75 MG	NO
J1885	INJECTION, KETOROLAC TROMETHAMINE, PER 15 MG	NO
J1931	INJECTION, LARONIDASE, 0.1 MG	NO
J1945	INJECTION, LEPIRUDIN, 50 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1950	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG	NO
J1955	INJECTION, LEVOCARNITINE, PER 1 GM	NO
J1956	INJECTION, LEVOFLOXACIN, 250 MG	NO
J1960	INJECTION, LEVORPHANOL TARTRATE, UP TO 2 MG	NO
J2001	INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG	NO
J2010	INJECTION, LINCOMYCIN HCL, UP TO 300 MG	NO
J2060	INJECTION, LORAZEPAM, 2 MG	NO
J3475	INJECTION, MAGNESIUM SULFATE, PER 500 MG	NO
J2150	INJECTION, MANNITOL, 25% IN 50 ML	NO
J1056	INJECTION, MEDROXYPROGESTERONE ACETATE / ESTRADIOL CYPIONATE, 5MG / 25MG	NO
J1055	INJECTION, MEDROXYPROGESTERONE ACETATE FOR CONTRACEPTIVE USE, 150 MG	NO
J1051	INJECTION, MEDROXYPROGESTERONE ACETATE, 50 MG	NO
J9245	INJECTION, MELPHALAN HYDROCHLORIDE, 50 MG	NO
J2180	INJECTION, MEPERIDINE AND PROMETHAZINE HCL, UP TO 50 MG	NO
J2175	INJECTION, MEPERIDINE HYDROCHLORIDE, PER 100 MG	NO
J0670	INJECTION, MEPIVACAINE HYDROCHLORIDE, PER 10 ML	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2185	INJECTION, MEROPENEM, 100 MG	NO
J0380	INJECTION, METARAMINOL BITARTRATE, PER 10 MG	NO
J2800	INJECTION, METHOCARBAMOL, UP TO 10 ML	NO
J0210	INJECTION, METHYLDOPATE HCL, UP TO 250 MG	NO
J2210	INJECTION, METHYLERGONOVINE MALEATE, UP TO 0.2 MG	NO
J1020	INJECTION, METHYLPREDNISOLONE ACETATE, 20 MG	NO
J1030	INJECTION, METHYLPREDNISOLONE ACETATE, 40 MG	NO
J1040	INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG	NO
J2930	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 125 MG	NO
J2920	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 40 MG	NO
J2765	INJECTION, METOCLOPRAMIDE HCL, UP TO 10 MG	NO
S0030	INJECTION, METRONIDAZOLE, 500 MG	NO
J2248	INJECTION, MICAFUNGIN SODIUM, 1 MG	NO
J2250	INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG	NO
J2260	INJECTION, MILRINONE LACTATE, 5 MG	NO
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2275	INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG	NO
J2271	INJECTION, MORPHINE SULFATE, 100 MG	NO
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	NO
S0032	INJECTION, NAFCILLIN SODIUM, 2 GRAMS	NO
J2300	INJECTION, NALBUPHINE HYDROCHLORIDE, PER 10 MG	NO
J2310	INJECTION, NALOXONE HYDROCHLORIDE, PER 1 MG	NO
J2321	INJECTION, NANDROLONE DECANOATE, UP TO 100 MG	NO
J2322	INJECTION, NANDROLONE DECANOATE, UP TO 200 MG	NO
J2320	INJECTION, NANDROLONE DECANOATE, UP TO 50 MG	NO
J9261	INJECTION, NELARABINE, 50 MG	NO
J2710	INJECTION, NEOSTIGMINE METHYLSULFATE, UP TO 0.5 MG	NO
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	NO
J2354	INJECTION, OCTREOTIDE, NON-DEPOT FORM FOR SUBCUTANEOUS OR INTRAVENOUS INJECTION, 25 MCG	NO
J2357	INJECTION, OMALIZUMAB, 5 MG	NO
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG	NO
J2355	INJECTION, OPRELVEKIN, 5 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2360	INJECTION, ORPHENADRINE CITRATE, UP TO 60 MG	NO
J2700	INJECTION, OXACILLIN SODIUM, UP TO 250 MG	NO
J9263	INJECTION, OXALIPLATIN, 0.5 MG	NO
J2410	INJECTION, OXYMORPHONE HCL, UP TO 1 MG	NO
J2460	INJECTION, OXYTETRACYCLINE HCL, UP TO 50 MG	NO
J2590	INJECTION, OXYTOCIN, UP TO 10 UNITS	NO
J9264	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG	NO
J2425	INJECTION, PALIFERMIN, 50 MICROGRAMS	NO
J2469	INJECTION, PALONOSETRON HCL, 25 MCG	NO
J2430	INJECTION, PAMIDRONATE DISODIUM, PER 30 MG	NO
S0164	INJECTION, PANTOPRAZOLE SODIUM, 40 MG	NO
J2440	INJECTION, PAPAVERINE HCL, UP TO 60 MG	NO
J2501	INJECTION, PARICALCITOL, 1 MCG	NO
J2504	INJECTION, PEGADEMASE BOVINE, 25 IU	NO
J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG	NO
J2505	INJECTION, PEGFILGRASTIM, 6 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
S0146	INJECTION, PEGYLATED INTERFERON ALFA-2B, 10 MCG PER 0.5 ML	NO
J9305	INJECTION, PEMETREXED, 10 MG	NO
J0540	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 1,200,000 UNITS	NO
J0550	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 2,400,000 UNITS	NO
J0530	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 600,000 UNITS	NO
J0570	INJECTION, PENICILLIN G BENZATHINE, UP TO 1,200,000 UNITS	NO
J0580	INJECTION, PENICILLIN G BENZATHINE, UP TO 2,400,000 UNITS	NO
J0560	INJECTION, PENICILLIN G BENZATHINE, UP TO 600,000 UNITS	NO
J2540	INJECTION, PENICILLIN G POTASSIUM, UP TO 600,000 UNITS	NO
J2510	INJECTION, PENICILLIN G PROCAINE, AQUEOUS, UP TO 600,000 UNITS	NO
J2513	INJECTION, PENTASTARCH, 10% SOLUTION, 100 ML	NO
J3070	INJECTION, PENTAZOCINE, 30 MG	NO
J2515	INJECTION, PENTOBARBITAL SODIUM, PER 50 MG	NO
J2560	INJECTION, PHENOBARBITAL SODIUM, UP TO 120 MG	NO
J2760	INJECTION, PHENTOLAMINE MESYLATE, UP TO 5 MG	NO
J2370	INJECTION, PHENYLEPHRINE HCL, UP TO 1 ML	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1165	INJECTION, PHENYTOIN SODIUM, PER 50 MG	NO
J3430	INJECTION, PHYTONADIONE (VITAMIN K), PER 1 MG	NO
S0081	INJECTION, PIPERACILLIN SODIUM, 500 MG	NO
J2543	INJECTION, PIPERACILLIN SODIUM/TAZOBACTAM SODIUM, 1 GRAM/0.125 GRAMS (1.125 GRAMS)	NO
J3480	INJECTION, POTASSIUM CHLORIDE, PER 2 MEQ	NO
J2730	INJECTION, PRALIDOXIME CHLORIDE, UP TO 1 GM	NO
J2650	INJECTION, PREDNISOLONE ACETATE, UP TO 1 ML	NO
J2690	INJECTION, PROCAINAMIDE HCL, UP TO 1 GM	NO
J0780	INJECTION, PROCHLORPERAZINE, UP TO 10 MG	NO
J2675	INJECTION, PROGESTERONE, PER 50 MG	NO
J2950	INJECTION, PROMAZINE HCL, UP TO 25 MG	NO
J2550	INJECTION, PROMETHAZINE HCL, UP TO 50 MG	NO
J1800	INJECTION, PROPRANOLOL HCL, UP TO 1 MG	NO
J2720	INJECTION, PROTAMINE SULFATE, PER 10 MG	NO
J2725	INJECTION, PROTIRELIN, PER 250 MCG	NO
J3415	INJECTION, PYRIDOXINE HCL, 100 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2780	INJECTION, RANITIDINE HYDROCHLORIDE, 25 MG	NO
J2783	INJECTION, RASBURICASE, 0.5 MG	NO
J2993	INJECTION, RETEPLASE, 18.1 MG	NO
J2790	INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, FULL DOSE, 300 MCG	NO
J2788	INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, MINIDOSE, 50 MCG	NO
J2792	INJECTION, RHO D IMMUNE GLOBULIN, INTRAVENOUS, HUMAN, SOLVENT DETERGENT, 100 IU	NO
J2794	INJECTION, RISPERIDONE, LONG ACTING, 0.5 MG	NO
J2795	INJECTION, ROPIVACAINE HYDROCHLORIDE, 1 MG	NO
J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG	NO
J2805	INJECTION, SINCALIDE, 5 MICROGRAMS	NO
J2916	INJECTION, SODIUM FERRIC GLUCONATE COMPLEX IN SUCROSE INJECTION, 12.5 MG	NO
J2941	INJECTION, SOMATROPIN, 1 MG	NO
J3320	INJECTION, SPECTINOMYCIN DIHYDROCHLORIDE, UP TO 2 GM	NO
J0697	INJECTION, STERILE CEFUROXIME SODIUM, PER 750 MG	NO
J2995	INJECTION, STREPTOKINASE, PER 250,000 IU	NO
J3000	INJECTION, STREPTOMYCIN, UP TO 1 GM	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0330	INJECTION, SUCCINYLCHOLINE CHLORIDE, UP TO 20 MG	NO
J3030	INJECTION, SUMATRIPTAN SUCCINATE, 6 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG	NO
J3100	INJECTION, TENECTEPLASE, 50MG	NO
Q2017	INJECTION, TENIPOSIDE, 50 MG	NO
J3105	INJECTION, TERBUTALINE SULFATE, UP TO 1 MG	NO
J1060	INJECTION, TESTOSTERONE CYPIONATE AND ESTRADIOL CYPIONATE, UP TO 1 ML	NO
J1080	INJECTION, TESTOSTERONE CYPIONATE, 1 CC, 200 MG	NO
J1070	INJECTION, TESTOSTERONE CYPIONATE, UP TO 100 MG	NO
J3120	INJECTION, TESTOSTERONE ENANTHATE, UP TO 100 MG	NO
J3130	INJECTION, TESTOSTERONE ENANTHATE, UP TO 200 MG	NO
J3411	INJECTION, THIAMINE HCL, 100 MG	NO
J3280	INJECTION, THIETHYLPERAZINE MALEATE, UP TO 10 MG	NO
J3243	INJECTION, TIGECYCLINE, 1 MG	NO
J1655	INJECTION, TINZAPARIN SODIUM, 1000 IU	NO
J3265	INJECTION, TORSEMIDE, 10 MG/ML	NO
J3285	INJECTION, TREPROSTINIL, 1 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J3305	INJECTION, TRIMETREXATE GLUCURONATE, PER 25 MG	NO
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG	NO
J3364	INJECTION, UROKINASE, 5000 IU VIAL	NO
J3370	INJECTION, VANCOMYCIN HCL, 500 MG	NO
J3396	INJECTION, VERTEPORFIN, 0.1 MG	NO
J7187	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR, PER IU VWF:RCO	NO
J3465	INJECTION, VORICONAZOLE, 10 MG	NO
J3485	INJECTION, ZIDOVUDINE, 10 MG	NO
J3486	INJECTION, ZIPRASIDONE MESYLATE, 10 MG	NO
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG	NO
J3230	INJECTION,CHLORPROMAZINE HCL,UP TO 50MG	NO
J3410	INJECTION,HYDROXYZINE HCL,UP TO 25MG	NO
J0640	INJECTION,LEUCOVORIN CALCIUM,PER 50MG	NO
J1670	INJECTION,TETANUS IMMUNE GLOBULIN,HUMAN,UP TO 250 UNITS	NO
J3260	INJECTION,TOBRAMYCIN SULFATE,UP TO 80MG	NO
J3301	INJECTION,TRIAMCINOLONE ACETONIDE,PER 10MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J3302	INJECTION,TRIAMCINOLONE DIACETATE, PER 5MG	NO
J3303	INJECTION,TRIAMCINOLONE HEXACETONIDE,PER 5MG	NO
J3250	INJECTION,TRIMETHOBENZAMIDE HCL,UP TO 200MG	NO
J3420	INJECTION,VITAMIN B-12 CYANOCOBALAMIN,UP TO 1000MCG	NO
J9213	INTERFERON, ALFA-2A, RECOMBINANT, 3 MILLION UNITS	NO
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS	NO
J9215	INTERFERON, ALFA-N3, (HUMAN LEUKOCYTE DERIVED), 250,000 IU	NO
J9216	INTERFERON, GAMMA 1-B, 3 MILLION UNITS	NO
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	NO
90767	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); ADDITIONAL SEQUENTIAL INFUSION, UP TO 1 HOUR (LIST SEPARATELY IN	NO
90768	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); CONCURRENT INFUSION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY	NO
90766	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY	NO
90765	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO 1 HOUR	NO
90761	INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
90760	INTRAVENOUS INFUSION, HYDRATION; INITIAL, UP TO 1 HOUR	NO
J9206	IRINOTECAN, 20 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
96523	IRRIGATION OF IMPLANTED VENOUS ACCESS DEVICE FOR DRUG DELIVERY SYSTEMS	NO
90735	JAPANESE ENCEPHALITIS VIRUS VACCINE, FOR SUBCUTANEOUS USE	NO
J9217	LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	NO
J9219	LEUPROLIDE ACETATE IMPLANT, 65 MG	NO
J9218	LEUPROLIDE ACETATE,PER 1MG	NO
J7302	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG	NO
J7504	LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, EQUINE, PARENTERAL, 250 MG	NO
J7511	LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, RABBIT, PARENTERAL, 25MG	NO
90708	MEASLES AND RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	NO
90705	MEASLES VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	YES
90707	MEASLES, MUMPS AND RUBELLA VIRUS VACCINE (MMR), LIVE, FOR SUBCUTANEOUS USE	NO
90710	MEASLES, MUMPS, RUBELLA, AND VARICELLA VACCINE (MMRV), LIVE, FOR SUBCUTANEOUS USE	NO
J9230	MECHLORETHAMINE HYDROCHLORIDE, (NITROGEN MUSTARD), 10 MG	NO
90734	MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS A, C, Y AND W-135 (TETRAVALENT), FOR INTRAMUSCULAR USE	NO
90733	MENINGOCOCCAL POLYSACCHARIDE VACCINE (ANY GROUP(S)), FOR SUBCUTANEOUS USE	NO
J9209	MESNA, 200 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9250	METHOTREXATE SODIUM, 5 MG	NO
J9260	METHOTREXATE SODIUM, 50 MG	NO
J9290	MITOMYCIN, 20 MG	NO
J9291	MITOMYCIN, 40 MG	NO
J9280	MITOMYCIN, 5 MG	NO
90704	MUMPS VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	YES
J9265	PACLITAXEL, 30 MG	NO
J9266	PEGASPARGASE, PER SINGLE DOSE VIAL	NO
J9268	PENTOSTATIN, PER 10 MG	NO
90727	PLAGUE VACCINE, FOR INTRAMUSCULAR USE	NO
90669	PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, WHEN ADMINISTERED TO CHILDREN YOUNGER THAN 5 YEARS, FOR INTRAMUSCULAR USE	NO
90732	PNEUMOCOCCAL POLYSACCHARIDE VACCINE, 23-VALENT, ADULT OR IMMUNOSUPPRESSED PATIENT DOSAGE, WHEN ADMINISTERED TO 2 YEARS OR OLDER, FOR SUBCUTANEOUS OR	NO
90713	POLIOVIRUS VACCINE, INACTIVATED, (IPV), FOR SUBCUTANEOUS OR INTRAMUSCULAR USE	NO
90375	RABIES IMMUNE GLOBULIN (RIG), HUMAN, FOR INTRAMUSCULAR AND/ OR SUBCUTANEOUS USE	NO
90676	RABIES VACCINE, FOR INTRADERMAL USE	NO
90675	RABIES VACCINE, FOR INTRAMUSCULAR USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
96522	REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SYSTEMIC (EG, INTRAVENOUS, INTRA-ARTERIAL)	NO
96521	REFILLING AND MAINTENANCE OF PORTABLE PUMP	NO
90378	RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN (RSV-IGIM), FOR INTRAMUSCULAR USE, 50 MG, EACH	YES
J7120	RINGERS LACTATE INFUSION, UP TO 1000 CC	NO
J9310	RITUXIMAB, 100 MG	NO
90706	RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	YES
J9320	STREPTOZOCIN, 1 GM	NO
J7525	TACROLIMUS, PARENTERAL, 5 MG	NO
S0189	TESTOSTERONE PELLET, 75MG	NO
90718	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NO
90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NO
90703	TETANUS TOXOID ADSORBED, FOR INTRAMUSCULAR USE	NO
90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NO
90775	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH OF A NEW SUBSTANCE/ DRUG (LIST	NO
90773	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRA-ARTERIAL	NO
90774	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRAVENOUS PUSH, SINGLE OR INITIAL SUBSTANCE/DRUG	NO

Procedure Code	Procedure Code Description	Prior Authorization
90772	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR	NO
J9340	THIOTEPA, 15 MG	NO
J9350	TOPOTECAN, 4 MG	NO
J9355	TRASTUZUMAB, 10 MG	NO
J3590	UNCLASSIFIED BIOLOGICS	NO
J9357	VALRUBICIN, INTRAVESICAL, 200 MG	NO
90716	VARICELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	NO
J9360	VINBLASTINE SULFATE, 1 MG	NO
J9370	VINCRISTINE SULFATE, 1 MG	NO
J9375	VINCRISTINE SULFATE, 2 MG	NO
J9380	VINCRISTINE SULFATE, 5 MG	NO
J9390	VINORELBINE TARTRATE, PER 10 MG	NO
90717	YELLOW FEVER VACCINE, LIVE, FOR SUBCUTANEOUS USE	NO

H.3 Physician Drug List by Procedure Code

The following table provides a listing of valid physician drug codes sorted numerically by procedure code. To view this list sorted alphabetically, refer to Section H.2, Physician Drug List by Name.

The following drugs can be injected subcutaneously, intramuscularly, or intravenously.

Replaced table

Appendix H as of 08/28/07

Procedure Code	Procedure Code Description	Prior Authorization
90371	HEPATITIS B IMMUNE GLOBULIN (HBIG), HUMAN, FOR INTRAMUSCULAR USE	NO
90375	RABIES IMMUNE GLOBULIN (RIG), HUMAN, FOR INTRAMUSCULAR AND/ OR SUBCUTANEOUS USE	NO
90378	RESPIRATORY SYNCYTIAL VIRUS IMMUNE GLOBULIN (RSV-IGIM), FOR INTRAMUSCULAR USE, 50 MG, EACH	YES
90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	NO
90585	BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR TUBERCULOSIS, LIVE, FOR PERCUTANEOUS USE	NO
90586	BACILLUS CALMETTE-GUERIN VACCINE (BCG) FOR BLADDER CANCER, LIVE, FOR INTRAVESICAL USE	NO
90633	HEPATITIS A VACCINE, PEDIATRIC/ADOLESCENT DOSAGE-2 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	NO
90636	HEPATITIS A AND HEPATITIS B VACCINE (HEPA-HEPB), ADULT DOSAGE, FOR INTRAMUSCULAR USE	NO
90645	HEMOPHILUS INFLUENZA B VACCINE (HIB), HBOC CONJUGATE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90647	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90648	HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-T CONJUGATE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90649	HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6, 11, 16, 18 (QUADRIVALENT), 3 DOSE SCHEDULE, FOR INTRAMUSCULAR USE	NO
90655	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
90656	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO 3 YEARS AND OLDER, FOR INTRAMUSCULAR USE	NO
90657	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE	NO
90658	INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE	NO
90660	INFLUENZA VIRUS VACCINE, LIVE, FOR INTRANASAL USE	NO
90669	PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, WHEN ADMINISTERED TO CHILDREN YOUNGER THAN 5 YEARS, FOR INTRAMUSCULAR USE	NO
90675	RABIES VACCINE, FOR INTRAMUSCULAR USE	NO
90676	RABIES VACCINE, FOR INTRADERMAL USE	NO
90700	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	NO
90702	DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE	NO
90703	TETANUS TOXOID ADSORBED, FOR INTRAMUSCULAR USE	NO
90704	MUMPS VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	YES
90705	MEASLES VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	YES
90706	RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	YES
90707	MEASLES, MUMPS AND RUBELLA VIRUS VACCINE (MMR), LIVE, FOR SUBCUTANEOUS USE	NO
90708	MEASLES AND RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	NO
90710	MEASLES, MUMPS, RUBELLA, AND VARICELLA VACCINE (MMRV), LIVE, FOR SUBCUTANEOUS USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
90713	POLIOVIRUS VACCINE, INACTIVATED, (IPV), FOR SUBCUTANEOUS OR INTRAMUSCULAR USE	NO
90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NO
90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NO
90716	VARICELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE	NO
90717	YELLOW FEVER VACCINE, LIVE, FOR SUBCUTANEOUS USE	NO
90718	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED WHEN ADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	NO
90719	DIPHTHERIA TOXOID, FOR INTRAMUSCULAR USE	YES
90721	DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE AND HEMOPHILUS INFLUENZA B VACCINE (DTAP-HIB), FOR INTRAMUSCULAR USE	NO
90723	DIPHTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE, HEPATITIS B, AND POLIOVIRUS VACCINE,	NO
90727	PLAGUE VACCINE, FOR INTRAMUSCULAR USE	NO
90732	PNEUMOCOCCAL POLYSACCHARIDE VACCINE, 23-VALENT, ADULT OR IMMUNOSUPPRESSED PATIENT DOSAGE, WHEN ADMINISTERED TO 2 YEARS OR OLDER, FOR SUBCUTANEOUS OR	NO
90733	MENINGOCOCCAL POLYSACCHARIDE VACCINE (ANY GROUP(S)), FOR SUBCUTANEOUS USE	NO
90734	MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS A, C, Y AND W-135 (TETRAVALENT), FOR INTRAMUSCULAR USE	NO
90735	JAPANESE ENCEPHALITIS VIRUS VACCINE, FOR SUBCUTANEOUS USE	NO
90740	HEPATITIS B VACCINE, DIALYSIS OR IMMUNOSUPPRESSED PATIENT DOSAGE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90744	HEPATITIS B VACCINE, PEDIATRIC/ADOLESCENT DOSAGE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
90746	HEPATITIS B VACCINE, ADULT DOSAGE, FOR INTRAMUSCULAR USE	NO
90747	HEPATITIS B VACCINE, DIALYSIS OR IMMUNOSUPPRESSED PATIENT DOSAGE (4 DOSE SCHEDULE), FOR INTRAMUSCULAR USE	NO
90748	HEPATITIS B AND HEMOPHILUS INFLUENZA B VACCINE (HEPB-HIB), FOR INTRAMUSCULAR USE	NO
90760	INTRAVENOUS INFUSION, HYDRATION; INITIAL, UP TO 1 HOUR	NO
90761	INTRAVENOUS INFUSION, HYDRATION; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
90765	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); INITIAL, UP TO 1 HOUR	NO
90766	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY	NO
90767	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); ADDITIONAL SEQUENTIAL INFUSION, UP TO 1 HOUR (LIST SEPARATELY IN	NO
90768	INTRAVENOUS INFUSION, FOR THERAPY, PROPHYLAXIS, OR DIAGNOSIS (SPECIFY SUBSTANCE OR DRUG); CONCURRENT INFUSION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY	NO
90772	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR	NO
90773	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRA-ARTERIAL	NO
90774	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRAVENOUS PUSH, SINGLE OR INITIAL SUBSTANCE/DRUG	NO
90775	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH OF A NEW SUBSTANCE/ DRUG (LIST	NO
96401	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; NON-HORMONAL ANTI-NEOPLASTIC	NO
96402	CHEMOTHERAPY ADMINISTRATION, SUBCUTANEOUS OR INTRAMUSCULAR; HORMONAL ANTI-NEOPLASTIC	NO
96405	CHEMOTHERAPY ADMINISTRATION; INTRALESIONAL, UP TO AND INCLUDING 7 LESIONS	NO

Procedure Code	Procedure Code Description	Prior Authorization
96406	CHEMOTHERAPY ADMINISTRATION; INTRALESIONAL, MORE THAN 7 LESIONS	NO
96409	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, SINGLE OR INITIAL SUBSTANCE/DRUG	NO
96411	CHEMOTHERAPY ADMINISTRATION; INTRAVENOUS, PUSH TECHNIQUE, EACH ADDITIONAL SUBSTANCE/ DRUG (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
96413	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; UP TO 1 HOUR, SINGLE OR INITIAL SUBSTANCE/DRUG	NO
96415	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
96416	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; INITIATION OF PROLONGED CHEMOTHERAPY INFUSION (MORE THAN 8 HOURS), REQUIRING USE OF A	NO
96417	CHEMOTHERAPY ADMINISTRATION, INTRAVENOUS INFUSION TECHNIQUE; EACH ADDITIONAL SEQUENTIAL INFUSION (DIFFERENT SUBSTANCE/ DRUG), UP TO 1 HOUR (LIST SEPARATELY	NO
96420	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; PUSH TECHNIQUE	NO
96422	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, UP TO ONE HOUR	NO
96423	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	NO
96425	CHEMOTHERAPY ADMINISTRATION, INTRA-ARTERIAL; INFUSION TECHNIQUE, INITIATION OF PROLONGED INFUSION (MORE THAN 8 HOURS), REQUIRING THE USE OF A PORTABLE OR	NO
96440	CHEMOTHERAPY ADMINISTRATION INTO PLEURAL CAVITY, REQUIRING AND INCLUDING THORACENTESIS	NO
96445	CHEMOTHERAPY ADMINISTRATION INTO PERITONEAL CAVITY, REQUIRING AND INCLUDING PERITONEOCENTESIS	NO
96450	CHEMOTHERAPY ADMINISTRATION, INTO CNS (EG, INTRATHECAL), REQUIRING AND INCLUDING SPINAL PUNCTURE	NO
96521	REFILLING AND MAINTENANCE OF PORTABLE PUMP	NO
96522	REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SYSTEMIC (EG, INTRAVENOUS, INTRA-ARTERIAL)	NO

Procedure Code	Procedure Code Description	Prior Authorization
96523	IRRIGATION OF IMPLANTED VENOUS ACCESS DEVICE FOR DRUG DELIVERY SYSTEMS	NO
J0128	INJECTION, ABARELIX, 10 MG	NO
J0129	INJECTION, ABATACEPT, 10 MG	YES
J0132	INJECTION, ACETYLCYSTEINE, 100 MG	NO
J0133	INJECTION, ACYCLOVIR, 5 MG	NO
J0135	INJECTION, ADALIMUMAB, 20 MG	YES
J0150	INJECTION, ADENOSINE FOR THERAPEUTIC USE, 6 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS, INSTEAD USE A9270)	NO
J0152	INJECTION, ADENOSINE FOR DIAGNOSTIC USE, 30 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS; INSTEAD USE A9270)	NO
J0170	INJECTION, ADRENALIN, EPINEPHRINE, UP TO 1 ML AMPULE	NO
J0180	INJECTION, AGALSIDASE BETA, 1 MG	NO
J0205	INJECTION, ALGLUCERASE, PER 10 UNITS	NO
J0207	INJECTION, AMIFOSTINE, 500 MG	NO
J0210	INJECTION, METHYLDOPATE HCL, UP TO 250 MG	NO
J0215	INJECTION, ALEFACEPT, 0.5 MG	NO
J0256	INJECTION, ALPHA 1 - PROTEINASE INHIBITOR - HUMAN, 10 MG	NO
J0280	INJECTION, AMINOPHYLLIN, UP TO 250 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0282	INJECTION, AMIODARONE HYDROCHLORIDE, 30 MG	NO
J0285	INJECTION, AMPHOTERICIN B, 50 MG	NO
J0287	INJECTION, AMPHOTERICIN B LIPID COMPLEX, 10 MG	NO
J0288	INJECTION, AMPHOTERICIN B CHOLESTERYL SULFATE COMPLEX, 10 MG	NO
J0289	INJECTION, AMPHOTERICIN B LIPOSOME, 10 MG	NO
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG	NO
J0295	INJECTION, AMPICILLIN SODIUM/SULBACTAM SODIUM, PER 1.5 GM	NO
J0300	INJECTION, AMOBARBITAL, UP TO 125 MG	NO
J0330	INJECTION, SUCCINYLCHOLINE CHLORIDE, UP TO 20 MG	NO
J0348	INJECTION, ANADULAFUNGIN, 1 MG	NO
J0360	INJECTION, HYDRALAZINE HCL, UP TO 20 MG	NO
J0364	INJECTION, APOMORPHINE HYDROCHLORIDE, 1 MG	NO
J0365	INJECTION, APROTONIN, 10,000 KIU	NO
J0380	INJECTION, METARAMINOL BITARTRATE, PER 10 MG	NO
J0456	INJECTION, AZITHROMYCIN, 500 MG	NO
J0460	INJECTION, ATROPINE SULFATE, UP TO 0.3 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0470	INJECTION, DIMERCAPROL, PER 100 MG	NO
J0475	INJECTION, BACLOFEN, 10 MG	NO
J0476	INJECTION, BACLOFEN, 50 MCG FOR INTRATHECAL TRIAL	NO
J0500	INJECTION, DICYCLOMINE HCL, UP TO 20 MG	NO
J0515	INJECTION, BENZTROPINE MESYLATE, PER 1 MG	NO
J0520	INJECTION, BETHANECHOL CHLORIDE, MYOTONACHOL OR URECHOLINE, UP TO 5 MG	NO
J0530	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 600,000 UNITS	NO
J0540	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 1,200,000 UNITS	NO
J0550	INJECTION, PENICILLIN G BENZATHINE AND PENICILLIN G PROCAINE, UP TO 2,400,000 UNITS	NO
J0560	INJECTION, PENICILLIN G BENZATHINE, UP TO 600,000 UNITS	NO
J0570	INJECTION, PENICILLIN G BENZATHINE, UP TO 1,200,000 UNITS	NO
J0580	INJECTION, PENICILLIN G BENZATHINE, UP TO 2,400,000 UNITS	NO
J0583	INJECTION, BIVALIRUDIN, 1 MG	NO
J0585	BOTULINUM TOXIN TYPE A, PER UNIT	NO
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS	NO
J0592	INJECTION, BUPRENORPHINE HYDROCHLORIDE, 0.1 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0595	INJECTION, BUTORPHANOL TARTRATE, 1 MG	NO
J0600	INJECTION, EDETATE CALCIUM DISODIUM, UP TO 1000 MG	NO
J0610	INJECTION, CALCIUM GLUCONATE, PER 10 ML	NO
J0620	INJECTION, CALCIUM GLYCEROPHOSPHATE AND CALCIUM LACTATE, PER 10 ML	NO
J0630	INJECTION, CALCITONIN SALMON, UP TO 400 UNITS	NO
J0636	INJECTION, CALCITRIOL, 0.1 MCG	NO
J0637	INJECTION, CASPOFUNGIN ACETATE, 5 MG	NO
J0640	INJECTION,LEUCOVORIN CALCIUM,PER 50MG	NO
J0670	INJECTION, MEPIVACAINE HYDROCHLORIDE, PER 10 ML	NO
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG	NO
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG	NO
J0694	INJECTION, CEFOXITIN SODIUM, 1 GM	NO
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG	NO
J0697	INJECTION, STERILE CEFUROXIME SODIUM, PER 750 MG	NO
J0698	INJECTION, CEFOTAXIME SODIUM, PER GM	NO
J0702	INJECTION, BETAMETHASONE ACETATE AND BETAMETHASONE SODIUM PHOSPHATE, PER 3 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0704	INJECTION, BETAMETHASONE SODIUM PHOSPHATE, PER 4 MG	NO
J0706	INJECTION, CAFFEINE CITRATE, 5MG	NO
J0713	INJECTION, CEFTAZIDIME, PER 500 MG	NO
J0715	INJECTION, CEFTIZOXIME SODIUM, PER 500 MG	NO
J0720	INJECTION, CHLORAMPHENICOL SODIUM SUCCINATE, UP TO 1 GM	NO
J0725	INJECTION, CHORIONIC GONADOTROPIN, PER 1,000 USP UNITS	NO
J0735	INJECTION, CLONIDINE HYDROCHLORIDE, 1 MG	NO
J0740	INJECTION, CIDOFOVIR, 375 MG	NO
J0743	INJECTION, CILASTATIN SODIUM; IMIPENEM, PER 250 MG	NO
J0744	INJECTION, CIPROFLOXACIN FOR INTRAVENOUS INFUSION, 200 MG	NO
J0745	INJECTION, CODEINE PHOSPHATE, PER 30 MG	NO
J0760	INJECTION, COLCHICINE, PER 1MG	NO
J0770	INJECTION, COLISTIMETHATE SODIUM, UP TO 150 MG	NO
J0780	INJECTION, PROCHLORPERAZINE, UP TO 10 MG	NO
J0795	INJECTION, CORTICORELIN OVINE TRIFLUTATE, 1 MICROGRAM	NO
J0800	INJECTION, CORTICOTROPIN, UP TO 40 UNITS	NO

Procedure Code	Procedure Code Description	Prior Authorization
J0835	INJECTION, COSYNTROPIN, PER 0.25 MG	NO
J0850	INJECTION, CYTOMEGALOVIRUS IMMUNE GLOBULIN INTRAVENOUS (HUMAN), PER VIAL	NO
J0878	INJECTION, DAPTOMYCIN, 1 MG	NO
J0881	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (NON-ESRD USE)	NO
J0882	INJECTION, DARBEPOETIN ALFA, 1 MICROGRAM (FOR ESRD ON DIALYSIS)	NO
J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS	NO
J0886	INJECTION, EPOETIN ALFA, 1000 UNITS (FOR ESRD ON DIALYSIS)	NO
J0895	INJECTION, DEFEROXAMINE MESYLATE, 500 MG	NO
J0945	INJECTION, BROMPHENIRAMINE MALEATE, PER 10 MG	NO
J0970	INJECTION, ESTRADIOL VALERATE, UP TO 40 MG	NO
J1000	INJECTION, DEPO-ESTRADIOL CYPIONATE, UP TO 5 MG	NO
J1020	INJECTION, METHYLPREDNISOLONE ACETATE, 20 MG	NO
J1030	INJECTION, METHYLPREDNISOLONE ACETATE, 40 MG	NO
J1040	INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG	NO
J1051	INJECTION, MEDROXYPROGESTERONE ACETATE, 50 MG	NO
J1055	INJECTION, MEDROXYPROGESTERONE ACETATE FOR CONTRACEPTIVE USE, 150 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1056	INJECTION, MEDROXYPROGESTERONE ACETATE / ESTRADIOL CYPIONATE, 5MG / 25MG	NO
J1060	INJECTION, TESTOSTERONE CYPIONATE AND ESTRADIOL CYPIONATE, UP TO 1 ML	NO
J1070	INJECTION, TESTOSTERONE CYPIONATE, UP TO 100 MG	NO
J1080	INJECTION, TESTOSTERONE CYPIONATE, 1 CC, 200 MG	NO
J1094	INJECTION, DEXAMETHASONE ACETATE, 1 MG	NO
J1100	INJECTION, DEXAMETHASONE SODIUM PHOSPHATE, 1MG	NO
J1110	INJECTION, DIHYDROERGOTAMINE MESYLATE, PER 1 MG	NO
J1160	INJECTION, DIGOXIN, UP TO 0.5 MG	NO
J1162	INJECTION, DIGOXIN IMMUNE FAB (OVINE), PER VIAL	NO
J1165	INJECTION, PHENYTOIN SODIUM, PER 50 MG	NO
J1170	INJECTION, HYDROMORPHONE, UP TO 4 MG	NO
J1180	INJECTION, DYPHYLLINE, UP TO 500 MG	NO
J1190	INJECTION, DEXRAZOXANE HYDROCHLORIDE, PER 250 MG	NO
J1200	INJECTION, DIPHENHYDRAMINE HCL, UP TO 50 MG	NO
J1205	INJECTION, CHLOROTHIAZIDE SODIUM, PER 500 MG	NO
J1212	INJECTION, DMSO, DIMETHYL SULFOXIDE, 50%, 50 ML	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1240	INJECTION, DIMENHYDRINATE, UP TO 50 MG	NO
J1245	INJECTION, DIPYRIDAMOLE, PER 10 MG	NO
J1250	INJECTION, DOBUTAMINE HYDROCHLORIDE, PER 250 MG	NO
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG	NO
J1265	INJECTION, DOPAMINE HCL, 40 MG	NO
J1270	INJECTION, DOXERCALCIFEROL, 1 MCG	NO
J1320	INJECTION, AMITRIPTYLINE HCL, UP TO 20 MG	NO
J1327	INJECTION, EPTIFIBATIDE, 5 MG	NO
J1335	INJECTION, ERTAPENEM SODIUM, 500 MG	NO
J1364	INJECTION, ERYTHROMYCIN LACTOBIONATE, PER 500 MG	NO
J1380	INJECTION, ESTRADIOL VALERATE, UP TO 10 MG	NO
J1390	INJECTION, ESTRADIOL VALERATE, UP TO 20 MG	NO
J1410	INJECTION, ESTROGEN CONJUGATED, PER 25 MG	NO
J1430	INJECTION, ETHANOLAMINE OLEATE, 100 MG	NO
J1435	INJECTION, ESTRONE, PER 1 MG	NO
J1436	INJECTION, ETIDRONATE DISODIUM, PER 300 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1438	INJECTION, ETANERCEPT, 25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG	YES
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG	NO
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG	NO
J1450	INJECTION FLUCONAZOLE, 200 MG	NO
J1451	INJECTION, FOMEPIZOLE, 15 MG	NO
J1455	INJECTION, FOSCARNET SODIUM, PER 1000 MG	NO
J1457	INJECTION, GALLIUM NITRATE, 1 MG	NO
J1458	INJECTION, GALSULFASE, 1 MG	NO
J1460	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 1 CC	NO
J1470	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 2 CC	NO
J1480	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 3 CC	NO
J1490	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 4 CC	NO
J1500	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 5 CC	NO
J1510	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 6 CC	NO
J1520	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 7 CC	NO
J1530	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 8 CC	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1540	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 9 CC	NO
J1550	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, 10 CC	NO
J1560	INJECTION, GAMMA GLOBULIN, INTRAMUSCULAR, OVER 10 CC	NO
J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G. POWDER), 500 MG	NO
J1570	INJECTION, GANCICLOVIR SODIUM, 500 MG	NO
J1580	INJECTION, GARAMYCIN, GENTAMICIN, UP TO 80 MG	NO
J1590	INJECTION, GATIFLOXACIN, 10MG	NO
J1595	INJECTION, GLATIRAMER ACETATE, 20 MG	NO
J1600	INJECTION, GOLD SODIUM THIOMALATE, UP TO 50 MG	NO
J1610	INJECTION, GLUCAGON HYDROCHLORIDE, PER 1 MG	NO
J1620	INJECTION, GONADORELIN HYDROCHLORIDE, PER 100 MCG	NO
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG	NO
J1630	INJECTION, HALOPERIDOL, UP TO 5 MG	NO
J1631	INJECTION, HALOPERIDOL DECANOATE, PER 50 MG	NO
J1640	INJECTION, HEMIN, 1 MG	NO
J1642	INJECTION, HEPARIN SODIUM, (HEPARIN LOCK FLUSH), PER 10 UNITS	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1644	INJECTION, HEPARIN SODIUM, PER 1000 UNITS	NO
J1645	INJECTION, DALTEPARIN SODIUM, PER 2500 IU	NO
J1650	INJECTION, ENOXAPARIN SODIUM, 10 MG	NO
J1652	INJECTION, FONDAPARINUX SODIUM, 0.5 MG	NO
J1655	INJECTION, TINZAPARIN SODIUM, 1000 IU	NO
J1670	INJECTION,TETANUS IMMUNE GLOBULIN,HUMAN,UP TO 250 UNITS	NO
J1700	INJECTION, HYDROCORTISONE ACETATE, UP TO 25 MG	NO
J1720	INJECTION, HYDROCORTISONE SODIUM SUCCINATE, UP TO 100 MG	NO
J1730	INJECTION, DIAZOXIDE, UP TO 300 MG	NO
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG	NO
J1742	INJECTION, IBUTILIDE FUMARATE, 1 MG	NO
J1745	INJECTION INFLIXIMAB, 10 MG	YES
J1751	INJECTION, IRON DEXTRAN 165, 50 MG	NO
J1752	INJECTION, IRON DEXTRAN 267, 50 MG	NO
J1756	INJECTION, IRON SUCROSE, 1 MG	NO
J1790	INJECTION, DROPERIDOL, UP TO 5 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1800	INJECTION, PROPRANOLOL HCL, UP TO 1 MG	NO
J1810	INJECTION, DROPERIDOL AND FENTANYL CITRATE, UP TO 2 ML AMPULE	NO
J1815	INJECTION, INSULIN, PER 5 UNITS	NO
J1825	INJECTION, INTERFERON BETA-1A, 33 MCG	NO
J1830	INJECTION INTERFERON BETA-1B, 0.25 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN	NO
J1840	INJECTION, KANAMYCIN SULFATE, UP TO 500 MG	NO
J1850	INJECTION, KANAMYCIN SULFATE, UP TO 75 MG	NO
J1885	INJECTION, KETOROLAC TROMETHAMINE, PER 15 MG	NO
J1931	INJECTION, LARONIDASE, 0.1 MG	NO
J1940	INJECTION, FUROSEMIDE, UP TO 20 MG	NO
J1945	INJECTION, LEPIRUDIN, 50 MG	NO
J1950	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG	NO
J1955	INJECTION, LEVOCARNITINE, PER 1 GM	NO
J1956	INJECTION, LEVOFLOXACIN, 250 MG	NO
J1960	INJECTION, LEVORPHANOL TARTRATE, UP TO 2 MG	NO
J1980	INJECTION, HYOSCYAMINE SULFATE, UP TO 0.25 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J1990	INJECTION, CHLORDIAZEPOXIDE HCL, UP TO 100 MG	NO
J2001	INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG	NO
J2010	INJECTION, LINCOMYCIN HCL, UP TO 300 MG	NO
J2060	INJECTION, LORAZEPAM, 2 MG	NO
J2150	INJECTION, MANNITOL, 25% IN 50 ML	NO
J2175	INJECTION, MEPERIDINE HYDROCHLORIDE, PER 100 MG	NO
J2180	INJECTION, MEPERIDINE AND PROMETHAZINE HCL, UP TO 50 MG	NO
J2185	INJECTION, MEROPENEM, 100 MG	NO
J2210	INJECTION, METHYLERGONOVINE MALEATE, UP TO 0.2 MG	NO
J2248	INJECTION, MICAFUNGIN SODIUM, 1 MG	NO
J2250	INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG	NO
J2260	INJECTION, MILRINONE LACTATE, 5 MG	NO
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	NO
J2271	INJECTION, MORPHINE SULFATE, 100 MG	NO
J2275	INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG	NO
J2300	INJECTION, NALBUPHINE HYDROCHLORIDE, PER 10 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2310	INJECTION, NALOXONE HYDROCHLORIDE, PER 1 MG	NO
J2320	INJECTION, NANDROLONE DECANOATE, UP TO 50 MG	NO
J2321	INJECTION, NANDROLONE DECANOATE, UP TO 100 MG	NO
J2322	INJECTION, NANDROLONE DECANOATE, UP TO 200 MG	NO
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	NO
J2354	INJECTION, OCTREOTIDE, NON-DEPOT FORM FOR SUBCUTANEOUS OR INTRAVENOUS INJECTION, 25 MCG	NO
J2355	INJECTION, OPRELVEKIN, 5 MG	NO
J2357	INJECTION, OMALIZUMAB, 5 MG	NO
J2360	INJECTION, ORPHENADRINE CITRATE, UP TO 60 MG	NO
J2370	INJECTION, PHENYLEPHRINE HCL, UP TO 1 ML	NO
J2400	INJECTION, CHLOROPROCAINE HYDROCHLORIDE, PER 30 ML	NO
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG	NO
J2410	INJECTION, OXYMORPHONE HCL, UP TO 1 MG	NO
J2425	INJECTION, PALIFERMIN, 50 MICROGRAMS	NO
J2430	INJECTION, PAMIDRONATE DISODIUM, PER 30 MG	NO
J2440	INJECTION, PAPAVERINE HCL, UP TO 60 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2460	INJECTION, OXYTETRACYCLINE HCL, UP TO 50 MG	NO
J2469	INJECTION, PALONOSETRON HCL, 25 MCG	NO
J2501	INJECTION, PARICALCITOL, 1 MCG	NO
J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG	NO
J2504	INJECTION, PEGADEMASE BOVINE, 25 IU	NO
J2505	INJECTION, PEGFILGRASTIM, 6 MG	NO
J2510	INJECTION, PENICILLIN G PROCAINE, AQUEOUS, UP TO 600,000 UNITS	NO
J2513	INJECTION, PENTASTARCH, 10% SOLUTION, 100 ML	NO
J2515	INJECTION, PENTOBARBITAL SODIUM, PER 50 MG	NO
J2540	INJECTION, PENICILLIN G POTASSIUM, UP TO 600,000 UNITS	NO
J2543	INJECTION, PIPERACILLIN SODIUM/TAZOBACTAM SODIUM, 1 GRAM/0.125 GRAMS (1.125 GRAMS)	NO
J2550	INJECTION, PROMETHAZINE HCL, UP TO 50 MG	NO
J2560	INJECTION, PHENOBARBITAL SODIUM, UP TO 120 MG	NO
J2590	INJECTION, OXYTOCIN, UP TO 10 UNITS	NO
J2597	INJECTION, DESMOPRESSIN ACETATE, PER 1 MCG	NO
J2650	INJECTION, PREDNISOLONE ACETATE, UP TO 1 ML	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2675	INJECTION, PROGESTERONE, PER 50 MG	NO
J2680	INJECTION, FLUPHENAZINE DECANOATE, UP TO 25 MG	NO
J2690	INJECTION, PROCAINAMIDE HCL, UP TO 1 GM	NO
J2700	INJECTION, OXACILLIN SODIUM, UP TO 250 MG	NO
J2710	INJECTION, NEOSTIGMINE METHYLSULFATE, UP TO 0.5 MG	NO
J2720	INJECTION, PROTAMINE SULFATE, PER 10 MG	NO
J2725	INJECTION, PROTIRELIN, PER 250 MCG	NO
J2730	INJECTION, PRALIDOXIME CHLORIDE, UP TO 1 GM	NO
J2760	INJECTION, PHENTOLAMINE MESYLATE, UP TO 5 MG	NO
J2765	INJECTION, METOCLOPRAMIDE HCL, UP TO 10 MG	NO
J2780	INJECTION, RANITIDINE HYDROCHLORIDE, 25 MG	NO
J2783	INJECTION, RASBURICASE, 0.5 MG	NO
J2788	INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, MINIDOSE, 50 MCG	NO
J2790	INJECTION, RHO D IMMUNE GLOBULIN, HUMAN, FULL DOSE, 300 MCG	NO
J2792	INJECTION, RHO D IMMUNE GLOBULIN, INTRAVENOUS, HUMAN, SOLVENT DETERGENT, 100 IU	NO
J2794	INJECTION, RISPERIDONE, LONG ACTING, 0.5 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J2795	INJECTION, ROPIVACAINE HYDROCHLORIDE, 1 MG	NO
J2800	INJECTION, METHOCARBAMOL, UP TO 10 ML	NO
J2805	INJECTION, SINCALIDE, 5 MICROGRAMS	NO
J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG	NO
J2916	INJECTION, SODIUM FERRIC GLUCONATE COMPLEX IN SUCROSE INJECTION, 12.5 MG	NO
J2920	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 40 MG	NO
J2930	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 125 MG	NO
J2941	INJECTION, SOMATROPIN, 1 MG	NO
J2950	INJECTION, PROMAZINE HCL, UP TO 25 MG	NO
J2993	INJECTION, RETEPLASE, 18.1 MG	NO
J2995	INJECTION, STREPTOKINASE, PER 250,000 IU	NO
J2997	INJECTION, ALTEPLASE RECOMBINANT, 1 MG	NO
J3000	INJECTION, STREPTOMYCIN, UP TO 1 GM	NO
J3010	INJECTION, FENTANYL CITRATE, 0.1 MG	NO
J3030	INJECTION, SUMATRIPTAN SUCCINATE, 6 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG	NO
J3070	INJECTION, PENTAZOCINE, 30 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J3100	INJECTION, TENECTEPLASE, 50MG	NO
J3105	INJECTION, TERBUTALINE SULFATE, UP TO 1 MG	NO
J3120	INJECTION, TESTOSTERONE ENANTHATE, UP TO 100 MG	NO
J3130	INJECTION, TESTOSTERONE ENANTHATE, UP TO 200 MG	NO
J3230	INJECTION,CHLORPROMAZINE HCL,UP TO 50MG	NO
J3243	INJECTION, TIGECYCLINE, 1 MG	NO
J3250	INJECTION,TRIMETHOBENZAMIDE HCL,UP TO 200MG	NO
J3260	INJECTION,TOBRAMYCIN SULFATE,UP TO 80MG	NO
J3265	INJECTION, TORSEMIDE, 10 MG/ML	NO
J3280	INJECTION, THIETHYLPERAZINE MALEATE, UP TO 10 MG	NO
J3285	INJECTION, TREPROSTINIL, 1 MG	NO
J3301	INJECTION,TRIAMCINOLONE ACETONIDE,PER 10MG	NO
J3302	INJECTION,TRIAMCINOLONE DIACETATE, PER 5MG	NO
J3303	INJECTION,TRIAMCINOLONE HEXACETONIDE,PER 5MG	NO
J3305	INJECTION, TRIMETREXATE GLUCURONATE, PER 25 MG	NO
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J3320	INJECTION, SPECTINOMYCIN DIHYDROCHLORIDE, UP TO 2 GM	NO
J3360	INJECTION, DIAZEPAM, UP TO 5 MG	NO
J3364	INJECTION, UROKINASE, 5000 IU VIAL	NO
J3365	INJECTION, IV, UROKINASE, 250,000 I.U. VIAL	NO
J3370	INJECTION, VANCOMYCIN HCL, 500 MG	NO
J3396	INJECTION, VERTEPORFIN, 0.1 MG	NO
J3410	INJECTION,HYDROXYZINE HCL,UP TO 25MG	NO
J3411	INJECTION, THIAMINE HCL, 100 MG	NO
J3415	INJECTION, PYRIDOXINE HCL, 100 MG	NO
J3420	INJECTION,VITAMIN B-12 CYANOCOBALAMIN,UP TO 1000MCG	NO
J3430	INJECTION, PHYTONADIONE (VITAMIN K), PER 1 MG	NO
J3465	INJECTION, VORICONAZOLE, 10 MG	NO
J3475	INJECTION, MAGNESIUM SULFATE, PER 500 MG	NO
J3480	INJECTION, POTASSIUM CHLORIDE, PER 2 MEQ	NO
J3485	INJECTION, ZIDOVUDINE, 10 MG	NO
J3486	INJECTION, ZIPRASIDONE MESYLATE, 10 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG	NO
J3590	UNCLASSIFIED BIOLOGICS	NO
J7030	INFUSION, NORMAL SALINE SOLUTION , 1000 CC	NO
J7040	INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML=1 UNIT)	NO
J7042	5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)	NO
J7050	INFUSION, NORMAL SALINE SOLUTION , 250 CC	NO
J7060	5% DEXTROSE/WATER (500 ML = 1 UNIT)	NO
J7070	INFUSION, D5W, 1000 CC	NO
J7100	INFUSION, DEXTRAN 40, 500 ML	NO
J7110	INFUSION, DEXTRAN 75, 500 ML	NO
J7120	RINGERS LACTATE INFUSION, UP TO 1000 CC	NO
J7130	HYPERTONIC SALINE SOLUTION, 50 OR 100 MEQ, 20 CC VIAL	NO
J7187	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR, PER IU VWF:RCO	NO
J7189	FACTOR VIIA (ANTIHEMOPHILIC FACTOR, RECOMBINANT), PER 1 MICROGRAM	NO
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	NO
J7302	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J7303	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING VAGINAL RING, EACH	NO
J7304	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH	NO
J7501	AZATHIOPRINE, PARENTERAL, 100 MG	NO
J7504	LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, EQUINE, PARENTERAL, 250 MG	NO
J7511	LYMPHOCYTE IMMUNE GLOBULIN, ANTITHYMOCYTE GLOBULIN, RABBIT, PARENTERAL, 25MG	NO
J7516	CYCLOSPORIN, PARENTERAL, 250 MG	NO
J7525	TACROLIMUS, PARENTERAL, 5 MG	NO
J9000	DOXORUBICIN HCL, 10 MG	NO
J9001	DOXORUBICIN HYDROCHLORIDE, ALL LIPID FORMULATIONS, 10 MG	NO
J9010	ALEMTUZUMAB, 10 MG	NO
J9015	ALDESLEUKIN, PER SINGLE USE VIAL	NO
J9017	ARSENIC TRIOXIDE, 1MG	NO
J9020	ASPARAGINASE, 10,000 UNITS	NO
J9025	INJECTION, AZACITIDINE, 1 MG	NO
J9031	BCG (INTRAVESICAL) PER INSTILLATION	NO
J9035	INJECTION, BEVACIZUMAB, 10 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9040	BLEOMYCIN SULFATE, 15 UNITS	NO
J9041	INJECTION, BORTEZOMIB, 0.1 MG	NO
J9045	CARBOPLATIN, 50 MG	NO
J9050	CARMUSTINE, 100 MG	NO
J9055	INJECTION, CETUXIMAB, 10 MG	NO
J9060	CISPLATIN, POWDER OR S0LUTION, PER 10 MG	NO
J9062	CISPLATIN, 50 MG	NO
J9065	INJECTION, CLADRIBINE, PER 1 MG	NO
J9070	CYCLOPHOSPHAMIDE, 100 MG	NO
J9080	CYCLOPHOSPHAMIDE, 200 MG	NO
J9090	CYCLOPHOSPHAMIDE, 500 MG	NO
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM	NO
J9092	CYCLOPHOSPHAMIDE, 2.0 GRAM	NO
J9093	CYCLOPHOSPHAMIDE, LYOPHILIZED, 100 MG	NO
J9094	CYCLOPHOSPHAMIDE, LYOPHILIZED, 200 MG	NO
J9095	CYCLOPHOSPHAMIDE, LYOPHILIZED, 500 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9096	CYCLOPHOSPHAMIDE, LYOPHILIZED, 1.0 GRAM	NO
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM	NO
J9098	CYTARABINE LIPOSOME, 10 MG	NO
J9100	CYTARABINE, 100 MG	NO
J9110	CYTARABINE, 500 MG	NO
J9120	DACTINOMYCIN, 0.5 MG	NO
J9130	DACARBAZINE, 100 MG	NO
J9140	DACARBAZINE, 200 MG	NO
J9150	DAUNORUBICIN, 10 MG	NO
J9170	DOCETAXEL, 20 MG	NO
J9175	INJECTION, ELLIOTTS' B SOLUTION, 1 ML	NO
J9178	INJECTION, EPIRUBICIN HCL, 2 MG	NO
J9181	ETOPOSIDE, 10 MG	NO
J9182	ETOPOSIDE, 100 MG	NO
J9185	FLUDARABINE PHOSPHATE, 50 MG	NO
J9190	FLUOROURACIL, 500 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9200	FLOXURIDINE, 500 MG	NO
J9201	GEMCITABINE HCL, 200 MG	NO
J9202	GOSERELIN ACETATE IMPLANT, PER 3.6 MG	NO
J9206	IRINOTECAN, 20 MG	NO
J9208	IFOSFAMIDE, 1 GM	NO
J9209	MESNA, 200 MG	NO
J9211	IDARUBICIN HYDROCHLORIDE, 5 MG	NO
J9212	INJECTION, INTERFERON ALFACON-1, RECOMBINANT, 1 MCG	NO
J9213	INTERFERON, ALFA-2A, RECOMBINANT, 3 MILLION UNITS	NO
J9214	INTERFERON, ALFA-2B, RECOMBINANT, 1 MILLION UNITS	NO
J9215	INTERFERON, ALFA-N3, (HUMAN LEUKOCYTE DERIVED), 250,000 IU	NO
J9216	INTERFERON, GAMMA 1-B, 3 MILLION UNITS	NO
J9217	LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), 7.5 MG	NO
J9218	LEUPROLIDE ACETATE,PER 1MG	NO
J9219	LEUPROLIDE ACETATE IMPLANT, 65 MG	NO
J9225	HISTRELIN IMPLANT, 50 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9230	MECHLORETHAMINE HYDROCHLORIDE, (NITROGEN MUSTARD), 10 MG	NO
J9245	INJECTION, MELPHALAN HYDROCHLORIDE, 50 MG	NO
J9250	METHOTREXATE SODIUM, 5 MG	NO
J9260	METHOTREXATE SODIUM, 50 MG	NO
J9261	INJECTION, NELARABINE, 50 MG	NO
J9263	INJECTION, OXALIPLATIN, 0.5 MG	NO
J9264	INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG	NO
J9265	PACLITAXEL, 30 MG	NO
J9266	PEGASPARGASE, PER SINGLE DOSE VIAL	NO
J9268	PENTOSTATIN, PER 10 MG	NO
J9280	MITOMYCIN, 5 MG	NO
J9290	MITOMYCIN, 20 MG	NO
J9291	MITOMYCIN, 40 MG	NO
J9293	INJECTION, MITOXANTRONE HYDROCHLORIDE, PER 5 MG	NO
J9300	GEMTUZUMAB OZOGAMICIN, 5MG	NO
J9305	INJECTION, PEMETREXED, 10 MG	NO

Procedure Code	Procedure Code Description	Prior Authorization
J9310	RITUXIMAB, 100 MG	NO
J9320	STREPTOZOCIN, 1 GM	NO
J9340	THIOTEPA, 15 MG	NO
J9350	TOPOTECAN, 4 MG	NO
J9355	TRASTUZUMAB, 10 MG	NO
J9357	VALRUBICIN, INTRAVESICAL, 200 MG	NO
J9360	VINBLASTINE SULFATE, 1 MG	NO
J9370	VINCRISTINE SULFATE, 1 MG	NO
J9375	VINCRISTINE SULFATE, 2 MG	NO
J9380	VINCRISTINE SULFATE, 5 MG	NO
J9390	VINORELBINE TARTRATE, PER 10 MG	NO
J9395	INJECTION, FULVESTRANT, 25 MG	NO
Q2009	INJECTION, FOSPHENYTOIN, 50 MG	NO
Q2017	INJECTION, TENIPOSIDE, 50 MG	NO
Q3025	INJECTION, INTERFERON BETA-1A, 11 MCG FOR INTRAMUSCULAR USE	NO
Q3026	INJECTION, INTERFERON BETA-1A, 11 MCG FOR SUBCUTANEOUS USE	NO

Procedure Code	Procedure Code Description	Prior Authorization
Q4081	INJECTION, EPOETIN ALFA, 100 UNITS (FOR ESRD ON DIALYSIS)	NO
Q4083	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4084	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4085	HYALURONAN OR DERIVATIVE, EUFLEXXA, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4086	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE	NO
Q4087	INJECTION, IMMUNE GLOBULIN, (OCTOGAM), INTRAVENOUS, NON-LYOPHILIZED, (E.G LIQUID), 500 MG	NO
Q4088	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD), INTRAVENOUS, NON-LYOPHILIZED, (E.G LIQUID), 500 MG	NO
Q4089	INJECTIN, RHO (D0 IMMUNE GLOBULIN (HUMAN) (RHOPHYLAC), INTRAVENOUS, 100 IU	NO
Q4090	INJECTION, HEPATITIS B IMMUNE GLOBULIN (HEPAOGAMB) INTRAMUSCULAR, 0.5 ML	NO
Q4091	INJECTION, IMMUNE GLOBULIN, (FLEBAGAMMA), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	NO
Q4092	INJECTION, IMMUNE GLOBULIN, (GAMUNEX), INTRAVENOUS, NON-LYOPHILIZED, (E.G. LIQUID), 500 MG	NO
S0020	INJECTION, BUPIVICAINE HYDROCHLORIDE, 30 ML	NO
S0023	INJECTION, CIMETIDINE HYDROCHLORIDE, 300 MG	NO
S0028	INJECTION, FAMOTIDINE, 20 MG	NO
S0030	INJECTION, METRONIDAZOLE, 500 MG	NO
S0032	INJECTION, NAFCILLIN SODIUM, 2 GRAMS	NO

Procedure Code	Procedure Code Description	Prior Authorization
S0073	INJECTION, AZTREONAM, 500 MG	NO
S0074	INJECTION, CEFOTETAN DISODIUM, 500 MG	NO
S0077	INJECTION, CLINDAMYCIN PHOSPHATE, 300 MG	NO
S0081	INJECTION, PIPERACILLIN SODIUM, 500 MG	NO
S0146	INJECTION, PEGYLATED INTERFERON ALFA-2B, 10 MCG PER 0.5 ML	NO
S0147	INJECTION, ALGLUCOSIDASE ALFA, 20 MG	NO
S0162	INJECTION, EFALIZUMAB, 125 MG	YES
S0164	INJECTION, PANTOPRAZOLE SODIUM, 40 MG	NO
S0171	INJECTION, BUMETANIDE, 0.5MG	NO
S0180	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES	NO
S0189	TESTOSTERONE PELLET, 75MG	NO

I ASC Procedures List

These CPT codes are currently covered for outpatient hospital and ambulatory surgical centers billing.

NOTE:

The following list is used for scheduling Medicaid recipients for outpatient surgeries. Occasionally Medicaid recipients question what procedures Medicaid covers.

Before performing any procedure, providers need to inform the recipient that the recipient is responsible for payment of services that Medicaid does not cover.

Use the AVRS line at EDS (1(800) 727-7848) to verify if it is a covered procedure code. Submit requests to add procedure codes to this list in writing to the Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624, Attention: Medical Services Division.

A “PA” in the PA column indicates that the procedure requires prior authorization. Mail your written request for prior authorization and supporting documentation of extenuating circumstances and the procedure code to EDS, Attn: Prior Authorization; P O Box 244032; Montgomery, AL 36124-4032.

An “EQ” in the EPSDT column indicates that the procedure requires an EPSDT referral or is for QMB recipients only.

A number in the Group column indicates which one of the following established group rates applies to the procedure payment:

Group Indicator	***Group Rate***
Group 1	$193.18
Group 2	258.57
Group 3	297.21
Group 4	365.56
Group 5	416.84
Group 6	593.80 (includes intraocular lens)
Group 7	578.82
Group 8	678.50 (includes intraocular lens)
Group 9	779.00
Group 99	Various rates less than Group 1

A number in the Limit column indicates the maximum allowable units that may be billed.

NOTE:

Benefit limits may also apply in addition to the hard-coded maximum units.

The inclusion or exclusion of a procedure code on the ASC Procedures List does not imply Medicaid coverage or reimbursement. The pricing file must be verified to determine coverage and reimbursement amounts for the specific date of service. ASCs may bill surgical procedures within the range of 10000 - 69XXX as well as the dental code D9420. Hospitals may bill these codes as well as other codes listed on the Outpatient Fee Schedule located on the Medicaid website. (www.medicaid.alabama.gov).

Appendix I as of 08/29/07

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
10060			01	1	<21	32005			02	1	
10061			02	1		32019			01	1	
10120			01	1		32020			02	1	
10121			01	1		32400			01	1	
10140			02	1	<21	32405			01	1	
10180			01	1		32420			01	1	
11010			01	1		32601			02	1	
11011			01	1		32602			02	1	
11012			02	1		32603			02	1	
11040			01	1	<21	32604			02	1	
11041			01	1	<21	32605			02	1	
11042			01	1	<21	32606			02	1	
11043			02	1		32650			03	1	
11044			02	1		32651			03	1	
11055			01	1	<21	32652			03	1	
11056			01	1	<21	32653			03	1	
11057			01	1	<21	32654			03	1	
11100			01	1	<21	32655			03	1	
11200			01	1	<21	32656			03	1	
11400		EQ	01	1	<21	32657			03	1	
11401		EQ	01	1	<21	32658			03	1	
11402		EQ	01	1	<21	32659			03	1	
11403		EQ	01	1	<100	32660			03	1	
11404			01	1		32661			03	1	
11406			02	1		32662			03	1	
11420			01	1	<21	32663			03	1	
11421			01	1	<21	32664			03	1	
11422			01	1	<21	32665			03	1	
11423			01	1	<21	32997			02	1	
11424			01	1		33010			02	1	
11426			01	1		33011			02	1	
11440			01	1	<21	33206			02	1	
11441			01	1	<21	33207			02	1	
11442			01	1	<21	33208			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
11443			01	1	<21	33210			02	1	
11444			01	1		33211			02	1	
11446			01	1		33212			03	1	
11450			01	1		33213			03	1	
11451			01	1		33214			02	1	
11462			01	1		33215			02	1	
11463			01	1		33216			02	1	
11470			02	1		33217			02	1	
11471			02	1		33218			02	1	
11600			01	1	<21	33220			02	1	
11601			01	1	<21	33222			02	1	
11602			01	1	<21	33223			02	1	
11603			01	1	<21	33224			02	1	
11604			01	1		33226			02	1	
11606			01	1		33233			02	1	
11620			01	1	<21	33234			02	1	
11621			01	1	<21	33235			02	1	
11622			01	1	<21	33241			02	1	
11623			01	1	<21	33244			02	1	
11624			01	1		33249			02	1	
11626			01	1		33282			01	1	
11640			01	1	<21	33284			01	1	
11641			01	1	<21	34804			05	1	
11642			01	1	<21	35206			07	1	
11643			01	1	<21	35301			02	1	
11644			01	1		35311			02	1	
11646			01	1		35321			02	1	
11730			01	1	<21	35331			02	1	
11750			01	1		35341			02	1	
11752			01	1	<21	35351			02	1	
11760			01	1	<21	35355			02	1	
11770			03	1		35361			02	1	
11771			03	1		35363			02	1	
11772			03	1		35371			02	1	
11960			02	1		35372			02	1	
11970	PA		02	1		35460			01	1	
11971			01	1		35761			01	1	
12002			01	1	<21	35860			01	1	
12005			01	1		35875			01	1	
12006			01	1		35876			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
12007			01	1		36010			02	1	
12011			01	1	<21	36260			04	1	
12016			02	1		36261			02		
12017			02	1		36262			01	1	
12018			02	1		36440		EQ	01	1	
12020			01	1		36455			01	1	
12021			01	1		36475			01	1	
12032			01	1		36478			01	1	
12034			01	1		36500			01	1	
12035			01	1		36511			01	1	
12036			02	1		36512			01	1	
12037			02	1		36513			01	1	
12041			01	1	<21	36514			01	1	
12042			01	1		36515			01	1	
12044			01	1		36550			01	1	
12045			02	1		36555			01	1	<5
12046			02	1		36556			02	1	>4
12047			02	1		36557			02	1	<5
12052			01	1	<21	36558			03	1	>4
12053			01	1	<21	36560			03	1	<5
12054			01	1		36561			03	1	>4
12055			01	1		36563			03	1	
12056			02	1		36565			03	1	
12057			02	1		36566			01	1	
13100			01	1		36568			01	1	<5
13101			03	1		36569			03	1	>4
13120			01	1		36570			03	1	<5
13121			03	1		36571			02	1	>4
13131			02	1		36575			02	1	
13132			03	1		36576			02	1	
13150			02	1		36578			01	1	
13151			02	1		36580			02	1	
13152			03	1		36581			03	1	
13160			03	1		36582			03	1	
14000			02	1		36583			01	1	
14001			03	1		36584			03	1	
14020			03	1		36585			01	1	
14021			03	1		36589			01	1	
14040			03	1		36590			01	1	
14041			03	1		36595			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
14060			03	1		36596			01	1	
14061			03	1		36597			01	1	
14300			04	1		36640			01	1	
14350			03	1		36800			03	1	
15002			02	1		36810			03	1	
15004			02	1		36815			03	1	
15005			01	1		36818			03	1	
15050			02	1		36819			03	1	
15100			02	1		36820			03	1	
15110			01	1	<21	36821			03	1	
15115			01	1	<21	36825			04	1	
15120			03	1		36830			04	1	
15130			01	1	<21	36831			01	1	
15135			01	1	<21	36832			04	1	
15150			01	1		36833			04	1	
15155			01	1		36835			04	1	
15170			01	1		36838			02	1	
15175			01	1	<100	36860			02	1	
15200			03	1		36861			03	1	
15201			02	1		36870			02	1	
15220			02	1		37201			01	1	
15240			03	1		37203			01	1	
15260			02	1		37204			01	1	
15300			01	1	<21	37205			01	1	
15320			01	1	<21	37607			01	1	
15330			01	1	<21	37609			02	1	
15335			01	1	<21	37620			02	1	
15340			01	1		37650			02	1	
15365			01	1		37700			02	1	
15400			02	1		37718			01	1	
15401			02	1		37722			01	1	
15420			01	1	<21	37735			03	1	
15430			01	1	<21	37760			03	1	
15570			03	1		37766			03	1	
15572			03	1		37780			03	1	
15574			03	1		37785			03	1	
15576			03	1		37788			03	1	
15600			03	1		37790			03	1	
15610			03	1		38220			01	1	
15620			03	1		38221			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
15630			03	1		38300			01	1	
15650			05	1		38305			02	1	
15731			03	1		38308			02	1	
15732			03	1		38500			02	1	
15734			03	1		38505			01	1	
15736			03	1		38510			02	1	
15738			03	1		38520			02	1	
15740			02	1		38525			02	1	
15750			02	1		38530			02	1	
15756			02	1		38542			02	1	
15757			01	1		38550			03	1	
15758			01	1		38555			04	1	
15760			02	1		38570			09	1	
15770			03	1		38571			09	1	
15780			01	1		38572			09	1	
15781			01	1		38700			02	1	
15782			01	1		38740			02	1	
15820	PA		02	1		38745			04	1	
15821	PA		02	1		38760			02	1	
15822	PA		02	1		38790			01	1	
15823	PA		02	1		38792			01	1	
15824	PA	EQ	03	1		39400			02	1	
15830			03	1		40500			02	1	
15840			04	1		40510			02	1	
15841			04	1		40520			02	1	
15842			04	1		40525			02	1	
15845			04	1		40527			02	1	
15850			01	1		40530			02	1	
15851			01	1		40650			03	1	
15852			01	1		40652			03	1	
15876	PA		02	1		40654			03	1	
15877	PA		02	1		40700			03	1	
15878	PA		02	1		40701			03	1	
15879	PA		02	1		40702			03	1	
15920			03	1		40720			03	1	
15922			04	1		40761			04	1	
15931			02	1		40801			02	1	
15933			03	1		40805			02	1	
15934			02	1		40806			01	1	
15935			03	1		40810			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
15936			02	1		40812			01	1	
15937			03	1		40814			02	1	
15940			02	1		40816			02	1	
15941			03	1		40818			01	1	
15944			02	1		40819			01	1	
15945			03	1		40820			01	1	
15946			02	1		40831			01	1	
15950			02	1		40840			02	1	
15951			03	1		40842			03	1	
15952			02	1		40843			03	1	
15953			03	1		40844			05	1	
15956			02	1		40845			05	1	
15958			03	1		41000			01	1	
16020			01	1		41005			01	1	
16025			01	1		41006			01	1	
16030			01	1		41007			01	1	
16035			02	1		41008			01	1	
17000			01	1	<21	41009			01	1	
17004			01	1	<21	41010			01	1	
17106			01	1	<21	41015			01	1	
17107			01	1	<21	41016			01	1	
17108			01	1	<21	41017			01	1	
17110	PA		01	1	<21	41018			01	1	
17111	PA		01	1		41100			01	1	
17261			01	1		41105			02	1	
17263			01	1		41108			01	1	
17264			01	1		41110			01	1	
17266			02	1		41112			02	1	
17270			01	1		41113			02	1	
17273			01	1		41114			02	1	
17274			01	1		41115			01	1	
17276			02	1		41116			01	1	
17281			01	1		41120			05	1	
17282			01	1		41250			02	1	
17283			01	1		41251			02	1	
17284			01	1		41252			02	1	
17286			02	1		41500			01	1	
19020			02	1		41510			01	1	
19100			01	1		41520			02	1	
19101			02	1		41800			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
19102			01	1		41805			01	1	
19103			02	1		41806			01	1	
19105			02	1		41825			02	1	
19110			01	1		41826			02	1	
19112			01	1		41827			02	1	
19120			03	1		41850			02	1	
19125			03	1		41872		EQ	03	1	
19260			05	1		42000			02	1	
19296			04	1		42100			01	1	
19298			04	1		42104			02	1	
19300			04	1		42106			02	1	
19301			03	1		42107			02	1	
19302			07	1		42120			04	1	
19303			04	1		42140			02	1	
19304			04	1		42145			05	1	
19307			03	1		42160			01	1	
19316	PA	EQ	02	1		42180			01	1	
19318	PA		04	1		42182			02	1	
19328	PA		01	1		42200			05	1	
19330	PA		01	1		42205			05	1	
19340	PA		02	1		42210			05	1	
19342	PA		03	1		42215			07	1	
19350	PA		02	1		42220			05	1	
19355	PA	EQ	03	1		42225			05	1	
19357	PA	EQ	03	1		42226			05	1	
19361	PA	EQ	04	1		42235			05	1	
19364	PA		05	1		42260			04	1	
19366	PA		05	1		42281			03	1	
19367	PA		04	1		42300			01	1	
19368	PA		04	1		42305			02	1	
19369	PA		04	1		42310			01	1	
19370	PA		03	1		42320			01	1	
19371	PA		03	1		42330			01	1	
19380	PA	EQ	04	1		42335			03	1	
20005			02	1		42340			02	1	
20100			02	1		42405			02	1	
20101			02	1		42408			03	1	
20102			02	1		42409			03	1	
20103			02	1		42410			05	1	
20150			02	1		42415			05	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
20200			01	1		42420			05	1	
20205			02	1		42425			05	1	
20206			01	1		42440			03	1	
20220			01	1		42450			02	1	
20225			02	1		42500			03	1	
20240			02	1		42505			04	1	
20245			03	1		42507			03	1	
20250			03	1		42508			04	1	
20251			03	1		42509			04	1	
20501			01	1		42510			04	1	
20525			03	1		42600			01	1	
20605			01	1		42650			01	1	
20610			01	1		42665			01	1	
20615			01	1		42700			01	1	
20650			03	1		42720			01	1	
20660			02	1		42725			02	1	
20661			03	1		42800			01	1	
20662			03	1		42802			01	1	
20663			03	1		42804			01	1	
20664			02	1		42806			02	1	
20665			01	1		42808			02	1	
20670			01	1		42809			01	1	
20680			03	1		42810			03	1	
20690			03	1		42815			04	1	
20692			03	1		42820			04	1	<12
20693			01	1		42821			04	1	
20694			01	1		42825			04	1	
20900			03	1		42826			04	1	>11
20902			04	1		42830			03	1	<12
20910			02	1		42831			03	1	>11
20912			03	1		42835			03	1	
20920			03	1		42836			04	1	
20922			03	1		42860			03	1	
20924			03	1		42870			03	1	
20926			03	1		42890			07	1	
20955			04	1		42892			07	1	
20956			04	1		42900			01	1	
20957			03	1		42950			02	1	
20962			04	1		42953			02	1	
20969			04	1		42955			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
20970			04	1		42960			01	1	
20972			04	1		42962			02	1	
20973			04	1		42972			03	1	
20975			02	1		43030			04	1	
20982			02	1		43200			01	1	
21010			02	1		43201			01	1	
21015			03	1		43202			01	1	
21025			02	1		43204			01	1	
21026			02	1		43205			02	1	
21029			02	1		43215			01	1	
21034			03	1		43216			01	1	
21040			02	1		43217			01	1	
21044			02	1		43219			01	1	
21046			02	1		43220			01	1	
21050			03	1		43226			01	1	
21060			02	1		43227			02	1	
21070			03	1		43228			02	1	
21076	PA		03	1		43231			02	1	
21077	PA		03	1		43232			02	1	
21079	PA		03	1		43234			01	1	
21080	PA		03	1		43235			01	1	
21081	PA		03	1		43236			02	1	
21082	PA		03	1		43237			02	1	
21083	PA		03	1		43238			02	1	
21084	PA		03	1		43239			02	1	
21086	PA		03	1		43240			02	1	
21087	PA		01	1		43241			02	1	
21088	PA		03	1		43242			02	1	
21100			01	1		43243			02	1	
21120	PA		03	1		43244			02	1	
21121	PA		01	1		43245			02	1	
21122	PA		06	1		43246			02	1	
21123	PA		06	1		43247			02	1	
21125	PA		04	1		43248			02	1	
21127	PA		06	1		43249			01	1	
21137	PA		06	1		43250			02	1	
21138	PA		06	1		43251			02	1	
21139	PA		06	1		43255			02	1	
21141	PA		06	1		43256			03	1	
21142	PA		06	1		43257			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
21143	PA		06	1		43258			03	1	
21145	PA		06	1		43259			03	1	
21146	PA		06	1		43260			02	1	
21147	PA		06	1		43261			02	1	
21150	PA		06	1		43262			02	1	
21151	PA		06	1		43263			02	1	
21154	PA		06	1		43264			02	1	
21155	PA		06	1		43265			02	1	
21159	PA		06	1		43267			02	1	
21160	PA		06	1		43268			02	1	
21172	PA		06	1		43269			02	1	
21181			07	1		43271			02	1	
21182	PA		06	1		43272			02	1	
21183	PA		06	1		43280			04	1	
21184	PA		06	1		43305			03	1	
21188	PA		06	1		43400			03	1	
21193	PA		05	1		43450			01	1	
21194	PA		06	1		43453			01	1	
21195	PA		06	1		43456			02	1	
21196	PA		06	1		43458			02	1	
21199	PA		05	1		43600			01	1	
21206			05	1		43647			01	1	
21208			07	1		43648			01	1	
21209			05	1		43653			02	1	
21210			07	1		43750			02	1	
21215			07	1		43760			01	1	
21230			07	1		43761			01	1	
21235			07	1		43870			04	1	
21240			04	1		43880		EQ	07	1	
21242			05	1		43886	PA		01	1	
21243			05	1		43887	PA		01	1	
21244			07	1		44015			01	1	
21245			07	1		44100			01	1	
21246			07	1		44180			02	1	
21247			07	1		44186			01	1	
21248			07	1		44312			01	1	
21249			07	1		44340			03	1	
21267			07	1		44345			04	1	
21270	PA		05	1		44346			04	1	
21275			07	1		44360			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
21280			05	1		44361			02	1	
21282			05	1		44363			02	1	
21295			01	1		44364			02	1	
21296			01	1		44365			02	1	
21320			02	1		44366			02	1	
21325			02	1		44369			02	1	
21330			03	1		44370			02	1	
21335			03	1		44372			02	1	
21336			04	1		44373			02	1	
21338			02	1		44376			02	1	
21339			02	1		44377			02	1	
21340			03	1		44378			02	1	
21343			03	1		44379			09	1	
21344			07	1		44380			01	1	
21345			03	1		44382			01	1	
21355			03	1		44383			09	1	
21356			03	1		44385			01	1	
21360			03	1		44386			01	1	
21365			04	1		44388			01	1	
21385			05	1		44389			01	1	
21386			05	1		44390			01	1	
21387			05	1		44391			01	1	
21390			07	1		44392			01	1	
21395			07	1		44393			01	1	
21400			02	1		44394			02	1	
21401			03	1		44397			01	1	
21406			04	1		44500			01	1	
21407			05	1		44950			03	1	
21421			04	1		44955			01	1	
21422			05	1		44960			03	1	
21431			03	1		44970			04	1	
21440			03	1		45000			01	1	
21445			04	1		45005			02	1	
21450			01	1		45020			02	1	
21451			03	1		45100			01	1	
21452			02	1		45108			02	1	
21453			03	1		45130			02	1	
21454			03	1		45150			02	1	
21461			04	1		45160			03	1	
21462			03	1		45170			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
21465			04	1		45190			03	1	
21470			04	1		45300			01	1	
21480			01	1		45303			01	1	
21485			01	1		45305			01	1	
21490			03	1		45307			01	1	
21495			03	1		45308			02	1	
21497			02	1		45309			02	1	
21501			02	1		45315			02	1	
21502			02	1		45317			02	1	
21510			03	1		45320			02	1	
21550			01	1		45321			02	1	
21555			02	1		45327			01	1	
21556			03	1		45330			01	1	
21557			04	1		45331			01	1	
21600			02	1		45332			01	1	
21610			03	1		45333			01	1	
21620			02	1		45334			01	1	
21630			04	1		45335			01	1	
21632			04	1		45337			02	1	
21685			02	1		45338			02	1	
21700			02	1		45339			01	1	
21720			02	1		45340			01	1	
21725			03	1		45341			01	1	
21800			01	1	<21	45342			01	1	
21805			02	1		45345			01	1	
21810			02	1		45355			01	1	
21820			01	1		45378			02	1	
21920			01	1		45379			02	1	
21925			01	1		45380			02	1	
21930			01	1		45381			02	1	
22100			03	1		45382			02	1	
22101			03	1		45383			02	1	
22102			03	1		45384			02	1	
22103			03	1		45385			02	1	
22305			01	1		45386			02	1	
22310			01	1		45387			02	1	
22315			02	1		45391			01	1	
22325			03	1		45392			02	1	
22326			03	1		45500			02	1	
22327			03	1		45505			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
22505			02	1		45520			02	1	
22520			01	1		45560			02	1	
22521			01	1		45562			02	1	
22522			01	1		45800			01	1	
22523			02	1		45805			01	1	
22524			02	1		45820			01	1	
22526			02	1		45825			01	1	
22852			02	1		45900			01	1	
22855			02	1		45905			01	1	
22900			03	1		45910			01	1	
23000			02	1		45915			01	1	
23020			02	1		45990			01	1	
23030			01	1		46020			03	1	
23031			01	1		46030			01	1	
23035			03	1		46040			03	1	
23040			03	1		46045			02	1	
23044			03	1		46050			01	1	
23066			01	1		46060			02	1	
23075			01	1		46080			03	1	
23076			01	1		46200			02	1	
23077			03	1		46210			02	1	
23100			02	1		46211			02	1	
23101			04	1		46220			01	1	
23105			04	1		46221			02	1	
23106			04	1		46230			02	1	
23107			04	1		46250			03	1	
23120			03	1		46255			03	1	
23125			05	1		46257			03	1	
23130			03	1		46258			03	1	
23140			03	1		46260			03	1	
23145			05	1		46261			03	1	
23146			05	1		46262			03	1	
23150			04	1		46270			03	1	
23155			05	1		46275			03	1	
23170			02	1		46280			03	1	
23172			02	1		46285			01	1	
23174			02	1		46288			03	1	
23180			04	1		46320			03	1	
23182			04	1		46505			01	1	
23184			04	1		46600			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
23190			04	1		46604			01	1	
23195			05	1		46606			01	1	
23330			01	1		46608			01	1	
23331			01	1		46610			01	1	
23395			05	1		46611			01	1	
23397			07	1		46612			01	1	
23400			07	1		46614			01	1	
23405			02	1		46615			01	1	
23406			02	1		46700			03	1	
23410			05	1		46705			03	1	
23412			07	1		46706			01	1	
23415			05	1		46750			03	1	
23420			07	1		46751			03	1	
23430			04	1		46753			03	1	
23440			04	1		46754			02	1	
23450			05	1		46760			02	1	
23455			07	1		46761			03	1	
23460			05	1		46762			07	1	
23462			07	1		46900			01	1	
23465			05	1		46910			01	1	
23466			07	1		46916			01	1	
23480			04	1		46917			02	1	
23485			07	1		46922			01	1	
23490			03	1		46924			01	1	
23491			03	1		46934			02	1	
23515			02	1		46935			02	1	
23520			01	1		46936			02	1	
23525			01	1		46937			02	1	
23530			02	1		46938			02	1	
23532			03	1		46940			01	1	
23540			01	1		46945			02	1	
23545			01	1		46946			02	1	
23550			02	1		46947			02	1	
23552			03	1		47000			01	1	
23570			01	1		47001			01	1	
23575			01	1		47500			01	1	
23585			03	1		47505			01	1	
23605			02	1		47510			02	1	
23615			04	1		47511			02	1	
23616			04	1		47525			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
23625			02	1		47530			01	1	
23630			05	1		47552			02	1	
23655			01	1		47553			03	1	
23660			03	1		47554			03	1	
23665			02	1		47555			03	1	
23670			03	1		47556			03	1	
23675			02	1		47560			03	1	
23680			03	1		47561			03	1	
23700			01	1		47562			03	1	
23800			04	1		47563			03	1	
23802			07	1		47564			04	1	
23921			03	1		47600			05	1	
23935			02	1		47630			03	1	
24000			03	1		48102			01	1	
24065			01	1		49000			04	1	
24066			01	1		49020			04	1	
24076			02	1		49021			04	1	
24077			03	1		49080			02	1	
24100			01	1		49081			02	1	
24101			03	1		49180			01	1	
24102			04	1		49200			02	1	
24105			02	1		49201			02	1	
24110			02	1		49250			02	1	
24115			03	1		49255			02	1	
24116			03	1		49320			03	1	
24120			03	1		49321			04	1	
24125			03	1		49322			04	1	
24126			03	1		49323			04	1	
24130			04	1		49324			03	1	
24134			02	1		49325			03	1	
24136			02	1		49329	PA		03	1	
24138			02	1		49400			01	1	
24140			03	1		49402			02	1	
24145			03	1		49419			01	1	
24147			02	1		49420			01	1	
24149			04	1		49421			01	1	
24150			03	1		49422			01	1	
24151			04	1		49423			01	1	
24152			03	1		49424			01	1	
24153			04	1		49425			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
24155			03	1		49426			02	1	
24160			02	1		49427			01	1	
24164			03	1		49428			01	1	
24200			01	1	<21	49429			01	1	
24201			02	1		49436			02	1	
24300			01	1		49491			04	1	
24301			04	1		49492			04	1	
24305			04	1		49495			04	1	
24310			03	1		49496			04	1	
24320			03	1		49500			04	1	<5
24330			03	1		49501			04	1	
24331			03	1		49505			04	1	>4
24332			03	1		49507			04	1	
24340			03	1		49520			04	1	
24341			03	1		49521			04	1	
24342			03	1		49525			04	1	
24345			02	1		49540			03	1	
24350			02	1		49550			04	1	
24351			02	1		49553			09	1	
24352			02	1		49555			04	1	
24354			02	1		49557			09	1	
24356			03	1		49560			04	1	
24360			05	1		49561			04	1	
24361			05	1		49565			04	1	
24362			05	1		49566			04	1	
24363			07	1		49568			01	1	
24365			02	1		49570			04	1	
24366			03	1		49572			04	1	
24400			04	1		49580			04	1	<5
24410			04	1		49582			04	1	
24420			03	1		49585			02	1	
24430			03	1		49587			04	1	
24435			04	1		49590			03	1	
24470			03	1		49600			03	1	
24495			02	1		49650			04	1	
24498			03	1		49651			07	1	
24505			01	1		50020			02	1	
24515			03	1		50021			02	1	
24516			04	1		50040			03	1	
24530			01	1		50200			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
24535			01	1		50205			03	1	
24538			02	1		50382			01	1	
24545			04	1		50384			01	1	
24546			05	1		50387			01	1	
24565			02	1		50389			01	1	
24566			02	1		50390			01	1	
24575			03	1		50391			01	1	
24576			01	1		50392			01	1	
24577			01	1		50393			01	1	
24579			03	1		50394			01	1	
24582			02	1		50395			01	1	
24586			04	1		50396			01	1	
24587			05	1		50398			01	1	
24600			01	1		50520			01	1	
24605			02	1		50541			03	1	
24615			03	1		50551			01	1	
24620			02	1		50553			01	1	
24635			03	1		50555			01	1	
24655			01	1		50557			01	1	
24665			03	1		50561			01	1	
24666			04	1		50562			01	1	
24675			01	1		50570			01	1	
24685			03	1		50572			01	1	
24800			02	1		50574			01	1	
24802			04	1		50576			01	1	
24925			02	1		50580			01	1	
25000			03	1		50590			08	1	
25001			03	1		50592			01	1	
25020			03	1		50684			01	1	
25023			03	1		50686			01	1	
25024			03	1		50688			01	1	
25025			03	1		50690			01	1	
25028			01	1		50920			01	1	
25031			02	1		50947			09	1	
25035			03	1		50948			09	1	
25040			02	1		50951			01	1	
25066			02	1		50953			01	1	
25075			01	1		50955			01	1	
25076			02	1		50957			01	1	
25077			03	1		50961			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
25085			03	1		50970			01	1	
25100			02	1		50972			01	1	
25101			02	1		50974			01	1	
25105			03	1		50976			01	1	
25107			03	1		50980			01	1	
25110			02	1		51005			01	1	
25111			02	1		51010			01	1	
25112			02	1		51020			04	1	
25115			03	1		51030			04	1	
25116			03	1		51040			03	1	
25118			02	1		51045			04	1	
25119			03	1		51050			04	1	
25120			02	1		51060			04	1	
25125			03	1		51065			04	1	
25126			03	1		51080			03	1	
25130			02	1		51500			03	1	
25135			03	1		51520			03	1	
25136			03	1		51525			04	1	
25145			03	1		51530			04	1	
25150			03	1		51535			04	1	
25151			03	1		51550			04	1	
25170			03	1		51600			01	1	
25210			03	1		51605			01	1	
25215			04	1		51610			01	1	
25230			03	1		51710			01	1	
25240			04	1		51715			02	1	
25246			01	1		51726			01	1	
25248			02	1		51772			01	1	
25250			01	1		51785			01	1	
25251			01	1		51840			03	1	
25259			01	1		51845			03	1	
25260			02	1		51860			02	1	
25263			02	1		51865			04	1	
25265			03	1		51880			01	1	
25270			03	1		51900			04	1	
25272			02	1		51920			03	1	
25274			04	1		51990			03	1	
25275			04	1		51992			05	1	
25280			04	1		52000			01	1	
25290			02	1		52001			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
25295			02	1		52005			02	1	
25300			03	1		52007			02	1	
25301			03	1		52010			02	1	
25310			03	1		52204			02	1	
25312			04	1		52214			02	1	
25315			03	1		52224			02	1	
25316			03	1		52234			02	1	
25320			03	1		52235			03	1	
25332			05	1		52240			03	1	
25335			03	1		52250			04	1	
25337			03	1		52260			02	1	
25350			03	1		52265			02	1	
25355			03	1		52270			02	1	
25360			03	1		52275			02	1	
25365			03	1		52276			03	1	
25370			03	1		52277			02	1	
25375			04	1		52281			02	1	
25390			03	1		52282			02	1	
25391			04	1		52283			02	1	
25392			03	1		52285			02	1	
25393			04	1		52290			02	1	
25394			03	1		52300			02	1	
25400			03	1		52301			02	1	
25405			04	1		52305			02	1	
25415			03	1		52310			02	1	
25420			04	1		52315			02	1	
25425			03	1		52317			01	1	
25426			04	1		52318			02	1	
25430			03	1		52320			04	1	
25431			03	1		52325			04	1	
25440			04	1		52327			04	1	
25441			05	1		52330			03	1	
25442			05	1		52332			03	1	
25443			05	1		52334			03	1	
25444			05	1		52341			01	1	
25445			05	1		52342			02	1	
25446			07	1		52343			03	1	
25447			05	1		52344			01	1	
25449			05	1		52345			03	1	
25450			03	1		52346			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
25455			03	1		52351			03	1	
25490			03	1		52352			04	1	
25491			03	1		52353			04	1	
25492			03	1		52354			04	1	
25505			01	1		52355			04	1	
25515			03	1		52400			03	1	
25520			01	1		52402			03	1	
25525			04	1		52450			03	1	
25526			05	1		52500			03	1	
25535			01	1		52510			03	1	
25545			03	1		52601			04	1	
25565			02	1		52606			01	1	
25574			03	1		52612			02	1	
25575			03	1		52614			01	1	
25605			03	1		52620			01	1	
25606			03	1		52630			02	1	
25607			05	1		52640			02	1	
25608			05	1		52647			04	1	
25609			05	1		52648			04	1	
25624			01	1		52700			02	1	
25628			03	1		53000			01	1	
25635			01	1		53010			01	1	
25645			03	1		53020			01	1	
25651			01	1		53025			01	1	
25652			01	1		53040			02	1	
25660			01	1		53080			02	1	
25670			03	1		53085			03	1	
25671			01	1		53200			01	1	
25675			01	1		53210			04	1	
25676			02	1		53215			04	1	
25680			02	1		53220			02	1	
25685			03	1		53230			02	1	
25690			01	1		53235			03	1	
25695			02	1		53240			02	1	
25800			03	1		53250			02	1	
25805			04	1		53260			02	1	
25810			04	1		53265			02	1	
25820			03	1		53275			02	1	
25825			04	1		53400			03	1	
25907			02	1		53405			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
25922			02	1		53410			02	1	
25929			02	1		53415			02	1	
26011			01	1		53420			03	1	
26020			02	1		53425			02	1	
26025			01	1		53430			02	1	
26030			02	1		53431			02	1	
26034			02	1		53440			02	1	
26035			04	1		53442			01	1	
26037			04	1		53444			02	1	
26040			03	1		53445			02	1	
26045			03	1		53446			01	1	
26055			02	1		53447			01	1	
26060			02	1		53449			01	1	
26070			02	1		53450			01	1	
26075			02	1		53460			01	1	
26080			02	1		53500			02	1	
26100			02	1		53502			02	1	
26105			01	1		53505			02	1	
26110			01	1		53510			02	1	
26115			02	1		53515			02	1	
26116			02	1		53520			02	1	
26117			03	1		53605			02	1	
26121			04	1		53620			01	1	
26123			04	1		53621			01	1	
26125			04	1		53660			01	1	
26130			03	1		53661			01	1	
26135			03	1		53665			01	1	
26140			02	1		53850			09	1	
26145			03	1		53852			05	1	
26160			02	1		53853			05	1	
26170			03	1		54000			02	1	<2
26180			03	1		54001			01	1	
26185			01	1		54015			01	1	
26200			02	1		54057			01	1	
26205			03	1		54060			01	1	
26210			02	1		54065			01	1	
26215			03	1		54100			01	1	
26230			02	1		54105			01	1	
26235			02	1		54110			02	1	
26236			02	1		54111			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
26250			03	1		54112			03	1	
26255			03	1		54115			01	1	
26260			02	1		54120			02	1	
26261			03	1		54125			02	1	
26262			02	1		54150			01	1	<2
26320			02	1		54160			02	1	<2
26340			01	1		54161			02	1	
26350			02	1		54162			02	1	
26352			03	1		54163			02	1	
26356			02	1		54164			02	1	
26357			02	1		54205			01	1	
26358			03	1		54220			01	1	
26370			03	1		54230			01	1	
26372			04	1		54231			02	1	
26373			03	1		54300			03	1	
26390			03	1		54304		EQ	05	1	
26392			02	1		54308			03	1	
26410			02	1		54312			03	1	
26412			03	1		54316			03	1	
26415			03	1		54318			03	1	
26416			03	1		54322			03	1	
26418			03	1		54324			04	1	
26420			03	1		54326			04	1	
26426			02	1		54328			03	1	
26428			03	1		54332			03	1	
26432			02	1		54340			03	1	
26433			02	1		54344			03	1	
26434			03	1		54348			03	1	
26437			03	1		54352			03	1	
26440			03	1		54360			03	1	
26442			03	1		54380			03	1	
26445			03	1		54385			03	1	
26449			03	1		54402		EQ	03	1	
26450			03	1		54407		EQ	05	1	
26455			03	1		54409		EQ	03	1	
26460			03	1		54420			04	1	
26471			02	1		54430			04	1	
26474			02	1		54435			04	1	
26476			02	1		54440			04	1	
26477			02	1		54450			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
26478			02	1		54500			01	1	
26479			02	1		54505			01	1	
26480			02	1		54510			02	1	
26483			03	1		54512			02	1	
26485			02	1		54520			03	1	
26489			03	1		54522			03	1	
26490			03	1		54530			04	1	
26492			04	1		54550			03	1	
26494			03	1		54600			04	1	
26496			03	1		54620			02	1	
26497			03	1		54640			04	1	
26498			04	1		54650			04	1	
26499	PA		03	1		54660			02	1	
26500			03	1		54670			03	1	
26502			04	1		54680			03	1	
26508			02	1		54690			03	1	
26510			02	1		54692			03	1	
26516			01	1		54700			02	1	
26517			02	1		54800			01	1	
26518			02	1		54830			03	1	
26520			02	1		54840			04	1	
26525			02	1		54860			03	1	
26530			03	1		54861			04	1	
26531			05	1		54865			01	1	
26535			02	1		55040			03	1	
26536			03	1		55041			05	1	
26540			03	1		55060			04	1	
26541			04	1		55100			01	1	
26542			04	1		55110			02	1	
26545			03	1		55120			02	1	
26546			04	1		55150			01	1	
26548			03	1		55175			01	1	
26550			02	1		55180			02	1	
26551			04	1		55200			02	1	
26553			03	1		55250			01	1	
26554			03	1		55500			03	1	
26555			03	1		55520			04	1	
26556			03	1		55530			04	1	
26560			02	1		55535			04	1	
26561			03	1		55540			05	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
26562			03	1		55550			09	1	
26565			03	1		55600			01	1	
26567			02	1		55605			01	1	
26568			03	1		55650			01	1	
26580			05	1		55680			01	1	
26585			05	1		55700			02	1	
26587			02	1		55705			02	1	
26590			03	1		55720			01	1	
26591			03	1		55725			02	1	
26593			03	1		55860			03	1	
26596			02	1		55873			09	1	
26597			03	1		55875			03	1	
26605			01	1		55876			03	1	
26607			02	1		56405			01	1	
26608			02	1		56420			01	1	
26615			03	1		56440			02	1	
26641			01	1		56441			01	1	
26645			01	1		56442			01	1	
26650			02	1		56501			01	1	
26665			03	1		56515			03	1	
26675			02	1		56605			01	1	
26676			02	1		56620			01	1	
26685			02	1		56625			02	1	
26686			03	1		56700			01	1	
26705			02	1		56740			03	1	
26706			02	1		56800			03	1	
26715			03	1		56805			03	1	
26727			03	1		56810			03	1	
26735			03	1		56821			01	1	
26742			01	1		57000			02	1	
26746			03	1		57010			02	1	
26755			01	1		57020			02	1	
26756			02	1		57022			01	1	
26765			03	1		57023			01	1	
26776			02	1		57061			01	1	
26785			02	1		57065			02	1	
26820			04	1		57100			01	1	
26841			03	1		57105			02	1	
26842			04	1		57130			02	1	
26843			03	1		57135			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
26844			04	1		57155			01	1	
26850			03	1		57180			01	1	
26852			04	1		57200			01	1	
26860			02	1		57210			02	1	
26861			01	1		57220			03	1	
26862			03	1		57230			03	1	
26863			03	1		57240			05	1	
26910			04	1		57250			05	1	
26951			02	1		57260			05	1	
26952			03	1		57265			07	1	
26990			01	1		57268			03	1	
26991			01	1		57284			04	1	
26992			02	1		57287			02	1	
27000			02	1		57288			02	1	
27001			03	1		57289			05	1	
27003			03	1		57291			05	1	
27006			03	1		57295			03	1	
27025			03	1		57300			03	1	
27030			03	1		57305			03	1	
27033			03	1		57307			03	1	
27035			04	1		57308			03	1	
27036			05	1		57310			03	1	
27040			01	1		57311			04	1	
27041			02	1		57320			03	1	
27047			02	1		57330			03	1	
27048			03	1		57400			02	1	
27049			03	1		57410			02	1	
27050			03	1		57415			04	1	
27052			03	1		57420			01	1	
27054			03	1		57421			01	1	
27060			03	1		57425			02	1	
27062			03	1		57452			01	1	
27065			04	1		57454			01	1	
27066			05	1		57455			01	1	
27067			05	1		57456			01	1	
27080			03	1		57460			01	1	
27086			01	1		57461			01	1	
27087			02	1		57500			01	1	
27093			01	1		57505			01	1	
27095			01	1		57510			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
27096			01	1		57511			01	1	
27097			03	1		57513			02	1	
27098			03	1		57520			02	1	
27100			04	1		57522			02	1	
27105			04	1		57530			03	1	
27110			04	1		57550			03	1	
27111			04	1		57556			05	1	
27120			04	1		57558			03	1	
27125			04	1		57700			01	1	
27176			03	1		57720			03	1	
27177			02	1		57800			01	1	
27187			02	1		58100			01	1	
27193			01	1		58120			02	1	
27194			02	1		58145			05	1	
27202			02	1		58260			02	1	
27220			02	1		58262			02	1	
27222			02	1		58263			02	1	
27230			01	1		58267			02	1	
27232			01	1		58270			02	1	
27235			01	1		58275			02	1	
27236			02	1		58280			02	1	
27238			01	1		58290			02	1	
27240			01	1		58291			02	1	
27244			02	1		58292			02	1	
27246			01	1		58293			02	1	
27250			01	1		58294			02	1	
27252			02	1		58301			01	1	
27256			02	1		58340			01	1	
27257			03	1		58346			02	1	
27258			03	1		58350			03	1	
27259			03	1		58353			01	1	
27265			01	1		58356			01	1	
27266			01	1		58400			04	1	
27275			02	1		58410			04	1	
27284			02	1		58541			03	1	
27286			02	1		58542			03	1	
27299	PA		03	1		58543			03	1	
27301			02	1		58544			03	1	
27303			03	1		58550			05	1	
27305			03	1		58552			05	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
27306			03	1		58553			05	1	
27307			03	1		58554			05	1	
27310			03	1		58555			01	1	
27323			01	1		58558			03	1	
27324			01	1		58559			02	1	
27325			02	1		58560			02	1	
27326			02	1		58561			03	1	
27327			01	1		58562			02	1	
27328			02	1		58563			04	1	
27330			03	1		58565	PA		02	1	
27331			03	1		58600			04	1	>20
27332			03	1		58615			04	1	>20
27333			03	1		58660			05	1	
27334			03	1		58661			05	1	
27335			03	1		58662			05	1	
27340			03	1		58670			03	1	>20
27345			03	1		58671			03	1	>20
27347			03	1		58672			05	1	
27350			04	1		58673			05	1	
27355			03	1		58700			04	1	
27356			04	1		58740			02	1	
27357			05	1		58800			05	1	
27360			05	1		58805			05	1	
27370			01	1		58820			05	1	
27372			04	1		58823			04	1	
27380			04	1		58825			05	1	
27381			04	1		58900			03	1	
27385			03	1		58940			03	1	
27386			03	1		59000			01	1	
27390			01	1		59070			01	1	
27391			02	1		59072			01	1	
27392			03	1		59074			01	1	
27393			02	1		59076			01	1	
27394			03	1		59100			05	1	>20
27395			03	1		59120			02	1	10 to 65
27396			03	1		59121			02	1	
27397			03	1		59130			02	1	10 to 65
27400			03	1		59135			02	1	21 to 65
27403			03	1		59136			02	1	
27405			04	1		59140			02	1	10 to 65

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
27407			04	1		59150			04	1	
27409			04	1		59151			04	1	
27418			04	1		59160			02	1	
27420			03	1		59320			01	1	
27422			04	1		59812			02	1	
27424			04	1		59820			02	1	
27425			03	1		59821			02	1	
27427			03	1		59830			02	1	
27428			04	1		59840			01	1	
27429			04	1		59841			02	1	
27430			04	1		59850			02	1	
27435			04	1		59851			02	1	
27437			04	1		59852		EQ	04	1	
27438			05	1		59855			02	1	
27440			05	1		59856			02	1	
27441			05	1		59857			04	1	
27442			05	1		59866			01	1	
27443			05	1		59870			01	1	
27448			02	1		59871			01	1	
27450			02	1		60000			01	1	
27455			02	1		60001			01	1	
27457			02	1		60200			02	1	
27465			02	1	<21	60210			02	1	
27466			02	1	<21	60212			02	1	
27468			02	1	<21	60220			02	1	
27475			04	1	<21	60225			03	1	
27477			04	1	<21	60260			03	1	
27479			04	1	<21	60280			04	1	
27497			03	1		60281			04	1	
27500			01	1		60521			03	1	
27501			02	1		61020			01	1	
27502			02	1		61026			01	1	
27503			03	1		61050			01	1	
27506			03	1		61055			01	1	
27507			04	1		61070			01	1	
27508			01	1		61154			03	1	
27509			03	1		61215			03	1	
27510			01	1		61500		EQ	04	1	
27511			04	1		61770			02	1	
27513			05	1		61790			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
27516			01	1		61791			03	1	
27517			01	1		61793			04	1	
27520			01	1		61880			01	1	
27524			03	1		61885			02	1	
27530			01	1		61886			02	1	
27532			01	1		61888			01	1	
27535			03	1		62194			01	1	
27538			01	1		62225			01	1	
27550			01	1		62230			02	1	
27552			01	1		62252			02	1	
27556			03	1		62256			02	1	
27557			03	1		62263			01	1	
27560			01	1		62264			01	1	
27562			01	1		62268			01	1	
27566			02	1		62269			01	1	
27570			01	1		62270			01	1	
27580			04	1		62272			01	1	
27600			03	1		62273			01	1	
27602			03	1		62280			01	1	
27603			02	1		62281			01	1	
27604			02	1		62282			01	1	
27605			01	1		62284			01	1	
27606			01	1		62287			09	1	
27607			02	1		62290			01	1	
27610			02	1		62294			03	1	
27612			03	1		62310			01	1	
27614			01	1		62311			01	1	
27618			02	1		62318			01	1	
27619			03	1		62319			01	1	
27620			04	1		62350			02	1	
27625			04	1		62351			02	1	
27626			04	1		62355			02	1	
27630			03	1		62360			02	1	
27635			03	1		62361			02	1	
27637			03	1		62362			02	1	
27638			03	1		62365			02	1	
27640			03	1		62367			02	1	
27648			01	1		62368			02	1	
27650			03	1		63012			03	1	
27652			03	1		63030			05	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
27654			03	1		63042			05	1	
27656			02	1		63600			02	1	
27658			01	1		63610			01	1	
27659			02	1		63650			02	1	
27664			02	1		63660			01	1	
27665			02	1		63685			02	1	
27675			02	1		63688			01	1	
27676			03	1		63744			03	1	
27680			03	1		63746			02	1	
27681			03	1		64400			01	1	
27685			03	1		64402			01	1	
27686			03	1		64405			01	1	
27687			03	1		64408			01	1	
27690			04	1		64410			01	1	
27691			04	1		64412			01	1	
27692			03	1		64413			01	1	
27695			02	1		64415			01	1	
27696			02	1		64417			01	1	
27698			02	1		64418			01	1	
27700			05	1		64420			01	1	
27704			02	1		64421			01	1	
27705			02	1		64425			01	1	
27707			02	1		64430			01	1	
27709			02	1		64435			01	1	
27715			04	1		64445			01	1	
27720			02	1		64449			01	1	
27730			02	1		64450			01	1	
27732			02	1		64470			01	1	
27734			02	1		64472			01	1	
27740			02	1		64475			01	1	
27742			02	1		64476			01	1	
27745			03	1		64479			01	1	
27750			01	1		64480			01	1	
27752			01	1		64483			01	1	
27756			03	1		64484			01	1	
27758			04	1		64505			01	1	
27759			04	1		64508			01	1	
27760			01	1		64510			01	1	
27762			01	1		64517			01	1	
27766			03	1		64520			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
27780			01	1		64530			01	1	
27781			01	1		64553			01	1	
27784			03	1		64555		EQ	01	1	
27786			01	1		64560			01	1	
27788			01	1		64561			03	1	
27792			03	1		64565			01	1	
27808			01	1		64573			01	1	
27810			01	1		64575			01	1	
27814			03	1		64577			01	1	
27816			01	1		64580			01	1	
27818			01	1		64581			03	1	
27822			03	1		64585			02	1	
27823			03	1		64590			02	1	
27824			01	1		64595			01	1	
27825			02	1		64600			01	1	
27826			03	1		64605			01	1	
27827			03	1		64610			01	1	
27828			04	1		64612			01	1	
27829			02	1		64613			01	1	
27830			01	1		64614			01	1	
27831			01	1		64620			01	1	
27832			02	1		64622			01	1	
27840			01	1		64623			01	1	
27842			01	1		64626			01	1	
27846			03	1		64630			02	1	
27848			03	1		64640			01	1	
27860			01	1		64650	PA		01	1	>-1
27870			04	1		64653	PA		02	1	
27871			04	1		64680			02	1	
27889			03	1		64681			01	1	
27892			03	1		64702			01	1	
27893			03	1		64704			01	1	
27894			03	1		64708			02	1	
27899	PA		03	1		64712			02	1	
28002			03	1		64713			02	1	
28003			03	1		64714			02	1	
28005			03	1		64716			03	1	
28008			03	1		64718			02	1	
28010			02	1		64719			02	1	
28011			03	1		64721			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
28020			02	1		64722			01	1	
28022			02	1		64726			01	1	
28024			02	1		64727			01	1	
28035			03	1		64732			02	1	
28043			01	1		64734			02	1	
28045			03	1		64736			02	1	
28050			02	1		64738			02	1	
28052			02	1		64740			02	1	
28054			01	1		64742			02	1	
28055			04	1		64744			02	1	
28060			02	1		64746			02	1	
28062			03	1		64771			02	1	
28070			02	1		64772			02	1	
28072			02	1		64774			02	1	
28080			02	1		64776			03	1	
28086			02	1		64778			02	1	
28088			02	1		64782			03	1	
28090			02	1		64783			02	1	
28092			02	1		64784			03	1	
28100			02	1		64786			03	1	
28102			03	1		64787			02	1	
28103			03	1		64788			03	1	
28104			02	1		64790			03	1	
28106			03	1		64792			03	1	
28107			03	1		64795			02	1	
28108			01	1		64802			02	1	
28110			02	1		64831			04	1	
28111			03	1		64832			01	1	
28112			03	1		64834			02	1	
28113			03	1		64835			03	1	
28114			03	1		64836			03	1	
28116			03	1		64837			01	1	
28118			04	1		64840			02	1	
28119			04	1		64856			02	1	
28120			03	1		64857			02	1	
28122			03	1		64858			02	1	
28124			02	1		64859		EQ	01	1	
28130			03	1		64861			03	1	
28150			03	1		64862			03	1	
28153			03	1		64864			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
28160			03	1		64865			04	1	
28171			03	1		64870			04	1	
28175			03	1		64872			02	1	
28190			01	1	<21	64874			03	1	
28192			02	1		64876			03	1	
28193			03	1		64885			02	1	
28200			03	1		64886			02	1	
28202			03	1		64890			02	1	
28208			03	1		64891			02	1	
28210			03	1		64892			02	1	
28220			01	1		64893			02	1	
28222			01	1		64895			03	1	
28225			01	1		64896			03	1	
28226			01	1		64897			03	1	
28230			03	1		64898			03	1	
28232			01	1		64901			02	1	
28234			01	1		64902			02	1	
28238			03	1		64905			02	1	
28240			02	1		64907			01	1	
28250			03	1		64910			03	1	
28260			03	1		64911			03	1	
28261			03	1		65091			03	1	
28262			03	1		65093			03	1	
28264			01	1		65101			03	1	
28270			03	1		65103			03	1	
28272			03	1		65105			04	1	
28280			01	1		65110			05	1	
28285			03	1		65112			05	1	
28286			03	1		65114			07	1	
28288			03	1		65125			02	1	
28289			03	1		65130			03	1	
28290			02	1		65135			02	1	
28292			02	1		65140			03	1	
28293			02	1		65150			02	1	
28294			03	1		65155			03	1	
28296			03	1		65175			01	1	
28297			03	1		65220			01	1	
28298			03	1		65222			01	1	
28299			03	1		65235			02	1	
28300			02	1		65260			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
28302			02	1		65265			04	1	
28304			02	1		65270			01	1	
28305			03	1		65272			02	1	
28306			04	1		65273			02	1	
28307			03	1		65275			03	1	
28308			02	1		65280			04	1	
28309			04	1		65285			04	1	
28310			03	1		65286			02	1	
28312			03	1		65290			03	1	
28313			02	1		65400			01	1	
28315			02	1		65410			02	1	
28320			03	1		65420			02	1	
28322			04	1		65426			05	1	
28340			04	1		65450			02	1	
28341			04	1		65710			07	1	
28344			01	1		65730			07	1	
28345			02	1		65750			07	1	
28405			02	1		65755			07	1	
28406			02	1		65770			07	1	
28415			03	1		65772			04	1	
28420			04	1		65775			04	1	
28435			02	1		65780			01	1	
28436			02	1		65781			01	1	
28445			03	1		65782			01	1	
28455			01	1		65800			01	1	
28456			02	1		65805			01	1	
28465			03	1		65810			03	1	
28475			01	1		65815			02	1	
28476			02	1		65820			02	1	
28485			03	1		65850			02	1	
28495			01	1		65855			02	1	
28496			02	1		65860			01	1	
28505			02	1		65865			01	1	
28515			01	1		65870			04	1	
28525			02	1		65875			04	1	
28531			02	1		65880			04	1	
28545			01	1		65900			05	1	
28546			02	1		65920			07	1	
28555			02	1		65930			05	1	
28575			01	1		66020			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
28576			03	1		66030			01	1	
28585			03	1		66130			07	1	
28605			01	1		66150			04	1	
28606			02	1		66155			04	1	
28615			03	1		66160			02	1	
28630			01	1		66165			04	1	
28635			01	1		66170			04	1	
28636			03	1		66172			04	1	
28645			02	1		66180			04	1	
28665			01	1		66185			02	1	
28666			03	1		66220			03	1	
28675			02	1		66225			04	1	
28705			04	1		66250			02	1	
28715			04	1		66500			01	1	
28725			04	1		66505			01	1	
28730			04	1		66600			03	1	
28735			04	1		66605			03	1	
28737			04	1		66625			03	1	
28740			03	1		66630			03	1	
28750			03	1		66635			03	1	
28755			03	1		66680			03	1	
28760			04	1		66682			02	1	
28810			02	1		66700			02	1	
28820			02	1		66710			02	1	
28825			02	1		66711			02	1	
29800			01	1		66720		EQ	02	1	
29804	PA		01	1		66740			02	1	
29805			03	1		66761			01	1	
29806			03	1		66762			01	1	
29807			03	1		66770			01	1	
29815			03	1		66820			04	1	
29819			03	1		66821			04	1	
29820			03	1		66825			02	1	
29821			03	1		66830			04	1	
29822			03	1		66840			04	1	
29823			03	1		66850			07	1	
29824			05	1		66852			07	1	
29825			03	1		66920			04	1	
29826			03	1		66930			05	1	
29827			03	1		66940			05	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
29830			03	1		66982			08	1	
29834			03	1		66983			08	1	
29835			03	1		66984			08	1	
29836			03	1		66985			06	1	
29837			03	1		66986			05	1	
29838			03	1		66999	PA		01	1	
29840			03			67005			04	1	
29843			03	1		67010			04	1	
29844			03	1		67015			01	1	
29845			03	1		67025			01	1	
29846			03	1		67027			04	1	
29847			03	1		67028			02	1	
29848			03	1		67030			01	1	
29850			04	1		67031			02	1	
29851			04	1		67036			04	1	
29855			04	1		67038			05	1	
29856			04	1		67039			05	1	
29860			02	1		67040			05	1	
29861			02	1		67101			04	1	
29862			03	1		67105			05	1	
29863			02	1		67107			05	1	
29868			03	1		67108			05	1	
29870			03	1		67110			05	1	
29871			03	1		67112			05	1	
29873			03	1		67115			02	1	
29874			03	1		67120			02	1	
29875			04	1		67121			02	1	
29876			04	1		67141			02	1	
29877			04	1		67145			01	1	
29879			03	1		67208			01	1	
29880			04	1		67210			01	1	
29881			03	1		67218			05	1	
29882			03	1		67220			02	1	
29883			03	1		67221			01	1	
29884			03	1		67227			01	1	
29885			03	1		67228			02	1	
29886			03	1		67250			03	1	
29887			03	1		67255			03	1	
29888			03	1		67311			03	1	
29889			03	1		67312			04	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
29891			03	1		67314			04	1	
29892			03	1		67316			04	1	
29893			01	1		67318			04	1	
29894			03	1		67343			04	1	
29895			03	1		67345			03	1	
29897			03	1		67346			01	1	
29898			03	1		67400			03	1	
29899			03	1		67405			04	1	
29900			03	1		67412			05	1	
29901			03	1		67413			05	1	
29902			03	1		67414			03	1	
29909	PA		04	1		67415			01	1	
30000			01	1		67420			05	1	
30020			01	1		67430			05	1	
30100			01	1		67440			05	1	
30110			01	1		67445			05	1	
30115			02	1		67450			05	1	
30117			03	1		67500			01	1	
30118			03	1		67550			04	1	
30120			01	1		67560			02	1	
30124			01	1		67570			03	1	
30125			02	1		67700			01	1	
30130			02	1		67710			02	1	
30140			02	1		67715			01	1	
30150			03	1		67800			01	1	
30160			04	1		67801			01	1	
30310			01	1		67805			01	1	
30320			02	1		67808			02	1	
30400	PA		03	1		67820			01	1	
30410	PA		04	1		67825			01	1	
30420	PA		04	1		67830			02	1	
30430	PA		03	1		67835			02	1	
30435	PA		04	1		67840			01	1	
30450	PA		05	1		67850			01	1	
30460			03	1		67875			01	1	
30462			03	1		67880			03	1	
30465			04	1		67882			03	1	
30520			04	1		67900	PA		03	1	
30540			04	1		67901	PA		05	1	
30545			04	1		67902	PA		05	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
30560			02	1		67903	PA		03	1	
30580			04	1		67904	PA		04	1	
30600			04	1		67906	PA		05	1	
30620			05	1		67908	PA		04	1	
30630			05	1		67909	PA		03	1	
30801			01	1		67911			01	1	
30802			02	1		67912			03	1	
30901			01	1		67914			01	1	
30903			01	1		67916			04	1	
30905			01	1		67917			04	1	
30906			01	1		67921			01	1	
30915			02	1		67922			03	1	
30920			03	1		67923			04	1	
30930			01	1		67924			04	1	
31020			02	1		67930			02	1	
31030			03	1		67935			02	1	
31032			03	1		67938			01	1	
31050			02	1		67950	PA		02	1	
31051			03	1		67961			03	1	
31070			02	1		67966			03	1	
31075			04	1		67971			03	1	
31080			04	1		67973			03	1	
31081			04	1		67974			03	1	
31084			04	1		67975			03	1	
31085			04	1		67999	PA		03	1	
31086			04	1		68020			01	1	
31087			04	1		68040			01	1	
31090			05	1		68100			01	1	
31200			02	1		68110			02	1	
31201			04	1		68115			02	1	
31205			03	1		68130			02	1	
31225			03	1		68320			04	1	
31231			02	1		68325			04	1	
31233			02	1		68326			04	1	
31235			01	1		68328	PA		04	1	
31237			02	1		68330			04	1	
31238			02	1		68335			04	1	
31239			02	1		68340			04	1	
31240			02	1		68360			02	1	
31250			01	1		68362			02	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
31252			02	1		68371			01	0	
31254			03	1		68500			03	1	
31255			03	1		68505			03	1	
31256			03	1		68510			01	1	
31258			03	1		68520			03	1	
31260			02	1		68525			01	1	
31263			03	1		68530			02	1	
31265			03	1		68540			03	1	
31267			03	1		68550			03	1	
31268			03	1		68700			02	1	
31270			01	1		68705			01	1	
31275			02	1		68720			04	1	
31276			03	1		68745			04	1	
31277			03	1		68750			04	1	
31285			03	1		68760			02	1	
31287			03	1		68770			04	1	
31288			03	1		68801			01	1	
31290			04	1		68810			01	1	
31291			04	1		68811			01	1	
31292			04	1		68815			01	1	
31293			04	1		69000			01	1	
31294			04	1		69005			02	1	
31300			05	1		69020			01	1	
31320			02	1		69100			01	1	
31400			02	1		69105			01	1	
31420			02	1		69110			01	1	
31500			01	1		69120			02	1	
31505			01	1		69140			02	1	
31510			01	1		69145			02	1	
31511			01	1		69150			03	1	
31512			01	1		69205			01	1	
31513			01	1		69210	PA	EQ	01	1	
31515			02	1		69220			01	1	
31520			02	1		69222			02	1	
31525			02	1		69300	PA		02	1	
31526			02	1		69310			03	1	
31527			02	1		69320			07	1	
31528			02	1		69400			01	1	
31529			02	1		69401			01	1	
31530			02	1		69405			01	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
31531			03	1		69420			01	1	
31535			02	1		69421			01	1	
31536			03	1		69424			01	1	
31540			03	1		69433			01	1	
31541			04	1		69436			01	1	
31545			03	1		69440			03	1	
31546			05	1		69450			01	1	
31560			05	1		69501			07	1	
31561			05	1		69502			07	1	
31570			02	1		69505			07	1	
31571			02	1		69511			07	1	
31575			02	1		69530			07	1	
31576			02	1		69550			05	1	
31577			02	1		69552			07	1	
31578			02	1		69601			07	1	
31579			02	1		69602			07	1	
31580			05	1		69603			07	1	
31582			05	1		69604			07	1	
31584			04	1		69605			07	1	
31588			05	1		69610			02	1	
31590			05	1		69620			02	1	
31595			02	1		69631			05	1	
31600			02	1		69632			05	1	
31601			02	1		69633			05	1	
31603			01	1		69635			07	1	
31611			04	1		69636			07	1	
31612			01	1		69637			07	1	
31613			02	1		69641			07	1	
31614			02	1		69642			07	1	
31615			01	1		69643			07	1	
31622			01	1		69644			07	1	
31623			01	1		69645			07	1	
31624			01	1		69646			07	1	
31625			02	1		69650			07	1	
31628			02	1		69660			05	1	
31629			02	1		69661			05	1	
31630			02	1		69662			04	1	
31631			02	1		69666			04	1	
31632			02	1		69667			04	1	
31633			02	1		69670			03	1	

PC	PA	EPSDT	Grp	Max Units	Limit To Recip	PC	PA	EPSDT	Grp	Max Units	LimitTo Recip
31635			02	1		69676			03	1	
31636			02	1		69700			03	1	
31638			02	1		69710			03	1	
31640			02	1		69711			01	1	
31641			02	1		69714			09	1	
31643			02	1		69715			09	1	
31645			01	1		69717			09	1	
31646			01	1		69718			09	1	
31656			01	1		69720			05	1	
31715			01	1		69725			05	1	
31717			01	1		69740			05	1	
31720			01	1		69745			05	1	
31730			01	1		69801			05	1	
31750			05	1		69802			07	1	
31755			02	1		69805			07	1	
31785			04	1		69806			07	1	
31800			02	1		69820			05	1	
31820			01	1		69840			05	1	
31825			02	1		69905			07	1	
31830			02	1		69910			07	1	
32000			01	1		69915			07	1	
32002			02	1		D9420			02	1	

J. Provider Explanation of Payment (EOP) Codes

Section J.1 and J.2 lists codes that may appear on a Provider Explanation of Payments (EOP) for paid, denied, or adjusted claims.

Section J.3 lists the upfront error messages. The Provider Electronic Solutions (PES) software performs up-front edits before claims go into the system. PES assigns an error message to each rejected claim, which providers may then correct and resubmit into the system.

J.1 Claim Adjustment Reason Code/Remittance Advice Remark Codes

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**447**	Daily management of an epidural or subarachnoid catheter may not be billed on the same day as a procedure for catheter placement.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**449**	Physician visit codes/primary anesthesia codes may not be billed within 3 days or on the same day of each other.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N123**	This is a split service and represents a portion of the units from the originally submitted service.	**737**	Units on this claim have been systematically reduced to meet the benefit limit.
B5	Payment adjusted because coverage/program, guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**70**	Encounter rate procedures and fee-for-service procedures cannot be billed on the same claim. Split bill.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**669**	Services cannot be billed on the same day for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M50**	Missing/Incomplete/ invalid revenue code(s).	**10**	Emergency facility procedure codes may be billed with revenue code 450 only.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**13**	Revenue codes 172, 175 or 179 cannot be billed in conjunction with a normal newborn diagnosis.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**18**	Home health providers cannot bill inpatient and outpatient services on the same claim.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**19**	HIV codes must be billed in conjunction with family planning codes.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**20**	Family planning procedure 99212-FP must be billed with 59430.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**21**	Outpatient physical therapy cannot be billed in conjunction with any other service.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**25**	Unborn recipient's Medicaid number should be used only for infant services.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M77**	Missing/Incomplete/ invalid place of service.	**26**	EPSDT-referred therapy services are restricted to place of service "11" or "99".
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M50**	Missing/incomplete/ invalid revenue code(s).	**33**	Revenue codes 170 - 171 are valid for the mother's number. Revenue codes 172, 175 or 179 are valid for the baby's number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**37**	Revenue codes 170 -171 must not exceed 10 units under mother's number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**57**	Ten units of code Z5294 must be billed prior to any units of Z5295.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**58**	Service for maternity waiver/care recipient must be billed with global

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					service fee.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**61**	Injectable and non-injectable procedures cannot be billed together.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**62**	FQHC services billed at pos-21 (inpatient hospitals) cannot be billed on the same claim with other FQHC services.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**79**	Procedure code not valid for renal dialysis facility.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**MA31**	Missing/incomplete/invalid beginning and ending dates of the period billed.	**90**	Global delivery procedure code cannot be span dated. Use date of delivery.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M50**	Missing/incomplete/invalid revenue code(s).	**97**	Procedure and revenue code combination not valid.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**102**	Service(s) past the maximum Medicaid filing limit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**103**	Therapy code payable only with therapeutic treatment.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**104**	ER and critical care code one per claim.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**109**	Observation must be billed in conjunction with facility fee.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N39**	Procedure code is not compatible with tooth number/letter.	**127**	Procedure not valid for procedure number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**130**	Invalid claim type for plan first program.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N24**	Missing/incomplete/invalid electronic funds transfer (EFT) banking information.	**358**	PHP providers must have a current EFT segment.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**451**	This schedule II drug is not refillable.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**529**	Ten units of code Z5294 must be billed prior to any units of Z5295.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**552**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**600**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**601**	Pulp therapy combination not allowed in this case
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**602**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**603**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**604**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**605**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**606**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**607**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**608**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**609**	Pulp therapy combination not allowed.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**610**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**613**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**621**	Pulp cap not allowed for this tooth/date of service.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**624**	An initial visit will not be paid on same date of service as an annual, periodic or home visit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded			**625**	Post-cataract follow-up care has been paid to the surgeon or post-cataract follow-up care cannot be paid until the surgeon has been paid. Contact the surgeon.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**626**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**627**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**629**	Comprehensive EPSDT screening and FP visit may not be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**638**	More than one encounter code cannot be billed on same date of service without justification - excluding dental.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**663**	Procedure codes 92553, 92556 and 92557 cannot be billed on the same day by the same or different provider
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**665**	Services cannot be billed on the same day by the same provider.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**666**	Service cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**667**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**674**	Services cannot be billed on the same day for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**676**	Procedure cannot be billed on the same day as critical care.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**677**	Services cannot be billed on the same day for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**678**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**679**	Services cannot be billed on the same day for the same recipient
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**680**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**682**	This service is not allowed on the same day as day treatment
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded	**N20**	Service not payable with other service rendered on the same date.	**685**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded	**N20**	Service not payable with other service rendered on the same date.	**686**	Only one service is payable per date of service.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**687**	Clinic codes z5145-z5149 cannot be billed on the same day with same unique number as 99241-99245 and 99281-99285.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**694**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N39**	Procedure adjusted because coverage/program guidelines were not met or were exceeded.	**703**	Core buildup not covered with other restoration.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N39**	Procedure adjusted because coverage/program guidelines were not met or were exceeded.	**704**	Two restorations not covered for the same tooth number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**705**	Two restorations not covered for the same tooth number, same date of service.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**751**	Family planning visit not payable after sterilization.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**766**	Crowns are not payable when billed without a paid root canal for the same tooth number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**773**	Procedure codes 95115, 95117 or z4998 shall not be paid on the same day as procedure codes 95120 - 95134.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**774**	Procedure codes 95120-95134 will not be paid on the same day as procedure codes 95135-95170.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**775**	Procedure code not allowed on the same day (95115 and 95117).
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**776**	Procedure codes not allowed on the same day (95130- 95134).
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**777**	Procedure code not allowed with a more comprehensive code.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**779**	Procedure code cannot be billed on the same day with procedure codes z5181-z5185.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**781**	Prenatal visit not be covered on the same day as postpartum visit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**782**	Prenatal visit not covered for the same date of service of family planning.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**784**	Procedure not covered when billed with 76805, 76810 or 76816 on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**785**	Procedure not covered when billed with 76805 on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**786**	Procedure cannot be billed on the same day as critical care.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**791**	The same physician may not bill intubation and newborn resuscitation on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**794**	Standby/ resuscitation/ attendance at delivery cannot be billed together.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**796**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**803**	Procedure cannot be billed on the same day by the provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**812**	Chemistry profile and chemical panel cannot be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**815**	Electroshock therapy may not be on the same day as a hospital visit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**818**	Multiple urinalysis tests cannot be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**824**	Salpingectomy will not be paid on the same day as a tubal ligation.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**831**	Components of a cbc may not be billed on the same day as a complete cbc
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**839**	Professional components and hospital visits may not be billed on the same

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**840**	Components of a cbc may not be billed on the same day as a complete cbc
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**845**	EPSDT vision screen and external ocular photography not covered on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**846**	Prevocational services and supported employment shall not be paid on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**847**	More than three office visits may not be billed with pregnancy diagnosis.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**857**	Components of a CBC may not be billed on the same day as a complete CBC.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**858**	Components of a urinalysis may not be billed on the same day as urinalysis.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**860**	Screening provider may not bill for screening exam and inclusive medical services on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**866**	Components of a CBC may not be billed on the same day as a complete CBC.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**870**	The same provider may not bill hospital visits/ psychotherapy on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**871**	The same provider may not bill psychotherapy/of fice visits on the same day

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**872**	Procedure is limited to one service at the time of or within thirty days prior to Norplant insertion
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**882**	Components of a CBC may not be billed on the same day as a complete CBC.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**883**	Subsequent critical care not valid without initial care.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**893**	More than one obstetrical delivery code may not be billed within six months.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**897**	Outpatient chemotherapy and emergency department service codes may not be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**906**	This schedule II drug is not refillable.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M97**	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	**927**	OTC drug not covered for LTC recipients.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**952**	Previously alerted claim cannot be overridden.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. This code will be deactivated on 2/1/2006. Replaced with ARC 172.			**189**	Diagnosis invalid for provider specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**218**	Performing provider identified for purge. Call EDS at 1(888) 223-3630 to update your records.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	**MA120**	Missing/incomplete/invalid CLIA certification number.	**88**	Clia number not on file/invalid or provider not authorized to bill procedure code.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**112**	There is no provider number for long term care file for this recipient.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**146**	Procedure/revenue code is inappropriate for this provider type.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service			**154**	Procedure code is not covered for this provider specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**155**	Procedure/revenue code is invalid for claim type.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**156**	Procedure code is on review for the provider.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**219**	Billing provider identified for purge. Call EDS at 1(888)223-3630 to update your records.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**224**	Enrollment file indicates that this provider number is not valid for these dates of service
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**228**	Dates of service are not within approved provider enrollment period.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**237**	The performing provider number is not on file.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**270**	This recipient is not listed on the long term care (LTC) file for dos indicated.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**272**	Provider does not match provider on LTC file for this recipient.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**276**	Recipient is not eligible for waivered services according to the LTC file.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	**N20**	Service not payable with other service rendered on the same date.	**668**	Services cannot be billed on the same day by the same provider

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B12	Services not documented in patients' medical record.			**965**	This claim has been adjusted to make changes to the dates of service.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			**504**	The claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			**521**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**524**	The payment for this service was previously made to another provider or to another number for the same provider.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**528**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**547**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**549**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**848**	The payment for this service was previously made to another provider or to another number for this provider.
B14	Payment denied because only one visit or consultation per physician per day is covered.			**688**	Dental encounter (09430) limit one per day, per recipient, per provider
B14	Payment denied because only one visit or consultation per physician per day is covered.			**689**	Only one hospital admission may be billed per hospital stay.
B14	Payment denied because only one visit or consultation per physician per day is covered.			**711**	Individual therapy and group therapy may not be billed on the same day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**778**	Only one outpatient observation visit may be billed per

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**833**	Emergency room visit/initial hospital visit may not be billed on the same day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**855**	The same physician may not bill hospital visit and discharge visit on the same day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**867**	Subsequent hospital care may not be billed on same day as initial hospital care.
B14	Payment denied because only one visit or consultation per physician per day is covered.			**878**	Physician is limited to one visit per day per recipient.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**885**	Hospital visits and subsequent critical care may not be billed on the same day.
B15	Payment adjusted because this procedure/service is not paid separately.	**N59**	Please refer to your provider manual for additional program and provider information.	**636**	When prophylaxis and fluoride are billed on the same day, the combined code must be billed. Request recoupment of previous paid claim before filing combined code.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**N56**	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**326**	Injectable is currently on the list.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**27**	The modifier may only be billed on Medicare-related claims.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**32**	Modifier not effective for this date of service.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**34**	Cataract services require proper modifier to be billed.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.			**290**	Dos billed is prior to program begin date.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.			**355**	Procedure code missing/invalid or the modifier invalid.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**438**	Hearing and vision screenings require EP modifier.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	**N10**	Claim/service adjusted based on the findings of a review organization/professio nal consult/manual adjudication/medical or dental advisor	**957**	This payment has been recouped to enable payment to the correct provider.
D21	This (these) diagnosis (es) is (are) missing or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**192**	The third diagnosis code is invalid.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**193**	Fourth diagnosis code is invalid.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M81**	You are required to code to the highest level of specificity.	**198**	Primary diagnosis code must be billed at highest subdivision.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**199**	Other diagnosis code must be billed at highest subdivision.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M65**	Missing/incomplete/ invalid admitting diagnosis.	**313**	Admitting diagnosis is missing, invalid or not on file.
1	Deductible amount			**961**	This claim has been adjusted to reflect a change in coinsurance and/or deductible.
2	Coinsurance Amount	**N58**	Missing/incomplete/ Invalid patient liability amount.	**47**	The coinsurance amount is invalid.
2	Coinsurance Amount	**MA34**	Missing/incomplete/ invalid number of coinsurance days during the billing period.	**94**	Coinsurance days billed are missing or invalid.
3	Co-payment Amount			**361**	Payment has been reduced or denied due to the application of copay.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			**14**	This service requires an appropriate modifier.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	Missing/incomplete /invalid HCPCS modifier.	**60**	Maternity waiver service modifier not billed correctly

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**145**	Modifier is invalid.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**147**	Invalid modifier for procedure.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			**283**	Modifier billed is not valid for the procedure code billed.
4	The procedure code billed is inconsistent with the modifier used or a required modifier is missing.	**M78**	Missing/incomplete/ invalid HCPCS modifier.	**359**	Bill the appropriate laparoscopic code w/modifier 22.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			**980**	Claim adjusted to add/delete modifier.
5	The procedure code/bill type is inconsistent with the place of service.	**MA30**	Missing/incomplete/ invalid type of bill.	**29**	Type of bill is invalid.
5	The procedure code/bill type is inconsistent with the place of service.	**M77**	Missing/incomplete/ invalid place of service.	**71**	Invalid place of service for FQHC provider
5	The procedure code/bill type is inconsistent with the place of service.			**81**	Procedure cannot be billed with a non-patient visit (type of bill 141).
5	The procedure code/bill type is inconsistent with the place of service.			**113**	The procedure code is not covered when provided by an ambulatory surgical center.
5	The procedure code/bill type is inconsistent with the place of service.	**M77**	Missing/Incomplete/ invalid place of service.	**136**	Place of service is invalid.
5	The procedure code/bill type is inconsistent with the place of service.	**M77**	Missing/incomplete/ invalid place of service.	**148**	Place of service code is invalid for procedure.
5	The procedure code/bill type is inconsistent with the place of service.			**185**	Procedure not covered at POS for provider.
5	The procedure code/bill type is inconsistent with the place of service.			**285**	Procedure billed not covered for FQHC facility
5	The procedure code/bill type is inconsistent with the place of service.			**292**	This type of service and/or procedure code is invalid for a radiology facility.
6	The procedure/revenue code is inconsistent with the patient's age.			**42**	EPSDT referred services are restricted to recipients under 21 on the date of service.
6	The procedure/revenue code is inconsistent with the patient's age.			**114**	Service non-payable for recipient less than six months

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					of age.
6	The procedure/revenue code is inconsistent with the patient's age.			**149**	Procedure/revenue code/NCD is not covered for recipient's age.
6	The procedure/revenue code is inconsistent with the patient's age.			**184**	Service not covered for recipient age.
6	The procedure/revenue code is inconsistent with the patient's age.	**N30**	Recipient ineligible for this service.	**264**	Service is not covered for recipient under 65 years of age.
6	The procedure/revenue code is inconsistent with the patient's age.			**265**	Recipient must be 21 years of age or younger as of admission date shown in fl 15.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).			**64**	Invalid procedure for FQHC crossover claims.
9	The diagnosis is inconsistent with the patient's age.			**194**	Primary diagnosis is invalid for recipient of this age.
9	The diagnosis is inconsistent with the patient's age.	**M64**	Missing/incomplete/invalid other diagnosis.	**195**	Other diagnosis code is invalid for recipient's age.
9	The diagnosis is inconsistent with the patient's age.			**207**	The detail diagnosis code is invalid for recipient's age.
10	The diagnosis is inconsistent with the patient's gender.			**150**	This service is not reimbursable for a recipient of this sex.
10	The diagnosis is inconsistent with the patient's gender.	**MA63**	Missing/incomplete/ invalid principal diagnosis.	**196**	Primary diagnosis is invalid for recipient's sex.
10	The diagnosis is inconsistent with the patient's gender.	**M64**	Missing/incomplete/ invalid other diagnosis.	**197**	Other diagnosis code is invalid for recipient's sex.
10	The diagnosis is inconsistent with the patient's gender.			**206**	The detail diagnosis is invalid for the recipient's sex.
11	The diagnosis is inconsistent with the procedure.	**M64**	Missing/incomplete/ invalid other diagnosis.	**153**	Diagnosis is inappropriate for the procedure being billed.
12	The diagnosis is inconsistent with the provider type.			**15**	The diagnosis code is not valid for transportation providers.
14	The date of birth follows the date of service.			**183**	Date of service is prior to recipient's date of birth

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/ invalid treatment authorization code.	**23**	Organ transplants (except kidney or cornea) require prior authorization. Contact Alabama Medicaid.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. .	**M62**	Missing/incomplete/ invalid treatment authorization code.	**67**	Ultrasound for maternity waiver/care recipient requires a pa
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**N59**	Please refer to your provider manual for additional program and provider information.	**386**	Invalid PA detail – New request may not be submitted with other request types.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**N54**	Claim information is inconsistent with precertified/authorized services.	**387**	Incomplete PA detail – Must contain either units or dollars.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/ invalid treatment authorization code.	**389**	Claim was denied because EDS had no record of the prior authorization.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			**390**	Provider number on claim does not match provider number on pa file.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			**397**	Prior authorization number shown on the claim is invalid.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			**399**	Service requires pa.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/in valid treatment authorization code.	**827**	Code, service, procedure, NCD or stay requires prior authorization
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**M53**	Missing/incomplete/ Invalid days or units of service.	**30**	Unit(s) billed is missing or invalid.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**M50** **M54**	Missing/ incomplete/ invalid revenue code(s). Missing/ incomplete/ invalid total charges.	**164**	Accommodation revenue code is not present on inpatient claim or claim denied because covered charges for days

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					billed equal non-covered charges.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**MA92**	Missing/incomplete/invalid plan information for other insurance.	**173**	TPL policy number and insurance company name required.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**M45**	Missing/incomplete/ invalid occurrence code(s).	**174**	Accident indicator occurrence code required.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**N258**	Missing/incomplete/ invalid billing provider/supplier address.	**222**	Provider's address is invalid. Contact EDS's provider enrollment unit.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**251**	Recipient has an unusable record. Contact EDS.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**506**	Claims adjusted by Medicare must be submitted to EDS adjustment unit with proper documentation.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**902**	Medicaid billing authorization form (XIX-TPD-1 - 76) is required for this claim.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**931**	Missing/invalid service provider ID qualifier.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**932**	Missing/invalid insurance segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**933**	Missing/invalid claim segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**934**	Product/service not covered.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**935**	Missing/invalid product/service ID qualifier.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**936**	Missing/invalid prescriber segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**937**	Missing/invalid prescriber ID qualifier.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**938**	Missing/invalid pricing segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**939**	Missing/invalid other payer amount paid qualifier.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever			**940**	Non-matched NDC number on reversal TXN.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	appropriate.				
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**941**	Recipient does not meet criteria for pregnancy co-pay exemption.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**179**	Sterilization denied because documentation does not meet hhs/Medicaid requirements.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**180**	Hysterectomy denied because documentation does not meet hhs/Medicaid requirements.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**181**	Abortion denied because documentation does not meet HHS/Medicaid requirements.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**182**	No consent form on file for recipient and date of surgery.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**267**	Census data is not on file for provider for the previous month.
18	Duplicate claim/service.			**490**	Pharmacy claim – exact dup.
18	Duplicate claim/service.			**491**	Pharmacy claim suspect dup of history claim or another detail.
18	Duplicate claim/service.			**493**	Drug prescription/refill number suspect.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
18	Duplicate claim/service.			**501**	Our records show this service has already been paid for the date of service billed.
18	Duplicate claim/service.			**502**	This claim or service was previously paid on date indicated.
18	Duplicate claim/service.	**M86**	Service denied because payment already made for same/similar procedure within set time frame.	**503**	Procedure codes cannot be billed more than six (6) times with the same modifier.
18	Duplicate claim/service.			**505**	Our records show this service for the date of service billed is a duplicate.
18	Duplicate claim/service.			**511**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**512**	This claim or service was previously paid on date indicated
18	Duplicate claim/service.			**513**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**515**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**520**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**523**	Prior claim with this prescription/refill number is in process.
18	Duplicate claim/service.			**527**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**531**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**532**	Our records show this service for the date(s) of service billed is a

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					duplicate.
18	Duplicate claim/service.			**533**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**535**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**538**	A cardiologist or a radiologist cannot bill this procedure code on the same day
18	Duplicate claim/service.			**542**	Procedure code not covered when billed on the same day.
18	Duplicate claim/service.			**543**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**544**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**628**	EPSDT visit has been paid for this recipient for the same date of service.
18	Duplicate claim/service.			**632**	Only one type of respite care is allowed for a given date of service.
18	Duplicate claim/service.	**N20**	Service not payable with other service rendered on the same date.	**633**	Residential habilitation, respite care, personal care/companion care services are not allowed for the same dos
18	Duplicate claim/service.			**738**	Our records indicate that this service has already been performed on this patient.
18	Duplicate claim/service.			**828**	Our records indicate that this service has already been performed on this recipient.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
18	Duplicate claim/service.			**834**	Our records indicate that this service has already been performed on this patient.
18	Duplicate claim/service.			**835**	Our records indicate that this service has already been performed on this patient.
18	Duplicate claim/service.			**970**	This claim has been recouped/adjusted due to a duplicate payment.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**176**	Third party file indicates Medicare comprehensive insurance for recipient.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	**N30**	Recipient ineligible for this service.	**248**	Eligible for Medicare only - no Medicaid benefits.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**280**	Recipient has other medical coverage; file third party carrier first.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**282**	Recipient has Medicare coverage - bill Medicare first.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**991**	Recipient has become retroactively eligible for Medicare for billed dates of service billed. File Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**68**	This service was covered in full by Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**362**	Copay and Medicare and other third party payments have reduced/denied payment.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**364**	Medicaid allowed amount reduced by other insurance amount.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**366**	Other insurance paid an amount greater than or equal to our allowed amount. Medicaid cannot make any additional payment.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**369**	This service was covered in full by Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**960**	This claim has been adjusted to reflect payment by other insurance.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.			**279**	Claim denied. Recipient has Medicare HMO coverage.
26	Expenses incurred prior to coverage.	**N30**	Recipient ineligible for this service.	**254**	Records show this recipient is totally ineligible for Medicaid for header date(s) of service.
26	Expenses incurred prior to coverage.	**N30**	Recipient ineligible for this service.	**262**	Records show this recipient is totally ineligible for Medicaid for detail date(s) of service.
29	The time limit for filing has expired.			**8**	Service(s) past the maximum Medicaid filing limit.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.			**429**	Recipient eligibility determination is being made. Please do not rebill.
31	Claim denied as patient cannot be identified as our insured.			**250**	The recipient's 13-digit Medicaid number is missing or invalid.
31	Claim denied as patient cannot be identified as our insured.			**256**	The recipient's 13-digit Medicaid number is missing or invalid.
38	Services not provided or authorized by designated (network/primary care) providers.			**107**	Recipient enrolled in the patient 1st program; services require referral from PMP.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
38	Services not provided or authorized by designated (network/primary care) providers.			**131**	Service is only covered under the plan first. Program.
38	Services not provided or authorized by designated (network/primary care) providers.			**132**	Birth control pills must be received from a physician for the plan first program.
38	Services not provided or authorized by designated (network/primary care) providers.			**133**	Plan first recipient must be seen by a plan first network provider
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**89**	Medicare paid amount equal to 100%.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**354**	Encounter rate paid, if any, represents the maximum amount allowed by Medicaid.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**357**	Payment amount, if any, represents the maximum payment allowed by Medicaid.
42	Charges exceed our fee schedule or maximum allowable amount.			**360**	Payment amount if any represents the maximum payment allowed by Medicaid.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**363**	Payment, if any, represents the allowance made by Medicaid after considering Medicare liability.
42	Charges exceed our fee schedule or maximum allowable amount.			**365**	Fee adjusted to maximum allowable.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**367**	Paid in full by Medicaid.
42	Charges exceed our fee schedule for maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**730**	ESWL pricing.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			**39**	Services are not covered for indicated diagnosis.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**M76**	Missing/incomplete/ invalid diagnosis or condition.	**76**	The diagnosis code billed is not covered for MHSP.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			**190**	Primary diagnosis code is invalid or non-covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**M64**	Missing/Incomplete/ invalid other diagnosis.	**191**	Secondary diagnosis code is invalid or non-covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**M64**	Missing/Incomplete/in valid other diagnosis.	**192**	The third diagnosis code is invalid.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**M64**	Missing/Incomplete/ invalid other diagnosis.	**193**	Fourth diagnosis code is invalid.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			**198**	Primary diagnosis code must be billed at highest subdivision.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**199**	Other diagnosis code must be billed at highest subdivision.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			**200**	Primary diagnosis code not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**M64**	Missing/incomplete/in valid other diagnosis.	**201**	Other diagnosis code not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.			**205**	Detail diagnosis is not on file.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**MA65**	Missing/incomplete/ invalid admitting diagnosis.	**313**	Admitting diagnosis is missing, invalid or not on file.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.			**48**	Referring provider must be a valid EPSDT screening provider. Contact EDS for a screening provider listing.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.			**50**	EPSDT screenings may only be billed by an EPSDT screening provider. Contact the provider enrollment unit at EDS.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.			**65**	Procedure billed is invalid for provider.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.			**74**	Type 30 for county health department is limited to providing services for recipients under 21. (EPSDT only provider billed non-EPSDT referral claim).
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	**N95**	This provider type/provider specialty may not bill this service.	**77**	PC invalid for this provider number.
52	The referring/ Prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.			**85**	Maternity care provider restricted to maternity service.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.			**221**	Enrollment file indicates provider is deceased.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed.			**223**	Provider is suspended from the Medicaid program.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed.			**227**	Provider is enrolled in the Medicaid program for crossovers claims only.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed.			**239**	Provider eligible for only QMB recipients and EPSDT referrals.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed.			**258**	Medicaid has restricted the services of this recipient to a specific provider and/or specific drugs.
52	The referring/prescribing/ rendering provider is not eligible to refer/ prescribe/ order/perform the service billed.			**300**	Provider not enrolled for VFC program.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed.	**N31**	Missing/incomplete/ invalid prescribing provider identifier.	**907**	The prescribing provider's license number is missing or invalid.
57	Payment denied/reduced because the payer deems the information submitted does not support this level			**903**	The days supply is greater than the authorized days, or is

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	of service, this many services, this length of service, this dosage, or this day's supply.				invalid.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.			**911**	Refill number is missing, greater than five or is greater than the refill authorization.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.			**144**	Place of service code is not valid for provider type.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.			**956**	This claim has been adjusted to reflect a change in the type of service.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	**N59**	Please refer to your provider manual for additional program and provider information.	**769**	Secondary surgical procedure within the same incision paid at 50% of Medicaid allowed.
62	Payment denied/reduced for absence of, or exceeded, precertification/ Authorization.	**N286**	Missing/incomplete/ invalid referring provider identifier.	**106**	Anesthesia claims require referring provider.
62	Payment denied/reduced for absence of, or exceeded, precertification/ authorization.			**158**	Recipient eligible for emergency services only.
62	Payment denied/reduced for absence of, or exceeded, precertification/ authorization.	**M62**	Missing/incomplete/ invalid treatment authorization code.	**375**	Drug code requires a PA for product selection.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.			**391**	The dos spans a pa change. Call EDS provider assistance center at 1(800) 688-7989 for assistance.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.			**392**	Units of service exceed the authorized units on the pa file.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.			**398**	Claim allowed charge is more than the authorized amount on the pa file.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.	**M123**	Missing/incompleted/ invalid name, strength, or dosage of the drug.	**420**	Quantity dispensed exceeds units/day PA (PA begin date).

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
88	Adjustment amount represents collection against receivable created in prior overpayment.			**116**	Recoupment - this amount is withheld from your check.
88	Adjustment amount represents collection against receivable created in prior overpayment.			**119**	Payment amount applied to receivable.
96	Non-covered charge(s).			**17**	A SLMB/QWDI (DISABLED WORKER) aid categories 92, 93, 94 and 97is not eligible for Medicaid services.
96	Non-covered charge(s).			**40**	Procedure code limited to QMB or EPSDT related claims.
96	Non-covered charge(s).	**N39**	Procedure code is not compatible with tooth number/letter.	**69**	Dental sealants are not payable for this recipient or tooth number.
96	Non-covered charge(s).	**N30**	Recipient ineligible for this service.	**73**	Family planning service not covered for this recipient.
96	Non-covered charge(s).	**M46**	Missing/incomplete/ invalid occurrence span code(s).	**78**	Critical care procedure cannot span more than two days.
96	Non-covered charge(s).	**N30**	Recipient ineligible for this service.	**84**	Service billed is not covered for a SOBRA eligible recipient
96	Non-covered charge(s).			**86**	Recipient not eligible for targeted case management.
96	Non-covered charge(s).			**98**	Service not covered by Medicaid.
96	Non-covered charge(s).	**M50**	Missing/incomplete/ invalid revenue code(s).	**111**	Inpatient/outpati ent non-covered revenue codes for EPSDT referred claims.
96	Non-covered charge(s).	**N39**	Procedure code is not compatible with tooth number/letter.	**129**	Procedure not covered for tooth number.
96	Non-covered charge(s).	**N30**	Recipient ineligible for this service.	**134**	Plan first recipient is only eligible for plan first services.
96	Non-covered charge(s).			**160**	Part-b charges billed by NH provider are not covered by Medicaid (lt).
96	Non-covered charge(s).			**163**	This procedure code is not covered for non-Medicare related

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					claims.
96	Non-covered charge(s).			**356**	This drug is not available as an injectable.
96	Non-covered charge(s).			**368**	This service is not covered by Medicaid.
96	Non-covered charge(s).			**370**	The assistant surgeon's fee for this procedure is not covered.
96	Non-covered charge(s).			**424**	Medicaid has no liability for this claim since Medicare/ Medicaid days run concurrently.
96	Non-covered charge(s).	**N20**	Service not payable with other service rendered on the same date.	**764**	This procedure code is not covered when billed with medical psychotherapy codes.
97	Payment is included in the allowance for another service/procedure.			**75**	Procedure code A0330 is an inclusive code. Only mileage and return trip may be billed in addition.
97	Payment is included in the allowance for another service/procedure.			**105**	This service is included in the facility fee (revenue code 450).
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**421**	Subsequent procedure included in primary anesthesia charge.
97	Payment is included in the allowance for another service/procedure.			**576**	This procedure is part of another procedure performed on the same day.
97	Payment is included in the allowance for another service/procedure			**580**	Administration fee may not be billed on the same day as an office visit and/or vaccine replacement
97	Payment is included in the Allowance for another Service/procedure.			**729**	Venipuncture and lab codes are not allowed on the same day.
97	Payment is included in the Allowance for another Service/procedure.	**N19**	Procedure code incidental to primary procedure.	**731**	Procedure is inclusive in primary procedure.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
97	Payment is included in the Allowance for another Service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**732**	Payment made for similar procedure.
97	Payment is included in the allowance for another service/procedure.			**733**	This service is included in the facility fee
97	Payment is included in the allowance for another service/procedure.			**734**	Procedure not covered with specific codes.
97	Payment is included in the allowance for another service/procedure.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**735**	Same provider cannot bill application/ removal/repair of cast for the same recipient.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**754**	This procedure is part of another procedure performed on the same day.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**849**	This procedure cannot be billed in addition to the delivery code billed.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**850**	Biopsy of ovary may not be billed with another exam on the same day.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**851**	Exploratory lap/lysis of adhesions may not be billed on the same day with other related surgery.
97	Payment is included in the allowance for another service/procedure.			**852**	This x-ray procedure may not be billed within 30 (thirty) days of a root canal
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**854**	Emergency oral exam may not be billed with definitive treatment the same day.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**861**	Antepartum, postpartum care/vaginal delivery may not be billed with global ob care.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**864**	Hysterectomy ancillary codes may not be paid in addition to the hysterectomy procedure code.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**865**	Hospital admission/visits may not be billed on or after ob global.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**868**	Local anesthesia procedures are covered in the total ob cost and may not be billed separately with a delivery procedure code.
97	Payment is included in the allowance for another service/procedure.			**873**	Routine ancillary services associated with an abortion are covered in the total abortion cost and are not reimbursable separately.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**879**	Administration fee may not be billed on the same day as an office visit and or vaccine replacement.
97	Payment is included in the allowance for another service/procedure.			**886**	Visual fields/tonometry is covered in the complete eye exam.
97	Payment is included in the allowance for another service/procedure.			**888**	Post-operative physician services for the same diagnosis may not be billed within 90 days of surgery.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**890**	Procedure code is not covered when outpatient surgical procedure is billed.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**895**	Routine prenatal lab, office/hospital visits may not be billed with global ob procedure.
97	Payment is included in the allowance for another service/procedure.			**896**	Postpartum services may not be billed with global ob on or within 62 days of delivery.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**898**	This procedure is part of another procedure performed on the same day.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
105	Tax withholding.	**MA45**	As previously advised, a portion or all of your payment is being held in a special account.	**117**	Refund check amount credited to your IRS year total.
105	Tax withholding.	**MA45**	As previously advised, a portion or all of your payment is being held in a special account.	**118**	Returned check amount credited to your IRS year total.
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	**N59**	Please refer to your provider manual for additional program and provider information.	**611**	No extraction code in history in 180 day time frame.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.			**59**	Maternity waiver/care claim must be billed by contract provider
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	**MA64**	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	**428**	Third party liability suspect.
110	Billing date predates service date.	**M52**	Missing/incomplete/ invalid "from" date(s) of service.	**100**	Detail from date of service is a future date or invalid.
119	Benefit maximum for this time period or occurrence has been reached .			**162**	Units billed exceed maximum allowed per day.
119	Benefit maximum for this time period or occurrence has been reached.			**400**	Procedure is limited to sixty (60) per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**401**	Procedure is limited to twenty (20) per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**402**	Procedure is limited to one (1) every five years.
119	Benefit maximum for this time period or occurrence has been reached.			**403**	Procedure is limited to thirty (30) per month.
119	Benefit maximum for this time period or occurrence has been reached.			**404**	Procedure is limited to one hundred twenty (120) per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**405**	Procedure code is limited to one-hundred (100) per month.
119	Benefit maximum for this time period or occurrence has been reached.	**N43**	Bed hold or leave days exceeded.	**406**	Revenue code 183 is limited to 6 days each calendar quarter.

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119	Benefit maximum for this time period or occurrence has been reached.			**407**	Procedure is limited to 60 (sixty) times per calendar month
119	Benefit maximum for this time period or occurrence has been reached.			**408**	Procedure is limited to 30 (thirty) per month.
119	Benefit maximum for this time period or occurrence has been reached.			**409**	Procedure code is limited to 40 (forty) per calendar month
119	Benefit maximum for this time period or occurrence has been reached.			**410**	This procedure is limited to eighteen (18) units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**411**	Procedure is limited to 1 (one) every two years.
119	Benefit maximum for this time period or occurrence has been reached.	**N43**	Bed hold or leave days exceeded.	**422**	Revenue code 184 is limited to 14 days per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**448**	Qualifying procedure limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**412**	Family planning periodic follow-up is limited to four (4) visits per year.
119	Benefit maximum for this time period or occurrence has been reached.			**413**	Procedure code is limited to 2 per month.
119	Benefit maximum for this time period or occurrence has been reached.			**414**	Ob ultrasound limit has been reached for this recipient. .Any further will require prior authorization.
119	Benefit maximum for this time period or occurrence has been reached.			**415**	Screening mammography is limited to one per year.
119	Benefit maximum for this time period or occurrence has been reached.			**416**	The limit of two units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**423**	Maximum quantity exceeded for 30 day period.
119	Benefit maximum for this time period or occurrence has been reached.			**436**	HBO limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**437**	Vision and hearing screening one per year.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**441**	Number of home health visits exceed limit.
119	Benefit maximum for this time period or occurrence has been reached.			**442**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**443**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**444**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**445**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**452**	The quantity dispensed is not numeric or exceeds the maximum quantity allowed for the drug prescribed.
119	Benefit maximum for this time period or occurrence has been reached.			**483**	The limit of three units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**484**	The limit of three (3) units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**485**	The limit of two units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**489**	The limit for these services has been reached for this waiver year.
119	Benefit maximum for this time period or occurrence has been reached.			**492**	Monthly script limit exceeded (min/max)
119	Benefit maximum for this time period or occurrence has been reached.			**539**	This procedure code is limited to one per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**559**	Inpatient/ outpatient/asc visits have been exceeded for the calendar year
119	Benefit maximum for this time period or occurrence has been reached.			**560**	Outpatient visits have been exceeded for this calendar year.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**564**	This ambulance service procedure code is limited to four units per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**574**	More than one contact lens fitting cannot be billed for the same date of service.
119	Benefit maximum for this time period or occurrence has been reached.			**577**	Units billed for procedure code exceed maximum units allowed.
119	Benefit maximum for this time period or occurrence has been reached.			**579**	Independent rural health clinics cannot be paid for more than one service per day.
119	Benefit maximum for this time period or occurrence has been reached.			**587**	Procedure limited to 720 hours per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**592**	Vision and hearing screening must be billed with a regular screening and are limited to once per year.
119	Benefit maximum for this time period or occurrence has been reached.			**593**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**614**	The calendar year limit has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**615**	The calendar year limit has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**616**	The calendar year limit has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**617**	Emergency oral exam (d0140) limited to once per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.	**N117**	This service is paid only once in a lifetime per beneficiary.	**618**	D1351 is limited to once per tooth per recipient's lifetime.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**619**	Procedure code limited to once every 6 months.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**620**	Prophylaxis is limited to once every 6 months.
119	Benefit maximum for this time period or occurrence has been reached.			**622**	This procedure is limited to one per postpartum period.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**623**	Fluoride is limited to once every 6 months.
119	Benefit maximum for this time period or occurrence has been reached.			**630**	Units billed for procedure code exceed maximum units allowed.
119	Benefit maximum for this time period or occurrence has been reached.			**631**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**634**	Procedure limited to 4320 units per fiscal year (October 1-September 30).
119	Benefit maximum for this time period or occurrence has been reached.			**640**	Mental health diagnostic testing limit.
119	Benefit maximum for this time period or occurrence has been reached.			**641**	This procedure is limited to one episode a year.
119	Benefit maximum for this time period or occurrence has been reached.			**642**	This procedure is limited to 52 units per year.
119	Benefit maximum for this time period or occurrence has been reached.			**644**	Procedure code is limited to 104 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**645**	Procedure code is limited to 104 times per year.
119	Benefit maximum for this time period or occurrence has been reached.			**646**	Procedure code is limited to 104 times a year.
119	Benefit maximum for this time period or occurrence has been reached.			**647**	This procedure is limited to 365 episodes a year.
119	Benefit maximum for this time period or occurrence has been reached.			**648**	This procedure is limited to 52 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**649**	Benefits have been exceeded for the calendar year.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**650**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**651**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**652**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**654**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**656**	Procedure is limited to 260 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**657**	Procedure is limited to 260 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**658**	Procedure is limited to 8 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**659**	Procedure code is limited to 312 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**660**	Procedure is limited to 1040 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**661**	Procedure is limited to 1040 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**662**	Procedure is limited to 2016 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**670**	Procedure is limited to 130 units a calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**671**	Procedure code is limited to 20 (twenty) per calendar month
119	Benefit maximum for this time period or occurrence has been reached.			**672**	Procedure is limited to 104 times a calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**673**	Procedure is limited to 365 times a calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**683**	Yearly limit for crisis intervention has been exceeded
119	Benefit maximum for this time period or occurrence has been reached.			**684**	The yearly limit for this procedure has been exceeded

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**692**	This procedure is limited to 12 units every 24 months.
119	Benefit maximum for this time period or occurrence has been reached.			**697**	The limit for these services has been reached for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**698**	The limit for these services has been reached for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**699**	Procedure is limited to once every thirty (30) days by the same billing provider.
119	Benefit maximum for this time period or occurrence has been reached.			**701**	Procedure limited to two per lifetime per tooth.
119	Benefit maximum for this time period or occurrence has been reached.			**702**	Dental re-cement of crowns not allowed within 180 days of crowns.
119	Benefit maximum for this time period or occurrence has been reached.			**707**	Initial screening is limited to once per lifetime, per provider.
119	Benefit maximum for this time period or occurrence has been reached.			**708**	Psychotherapy services are limited to 12 (twelve) per calendar year at place of service "21" (inpatient).
119	Benefit maximum for this time period or occurrence has been reached.			**710**	Diagnostic assessments are limited to one encounter per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**712**	Procedure is limited to 4160 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**718**	New patient code Z5147 may only be billed once per lifetime per recipient.
119	Benefit maximum for this time period or occurrence has been reached.			**719**	The procedure code billed is limited to one unit per day.
119	Benefit maximum for this time period or occurrence has been reached.			**723**	Procedure code is limited to 156 units per calendar year.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**727**	Procedure code is limited to one unit per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**728**	Procedure code is limited to 12 units per lifetime.
119	Benefit maximum for this time period or occurrence has been reached.			**741**	MHSP clinic visit limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**744**	EPSDT screening limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**745**	EPSDT screening limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**749**	This procedure is limited to six units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**750**	This procedure is limited to three units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**753**	More than one obstetrical delivery code may not be billed within six months.
119	Benefit maximum for this time period or occurrence has been reached.			**760**	Initial visit is limited to one per recipient, per provider, per lifetime.
119	Benefit maximum for this time period or occurrence has been reached.			**761**	This procedure code is limited to one every calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**768**	Procedure is limited to 1 (one) per month.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**770**	Procedure code is limited to one occurrence every six months.
119	Benefit maximum for this time period or occurrence has been reached.			**771**	Maximum unit limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**772**	Oral exam evaluations are limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**780**	Procedure code is limited to one per recipient within sixty days of delivery.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**788**	Procedure code 11795 is limited to one every 365 days and procedure code 11977 cannot be billed within 60 months of insertion.
119	Benefit maximum for this time period or occurrence has been reached.			**789**	Only one initial NICU procedure may be billed per hospital stay.
119	Benefit maximum for this time period or occurrence has been reached.			**790**	Procedure is limited to two per year.
119	Benefit maximum for this time period or occurrence has been reached.			**793**	Binaural hearing aid repair is limited to two. every six months
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**797**	Medical supplies limit is 1800.00 per waiver year, 02/22-02/21. The limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**799**	Requested inpatient hospital services partially exceed limit of 16. Rebill for remaining days.
119	Benefit maximum for this time period or occurrence has been reached.			**800**	Procedure code is limited to one occurrence every six months
119	Benefit maximum for this time period or occurrence has been reached.			**802**	Newborn code may not be billed more than once.
119	Benefit maximum for this time period or occurrence has been reached.			**806**	Batteries may not be purchased within 60 (sixty) days of purchase of hearing aid.
119	Benefit maximum for this time period or occurrence has been reached.			**807**	Procedure limited to one service during 60 (sixty) day postpartum period.
119	Benefit maximum for this time period or occurrence has been reached.			**813**	Procedure is limited to one every 4 calendar years.
119	Benefit maximum for this time period or occurrence has been reached.			**816**	The limit of three units per month has been exceeded for this procedure
119	Benefit maximum for this time period or occurrence has been reached.			**817**	The limit of two units per month has been exceeded for this procedure.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**821**	EPSDT screening limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**822**	This procedure code is limited to one per month.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**823**	Full series/panoramic x-rays are limited to one every three calendar years.
119	Benefit maximum for this time period or occurrence has been reached.			**825**	Procedure is limited to one service every 70 days.
119	Benefit maximum for this time period or occurrence has been reached.			**829**	Binaural are limited to two every four months.
119	Benefit maximum for this time period or occurrence has been reached.			**830**	Specimen collection fee is limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**832**	Binaural hearing aid batteries are limited to two packages every two months.
119	Benefit maximum for this time period or occurrence has been reached.			**837**	Procedure code is limited to one in a series.
119	Benefit maximum for this time period or occurrence has been reached.			**838**	Specimen collection fee is limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**842**	Comprehensive dental exam may only be billed once per lifetime per provider.
119	Benefit maximum for this time period or occurrence has been reached.			**856**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**859**	The same provider may not bill more than one new patient office visit per recipient.
119	Benefit maximum for this time period or occurrence has been reached.			**862**	Leg bags are limited to two per month.
119	Benefit maximum for this time period or occurrence has been reached.			**863**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**874**	Procedure is limited to one (1) every two years.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**875**	Inpatient/outpatient visits have been exceeded for this calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**877**	Procedure is limited to one (1) every three years.
119	Benefit maximum for this time period or occurrence has been reached.			**881**	Procedure code is limited to one in a series.
119	Benefit maximum for this time period or occurrence has been reached.			**887**	Catheters, catheter trays, and drainage bags are limited to two per month.
119	Benefit maximum for this time period or occurrence has been reached.			**889**	Requested inpatient hospital services exceed limit of 16.
119	Benefit maximum for this time period or occurrence has been reached.			**891**	Physician office visit limitation has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**892**	Initial critical care limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**983**	Claim adjusted/recouped because physician office visits have been exceeded for calendar year.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**942**	Electronic adjustment denied – refund in process.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**955**	The claim has been adjusted to reflect changes in the number of units billed and paid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M52**	Missing/Incomplete/ invalid “from” date(s) of service.	**1**	The “from” date of service is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA40**	Missing/Incomplete/ invalid admission date.	**2**	The admission date is invalid.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M59**	Missing/Incomplete/ invalid "to" date(s) of service.	**3**	The through date of service is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ invalid total charges.	**4**	The total non-covered charge is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA31**	Missing/ Incomplete/invalid beginning and ending dates of the period billed.	**5**	The surgical date is not between admit and through dates of service.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**6**	Submitted charge for the line item is equal to or less than non-covered charge.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA32**	Missing/Incomplete/ invalid number of covered days during the billing period.	**7**	Number of days billed and billing period disagree.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N50**	Missing/incomplete/ invalid discharge information.	**9**	The discharge date is earlier than the admission date. Transportation: describe other charges.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month	**16**	Ip-dos must not span 2 calendar years, span a rate change, or exceed 99 days.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA32**	Missing/Incomplete/ Invalid number of covered days during the billing period.	**22**	Covered days billed are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**28**	Header paid amount cannot be greater than specified dollar amount.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M53**	Missing/incomplete/ Invalid days or units of service.	**31**	Units (total days) x rate does not equal the total accommodation charge.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ Invalid total charges.	**36**	Submitted rate, units, and total charge do not balance.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.	**38**	Pricing file indicates zero price. Call EDS.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ Invalid total charges.	**43**	Billed amount must be numeric and greater than zero.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**44**	Medicare paid amount is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**45**	The Medicare allowed amount is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**46**	Medicare total billed amount is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA43**	Missing/incomplete Invalid patient status.	**51**	Patient status invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M79**	Missing/incomplete/ Invalid charge.	**52**	Medicare header allowed amount does not equal the sum of detail Medicare allowed amounts.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ Invalid total charges.	**53**	Net billed amount not equal to sum of detail charges less TPL amount.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/ Incomplete/ Invalid total charges.	**54**	The sum of the detail noncovered charge does not equal the header noncovered charge.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/ Incomplete/ Invalid total charges.	**55**	Billed amount not equal to sum of the detail charge amounts.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/ Incomplete/ Invalid total charges.	**56**	The Medicare header paid amount does not equal the sum of the detail Medicare paid amounts.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA37**	Missing/ Incomplete/ Invalid patient's address.	**63**	Recipient's county of residence for claim dates of service are not on file. Resubmit.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA41**	Missing/incomplete/ Invalid admission type.	**66**	Admit type is invalid as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N61**	Rebill services on separate claims.	**87**	Different targeted case management procedure codes must be billed on separate claims.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA35**	Missing/incomplete/in valid number of lifetime reserve days.	**95**	Lifetime reserve days are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**99**	Medicare deductible amount is invalid.

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125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M59**	Missing/Incomplete/ invalid "to" date(s) of service.	**101**	The to date is invalid or prior to the from date.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**110**	Invalid deductible amount for skilled nursing facility.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**116**	Recoupment- this amount is withheld from your check.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**119**	Payment amount applied to receivable.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N346**	Missing/incomplete/ invalid oral cavity designation code.	**123**	Oral cavity designation code invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N57**	Missing/incomplete/ invalid prescribing date.	**125**	Dispensed date invalid (ph).
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N37**	Missing/incomplete/ Invalid tooth number/letter.	**126**	The tooth surface on the dental request is missing/invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N37**	Missing/incomplete/ invalid tooth number/letter.	**128**	A valid tooth number is required for procedure.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N30**	Recipient ineligible for this service.	**135**	Procedure restricted to technology assisted waiver recipients.

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125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M50**	Missing/ Incomplete/ invalid revenue code(s).	**151**	Revenue/ procedure code/NCD is invalid for dos.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**152**	Procedure, revenue code or drug code is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M50**	Missing/ incomplete/invalid revenue code(s).	**161**	Procedure code or revenue code is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M67**	Missing/ Incomplete/ invalid other procedure code(s).	**175**	Operation or delivery requires surgical procedure code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N51**	Electronic interchange agreement not on file for provider/submitter.	**220**	Provider has not been approved to bill electronic media claims.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**225**	Date of service is not within the provider rate segments.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N34**	Incorrect claim form for this service.	**226**	Claim type is not valid for this provider.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**229**	Provider number is invalid, not on file or name/number disagree.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**230**	The attending physician's license number is missing or invalid.

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125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**233**	The referring provider is not on file or is not a valid referring provider.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N55**	Procedures for billing with group/referring/performing providers were not followed.	**235**	The billing provider must be the group provider number.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N55**	Procedures for billing with group/ referring/ performing providers were not followed.	**236**	Performing provider cannot be group provider number.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA112**	Missing/incomplete/ invalid group practice information.	**238**	Performing provider is not associated with the group.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**295**	Production provider cannot bill claims for test recipient/test provider cannot bill claims for production recipient
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N31**	Missing incomplete/ invalid prescribing provider identifier.	**304**	The operating physicians license number is missing or not on file.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month	**308**	The detail dos spanned the provider fiscal year beginning/end dates.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**310**	The claim line item and/or total charge is missing, not numeric or calculated incorrectly.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**311**	The non-covered charge amount is invalid.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month	**314**	Outpatient span billing is limited to no more than one calendar month per claim.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N61**	Rebill services on separate claims	**315**	Dos cannot span 1999 and 2000. Split bill claim.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N54**	Claim information is inconsistent with pre-certified/authorized services.	**319**	Covered days are greater than certified days. Refile only for certified days up to Medicaid's limitation.
125	Payment adjusted due to a submission/billing error(s).	**N54**	Claim information is inconsistent with pre-certified/authorized services.	**320**	PSRO/UR data is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M52**	Missing/ incomplete/ Invalid "from" date(s) of service.	**322**	Date of surgery is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**388**	Missing/invalid requesting provider – provider id or license number.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**476**	Lab services must be billed with combination code. See CPT.
125	Payment adjusted due o a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA34**	Missing/ incomplete/invalid number of coinsurance days during the billing period.	**478**	This claim does not contain required data to determine Medicaid liability for coinsurance days/lifetime. reserve days.
125	Payment adjusted due o a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA34**	Missing/ incomplete/invalid number of coinsurance days during the billing period.	**487**	This claim does not contain required data to determine Medicaid liability for coinsurance/lifetime reserve days.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**612**	Changing the response from 3 (invalid) to a blank.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N39**	Procedure code is not compatible with tooth number/letter.	**637**	Claims history shows tooth has been extracted.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**742**	Lab services must be billed with combination code. See cpt.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M83**	Service is not covered unless the patient is classified as at high risk.	**743**	Provider may not bill for newborn resuscitation unless life threatening.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**758**	Chemistry profiles must be billed using one multichannel test code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**900**	Prescription number cannot be spaces or zeroes.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M53**	Missing/ incomplete/Invalid days or units of service	**901**	The quantity dispensed is missing or not numeric.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N57**	Missing/incomplete/ invalid prescribing date.	**904**	Date prescribed is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**905**	Emergency indicator is invalid.

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125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N57**	Missing/incomplete/ invalid prescribing date.	**908**	Dispense date is earlier than date prescribed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**909**	The claim net charge is missing, calculated incorrectly or equal to zero.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**910**	EPSDT indicator is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**912**	Detail dos not within the header DOS.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**913**	Claim cannot be paid due to errors at the detail.
25	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N46**	Missing/incomplete/ invalid admission hour.	**914**	The admission hour field must be numeric and between 00 and 23.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**915**	Employment indicator invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N50**	Missing incomplete/invalid discharge information.	**916**	Discharge hour is invalid; must be between 00 and 23.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA33**	Missing/incomplete/in valid number of noncovered days during the billing period.	**917**	Non-covered days are invalid.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M45**	Missing/incomplete/ invalid occurrence code(s).	**918**	Occurrence code 1, 2, 3, 4 or 5 is not between from and to dates of service.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M45**	Missing/Incomplete/ invalid occurrence code(s).	**919**	The occurrence dates are invalid or a future date.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M45**	Missing/Incomplete/ invalid occurrence code(s).	**920**	Occurrence date 1, 2, 3, 4, or 5 is not between from and to dos.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M44**	Missing/incomplete/in valid condition code.	**921**	Condition codes are invalid. Refer to Alabama Medicaid guidelines.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**922**	Payment denied because third party amount is greater than the total submitted charge, missing or is not numeric.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**923**	Surgery, occurrence, and/or condition count is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M46**	Missing/incomplete/in valid occurrence span code(s).	**924**	Occurrence span code is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M46**	Missing/incomplete/in valid occurrence span code(s).	**925**	Occurrence span date is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**926**	Accident related indicator is invalid. Medical billing. authorization form (XIX-TPD-1-76) is required for this claim.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**929**	Detail count missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**930**	Dispense as written code invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**950**	DUR conflict, intervention, or outcome codes are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**942**	Electronic adjustment denied - refund in process.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**951**	Previous DUR alerted claim cannot be found.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N22**	This procedure code was added/changed because it more accurately describes the services rendered.	**954**	The claim has been adjusted to reflect a change in codes as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**958**	This claim has been adjusted to reflect a change in the original amount billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**962**	Other-If you have any questions resulting from this adjustment, please contact our Correspondence /Inquiry Unit.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever			**968**	Claim adjusted to reflect a rate change.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	appropriate.				
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**989**	This claim was recouped per your request.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**990**	This claim has been adjusted to reflect a change in the dispensed as written value code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**993**	Employment indicator invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N61**	Rebill services on separate claims.	**995**	Claim recouped. Provider must resubmit claims on separate claims in order for services to be considered for payment by Medicaid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**997**	Claim contains 15 or more error and therefore can not be processed as billed.
132	Prearranged demonstration project adjustment.	**N10**	Claim/service adjusted based on the findings of a review organization/professio nal consult/manual adjudication/medical or dental advisor	**953**	Special adjustments - please refer to our mini message included in your explanation of payment.
133	The disposition of this claim/service is pending further review.			**325**	This service is pending approval and code assignment, contact EDS for information.
133	The disposition of this claim/service is pending further review.			**425**	Provider eligibility determination is being made. Please do not rebill.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
133	The disposition of this claim/service is pending further review			**426**	Claim in process due to review of claim history. Please do not resubmit.
133	The disposition of this claim/service is pending further review.			**427**	Claim still in process. Please do not rebill.
133	The disposition of this claim/service is pending further review.			**430**	Please do not rebill. Claim is being reviewed by medical consultant.
140	Patient/Insured health identification number and name do not match.			**259**	The recipient name on this claim does not match the name on file for Medicaid number shown.
140	Patient/Insured health identification number and name do not match.			**393**	Recipient's Medicaid number does not match the Medicaid number on the pa file.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**82**	Dates exceed SOBRA/QMB eligibility. Obtain SOBRA/QMB dates and split bill.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**93**	Claim spans more than one managed care plan. Obtain managed care data and split bill.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**255**	Records show this recipient is partially ineligible for Medicaid for header date(s) of service.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**263**	Records show this recipient is partially ineligible for Medicaid for detail date(s) of service.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**317**	Katrina/Rita claim spans plan codes/eligibility periods.
142	Claim adjusted by the monthly Medicaid patient liability amount.			**371**	Recipient resources exceed the Medicaid allowed amount.
142	Claim adjusted by the monthly Medicaid patient liability amount.			**372**	Patient resources exceed the Medicaid

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					allowed amount.
142	Claim adjusted by the monthly Medicaid patient liability amount.			**964**	This claim has been adjusted to reflect correct recipient resources.
147	Provider contracted/ negotiated rate expired or not on file.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.	**12**	No level III base value for anesthesia for dates of service billed.
147	Provider contracted/negotiated rate expired or not on file.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**72**	Provider/procedure code not on level I pricing file.

J.2 Adjusted Claim Codes

Claim Adj Reason Code	Claim Adj Reason Code Description	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	**N10** Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	957	This payment has been recouped to enable payment to the correct provider.
B12	Services not documented in patients' medical record.		965	Services not documented in patients' medical record.
1	Deductible amount		961	This claim has been adjusted to reflect a change in coinsurance and/or deductible.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		980	Claim adjusted to add/delete modifier.
18	Duplicate claim/service.		970	This claim has been recouped/adjusted due to a duplicate payment.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		991	Recipient has become retroactively eligible for Medicare for billed dates of service billed. File Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.		960	This claim has been adjusted to reflect payment by other insurance.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.		956	This claim has been adjusted to reflect a change in the type of service.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		955	The claim has been adjusted to reflect changes in the number of units billed and paid.
119	Benefit maximum for this time period or occurrence has been reached.		983	Claim adjusted/recouped because physician office visits have been exceeded for calendar year.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N22** This procedure code was added/changed because it more accurately describes the services rendered.	954	The claim has been adjusted to reflect a change in codes as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever		958	This claim has been adjusted to reflect a change in the original amount billed.

Claim Adj Reason Code	Claim Adj Reason Code Description	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	appropriate.			
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		962	Other-If you have any questions resulting from this adjustment, please contact our Correspondence/Inquiry Unit.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		968	Claim adjusted to reflect a rate change.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		989	This claim was recouped per your request.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		990	This claim has been adjusted to reflect a change in the dispensed as written value code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		993	Employment indicator invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		995	Claim recouped. Provider must resubmit claims on separate claims in order for services to be considered for payment by Medicaid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		997	Claim contains 15 or more error and therefore can not be processed as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		Z12	Invalid MMIS data
132	Prearranged demonstration project adjustment.	**N10** Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	953	Special adjustments - please refer to our mini-message
142	Claim adjusted by the monthly Medicaid patient liability amount.		964	Claim adjusted by the monthly Medicaid patient liability amount.

J.3 Electronic Up-Front Rejections

Rejection Code	Description
0010	HEADER from date of service invalid
0011	HEADER from date of service cannot be a future date
0020	Admission date is invalid
0021	The Admit date cannot be in the future
0022	The Admit date cannot be Greater than the Billing From date of service
0030	Header TO date of service invalid
0031	Header TO date of service cannot be a future date
0032	Header to DOS cannot be prior to the from DOS
0051	Surgery date 1 not between admit and to DOS
0052	Surgery date 2 not between admit and to DOS
0053	Surgery date 3 not between admit and to DOS
0054	Surgery date 4 not between admit and to DOS
0055	Surgery date 5 not between admit and to DOS
0060	The Non covered charge is numeric and positive but greater than 0 and is >= to covered charge
0061	Non covered charge is not numeric
0062	Non covered charge is negative
0063	Non covered charge exceeds maximum size allowed by MMIS
0064	Non covered charge exceeds maximum size allowed by MMIS and is negative
0070	Number days / billing period disagree
0071	Non covered days is not numeric
0072	Non covered days exceeds 366 days
0073	Calculated days billed exceeds 366 days
0080	Header To DOS is beyond the 365-day filing limit
0081	Header To DOS is beyond the 120-day filing limit
0082	Header To DOS is beyond the PHP filing limit
0083	Previous RA Date is invalid or beyond the 365-day filing limit
0130	Neonatal revenue code/diagnosis code mismatch
0140	Valid modifier is required for billed procedure
0150	Transportation service must be medically necessary
0170	Recipient is not eligible
0180	Home health / therapy services cannot be billed together
0190	HIV counseling code billed without HIV
0220	Days covered invalid
0221	Covered days is negative
0222	Covered days is numeric but exceeds 366
0230	Organ transplants require prior approval
0250	Unborn recipient eligible only for infant services
0260	EPSDT referred therapy services restricted to POS 11 or 99
0271	Modifier 1 valid only on crossover claims

Rejection Code	Description
0272	Modifier 2 valid only on crossover claims
0273	Modifier 3 valid only on crossover claims
0274	Modifier 4 valid only on crossover claims
0280	Header paid amount exceeds the specified dollar limit
0290	Type of bill invalid
0300	Units are not numeric
0301	Claim type is not IP, IX, LT or LX and units are negative
0302	Units are numeric but MMIS size exceeded
0303	Units are numeric, but negative, and the MMIS size is exceeded
0304	Units not equal to 1
0305	Fractional units not allowed
0310	Detail rate submitted is invalid
0320	Modifier 1 not effective for DOS
0321	Modifier 2 not effective for DOS
0322	Modifier 3 not effective for DOS
0323	Modifier 4 not effective for DOS
0330	Invalid revenue code for recipient over one year old
0331	Invalid revenue code for recipient one year old or younger
0340	Cataract services require proper modifier to be billed
0360	Submitted rate, units, and detail charge do not balance
0370	Nursery days must not exceed 10 under mother's number
0371	Nursery days/revenue codes invalid
0380	Pricing file indicates zero price – contact EDS
0390	Services not covered for indicated diagnosis
0400	QMB/EPSDT service limited to QMB/EPSDT related claim
0410	Only fifty lines allowed per claim
0420	EPSDT referred services restricted to recipients over 21
0430	Billed amount is not greater than zero
0431	Billed amount is not numeric
0432	Billed amount exceeds maximum MMIS size
0433	Billed amount exceeds maximum size allowed by MMIS and is negative
0440	Medicare paid amount is Missing or Invalid
0450	Medicare Allowed amount is Missing or Invalid
0451	Medicare allowed amount must be greater than zero
0460	Medicare Total Bill amount is Missing or Invalid
0470	Co-insurance amount is invalid
0471	Co-insurance amount does not balance
0480	Referring physician required on EPSDT referral
0481	Referring physician not on file
0482	Referring physician must be an EPSDT screening provider
0500	EPSDT screenings limited to EPSDT screening providers
0510	Patient status invalid
0520	Medicare header allow amount not equal sum of detail Medicare allow amounts
0530	Net billed amount not equal to sum of detail charges less TPL amt

Rejection Code	Description
0531	Sum of detail charges exceeds maximum allowed
0540	Sum Of Detail Non Cov Chg Not Equal Header Non Covered Charge
0550	Billed amount not equal to sum of the detail charge amounts
0551	Sum of detail non-covered charges exceeds maximum allowed
0560	Medicare header Paid amount not equal sum of detail Medicare Paid amounts
0580	Service for Maternity Waiver/Care recipient must be billed with Global Service Fee
0590	Maternity Waiver/Care Claim must be billed by Contract Provider
0600	Maternity Waiver/Contract Provider can only bill Maternity Waiver/Care claims
0610	Injectible/non-injectible procedures cannot be billed together for EPSDT County Health providers
0630	Recipient has no county code on eligibility file
0660	Admit type is invalid as billed
0670	Service for Maternity Waiver/Care Recipient Requires PA
0680	Hospice coinsurance/deductible invalid
0710	Invalid place of service for FQHC provider
0720	Pcode not on Level 1 for the provider and date of service
0721	Pcode no longer covered for provider
0730	Family planning service not covered for this recipient
0731	Family planning srvc (surg code 1) not covered for this recipient
0732	Family planning srvc (surg code 2) not covered for this recipient
0733	Family planning srvc (surg code 3) not covered for this recipient
0734	Family planning srvc (surg code 4) not covered for this recipient
0735	Family planning srvc (surg code 5) not covered for this recipient
0740	EPSDT only provider must bill EPSDT referral
0750	Procedure not on Level 1 for the provider and date of service
0751	Procedure no longer covered for provider
0760	Diagnosis code billed is not covered for MHSP
0770	VFC Provider may only bill VFC procedures
0780	Critical care procedures cannot span more than two days
0790	Procedure code not valid for Renal Dialysis Facility
0810	Procedure code cannot be billed with type of bill 141
0820	Service dates span eligibility change
0840	Service is not covered for a SOBRA eligible recipient
0860	Recipient not eligible for targeted case management
0870	Different TCM procedure codes must be billed on separate claims
0880	CLIA number not on file
0881	CLIA number invalid for DOS
0882	Provider certified for CLIA PPMP or waiver pcodes only
0883	Provider certified for CLIA waivered pcodes only
0890	Medicare Paid amount equal 100%
0900	Global delivery procedure code cannot be span dated
0910	Medicare paid date invalid
0911	Medicare paid date cannot be a future date
0920	TPL adjudication date invalid

Rejection Code	Description
0921	TPL adjudication date cannot be a future date
0930	Details covered by more than one plan within managed care program, split bill
0931	Not all details covered by same managed care program, split bill
0932	Recipient partially covered by managed care plan, split bill
0934	Services partially covered by managed care plan, split bill
0940	Coinsurance not numeric or > 366
0941	Coinsurance days are > max
0950	LTR days not numeric or > 366
0951	LTR days are zero or > max
0960	Coinsurance and/or Lifetime Reserve days are invalid.
0970	Rev code and pcode combo not valid
0971	Pcode and rev code combo not valid
0980	Service not covered by Medicaid
0981	Revenue code not covered by Medicaid
0990	Medicare Deductible amount is invalid
0991	Medicare deductible amount is not greater than 0
0992	Medicare deductible amount exceeds maximum MMIS size
0993	Medicare deductible amount exceeds maximum size allowed by MMIS and is
1000	Detail from date of service invalid
1001	Detail from date of service cannot be a future date
1010	Detail TO date of service invalid
1011	Detail TO date of service cannot be a future date
1012	Detail to DOS cannot be prior to the from DOS
1020	Detail DOS beyond the 365-day filing limit
1021	Detail DOS beyond the 120-day filing limit
1022	Detail DOS beyond the 180-day filing limit
1030	Therapy code payable only with therapeutic treatment
1040	ER & critical care codes one per claim
1050	Service included in revenue code 450 facility fee
1060	Anesthesia claims require referring provider
1070	Patient 1st claim requires PMP provider on claim
1090	Observation code must be billed with facility fee
1100	Invalid deductible amount for skilled nursing facility
1130	Procedure not covered for an Ambulatory Surgical Center
1140	Service non-payable for recipient < six months of age
1231	Oral cavity designation code invalid
1236	Oral cavity designation code invalid
1237	Oral cavity designation code invalid
1238	Oral cavity designation code invalid
1239	Oral cavity designation code invalid
1240	More than one tooth number per claim detail
1260	Tooth surface is required for procedure
1261	Tooth surface is invalid
1270	Invalid tooth for procedure

Rejection Code	Description
1280	Tooth number is required for procedure
1281	Tooth number is invalid
1282	More than one tooth number per claim detail
1300	Invalid claim type for Plan First Program
1310	Service is only covered under the Plan First Program
1330	Plan First Recipient must be seen by a Plan First Network Provider
1340	Plan First Recipient is only eligible for Plan First Services
1350	Procedure code specific to Technology Assisted Waiver only
1360	Place of service code is invalid
1440	Place of service is not valid for provider type
1451	First modifier is invalid
1452	Second modifier is invalid
1453	Third modifier is invalid
1454	Fourth modifier is invalid
1460	Procedure code is inappropriate for this provider type
1471	First modifier is invalid for procedure code billed
1472	Second modifier is invalid for procedure code billed
1473	Third modifier is invalid for procedure code billed
1474	Fourth modifier is invalid for procedure code billed
1480	Place of service code is invalid for procedure
1490	Procedure code is inappropriate for the recipient's age
1491	Revenue code is inappropriate for the recipient's age
1499	NDC is inappropriate for the recipient's age
1500	Procedure code is inappropriate for the recipient's Sex
1501	Revenue code is inappropriate for the recipient's Sex
1509	NDC is inappropriate for the recipient's Sex
1510	Procedure code not found for DOS
1511	Revenue code not found for DOS
1515	Service dates span procedure code effective date segments
1516	Service dates span revenue code effective date segments
1519	NDC is invalid for DOS
1520	Service code missing or invalid
1521	Revenue code missing or invalid
1528	Invalid qualifier list code
1529	NDC is not on file
1530	Detail diagnosis is inappropriate for the procedure billed
1531	First diagnosis is inappropriate for the procedure
1532	Second diagnosis is inappropriate for the procedure
1533	Third diagnosis is inappropriate for the procedure
1534	Fourth diagnosis is inappropriate for the procedure
1535	Fifth diagnosis is inappropriate for the procedure
1536	Sixth diagnosis is inappropriate for the procedure
1537	Seventh diagnosis is inappropriate for the procedure

Rejection Code	Description
1538	Eighth diagnosis is inappropriate for the procedure
1540	Procedure code is inappropriate for this provider specialty
1550	Procedure code invalid for claim type
1551	Revenue code invalid for claim type
1580	Emergency services recipient is only eligible for emergency services
1590	Invalid claim type for emergency services program
1610	Procedure invalid for service performed
1611	Revenue code invalid or not on file
1620	Units Billed Exceed Max Allowed Per Day
1640	Header days and detail days disagree
1641	No accommodation revenue code~~s~~ billed
1740	Diagnosis requires accident indicator
1750	Operation or delivery requires surgical procedure code
1830	Date of service is before the recipient's date of birth
1840	Services not covered for recipient 22 or older
1850	Procedure not covered at POS for provider
1890	Diagnosis inappropriate for provider specialty
1900	Primary header diagnosis is invalid
1912	Header diagnosis 2 is invalid
1913	Header diagnosis 3 is invalid
1914	Header diagnosis 4 is invalid
1915	Header diagnosis 5 is invalid
1916	Header diagnosis 6 is invalid
1917	Header diagnosis 7 is invalid
1918	Header diagnosis 8 is invalid
1940	Primary diagnosis is not appropriate for recipient age
1952	Diagnosis 2 is not appropriate for recipient age
1953	Diagnosis 3 is not appropriate for recipient age
1954	Diagnosis 4 is not appropriate for recipient age
1955	Diagnosis 5 is not appropriate for recipient age
1956	Diagnosis 6 is not appropriate for recipient age
1957	Diagnosis 7 is not appropriate for recipient age
1958	Diagnosis 8 is not appropriate for recipient age
1960	Primary diagnosis is not appropriate for recipient sex
1972	Header diagnosis 2 is not appropriate for recipient sex
1973	Header diagnosis 3 is not appropriate for recipient sex
1974	Header diagnosis 4 is not appropriate for recipient sex
1975	Header diagnosis 5 is not appropriate for recipient sex
1976	Header diagnosis 6 is not appropriate for recipient sex
1977	Header diagnosis 7 is not appropriate for recipient sex
1978	Header diagnosis 8 is not appropriate for recipient sex
1980	Primary diagnosis must be billed at highest subdivision
1992	Diagnosis 2 must be billed at highest subdivision
1993	Diagnosis 3 must be billed at highest subdivision

Rejection Code	Description
1994	Diagnosis 4 must be billed at highest subdivision
1995	Diagnosis 5 must be billed at highest subdivision
1996	Diagnosis 6 must be billed at highest subdivision
1997	Diagnosis 7 must be billed at highest subdivision
1998	Diagnosis 8 must be billed at highest subdivision
2000	Primary diagnosis not covered
2012	Diagnosis 2 not covered
2013	Diagnosis 3 not covered
2014	Diagnosis 4 not covered
2015	Diagnosis 5 not covered
2016	Diagnosis 6 not covered
2017	Diagnosis 7 not covered
2018	Diagnosis 8 not covered
2051	Detail diagnosis 1 invalid
2052	Detail diagnosis 2 invalid
2053	Detail diagnosis 3 invalid
2054	Detail diagnosis 4 invalid
2180	Performing provider identified for purge
2190	Billing provider identified for purge. Call EDS at 1(888) 223-3630.
2200	Provider does not have authorization to bill electronically
2210	Provider is deceased on DOS being billed
2220	Provider address on file is not current – mail returned
2230	Provider suspended from the Medicaid program
2240	Provider has been canceled
2250	Provider rate not found for the date of service billed
2260	Claim type is not valid for this provider
2270	Provider not eligible for Medicaid
2280	Provider is ineligible on DOS being billed
2290	Provider number is invalid
2291	Provider number is not on file
2292	Provider name and number disagree
2293	Provider specialty not found for date of service submitted
2300	Attending Physician's License Number is Missing
2350	Billing provider must be group provider number
2360	Performing provider cannot be group provider number
2370	Provider number is Not on File
2371	Provider Action reason code segment is in cancelled status
2372	Provider Action reason code segment is in deceased status
2373	Performing provider number cannot be spaced or zeros
2380	Performing provider not associated with the group
2390	Provider eligible for only QMB recipients
2480	Eligible for Medicare only-no Medicaid or QMB benefits
2500	Recipient number not on file

Rejection Code	Description
2501	Recipient number missing or zeroes
2502	Recipient on Xref but not on Base-Call EDS
2510	Recipient has an unusable record - contact EDS
2540	Recipient is totally ineligible for header DOS
2550	Recipient is partially ineligible for header DOS
2560	Recipient number missing or invalid
2570	Birth date is invalid
2580	Recipient is locked in to a specific pharmacy/no pharmacy selected
2581	Recipient is locked in to a different provider
2582	Recipient is locked out of specific drugs
2583	Recipient is locked out of controlled substances
2590	Recipient's ID is invalid for the recipient's first name
2591	Recipient name is required
2620	Recipient is totally ineligible for detail DOS
2630	Recipient is partially ineligible for detail DOS
2640	Recipient ineligible for geriatric or inpatient psychiatric services
2700	Recipient is not on the LTC eligibility file for the date of service
2720	Provider does not match provider on LTC file for recipient
2760	Recipient ineligible for waivered service
2761	Recipient ineligible for waivered services from this provider
2762	Provider not eligible for waivered services
2790	Recipient has Medicare HMO coverage
2800	Recipient has other medical coverage – file third party carrier first
2820	Recipient is Medicare suspect
2831	Type of Service Not Valid for Modifier 1
2832	Type of Service Not Valid for Modifier 2
2833	Type of Service Not Valid for Modifier 3
2834	Type of Service Not Valid for Modifier 4
2950	Production provider cannot bill claims for test recipient
2951	Test provider cannot bill claims for production recipient
3000	Vaccine procedure only payable under vaccines for children program
3040	Surgery provider number is invalid
3100	Detail charge amount is zero
3101	Detail charge amount is not numeric
3102	Detail charge amount is negative
3103	Detail charge amount exceeds maximum size allowed by MMIS
3104	Detail charge amount exceeds maximum size allowed by MMIS and is negative
3109	Detail charge amount is unsigned
3130	Admitting diagnosis is invalid
3140	From DOS and to DOS must be within the same month
3150	From DOS and ~~t~~To DOS must not span the calendar year
3151	From DOS and To DOS must not span the fiscal year
3160	Date range cannot exceed 90 days

Rejection Code	Description
3221	Surgery date 1 required if surgery procedure code 1 present
3222	Surgery date 2 required if surgery procedure code 2 present
3223	Surgery date 3 required if surgery procedure code 3 present
3224	Surgery date 4 required if surgery procedure code 4 present
3225	Surgery date 5 required if surgery procedure code 5 present
3229	Operating physician required if surgery procedure(s)are present
3230	Invalid claim submission reason code
3231	Original ICN is not valid on an original claim
3232	Must supply original ICN on an adjustment request
3235	Invalid claim submission code
3236	Must supply original ICN on an adjustment request
3237	Supp pay indicator must be equal R
3750	Product is not preferred
3820	The original ICN cannot be adjusted
3821	Original claim status invalid for adjustment
3822	Adjustment of original claim already in progress
3823	Original provider and/or recipient not matched
3829	Invalid MMIS adjustment
3840	Service code home health but Prog blank
3850	Duplicate PA request
3860	First PA detail has certification type ‘I’, but current detail is not certification type ‘I’
3861	First PA detail is not certification type ‘I’, but current detail is certification type “I”
3862	First PA detail is not certification type ‘I’, and current detail is not certification type ‘I’, but the prior PA number on each do not agree
3870	Neither requested dollars or requested units are supplied
3871	Requested dollars are not numeric
3872	Requested dollars are negative
3873	Requested dollars are numeric but MMIS size exceeded
3874	Requested dollars are numeric, but negative, and the MMIS size is exceeded
3875	Requested units are not numeric
3876	Requested units are negative
3877	Requested units are numeric but MMIS size exceeded
3878	Requested units are numeric, but negative, and the MMIS size is exceeded
3881	Provider ID is zeros or spaces
3882	Provider not found on provider base or provider license
3890	Prior authorization number is not on file
3891	Prior authorization number is not numeric
3892	Previous prior authorization number is not approved
3900	Claim and prior authorization provider do not match
3901	Claim and prior authorization prescriber do not match

Rejection Code	Description
3910	Prior authorization required dates overlap dates of service on claim
3920	Prior authorization units are exhausted
3930	Recipient ID does not match the PA Recipient ID
3940	PA denied, NDC req PA
3941	Non-preferred product required PA
3943	PRAHOST open error
3944	PRAHOST read error
3945	PA req/resp mismatch
3946	PA resp data invalid
3947	PA req timeout – HID
3948	PA resp format error
3949	DASS RC not equal 0
3970	Active PA detail not found for PA number billed
3971	PA number does not match dates of service billed
3980	Allowed charges exceed authorized dollars on PA file
3990	Prior authorization required
3991	Prior authorization required for inpatient pysch related services
3992	Prior authorization required for certain transportation services
3993	Prior authorization required for place of service billed
3994	Prior authorization required for personal care/private duty nursing
3995	Private duty nursing services require PA and a EPSDT screening referral
3996	Inpatient Svcs for Plan First Recipients Limited to PA'd Tubal Ligations
3999	Prior authorization required
4200	Quantity dispensed exceeds units/day PA (PA begin date)
4900	Pharmacy claim – exact dup
4910	Pharmacy claim – suspect dup of history claim
4911	Pharmacy claim – suspect dup of another detail
4920	Monthly scrip limit exceeded (min/max)
4930	Duplicate RX code, refill number, and NDC
9000	Prescription number is missing or invalid
9010	Drug quantity cannot be zero
9011	Drug quantity must be numeric
9012	Drug quantity cannot exceed 99,999.999
9031	Days supply equal to zero
9032	Days supply must be numeric
9033	Days supply limit exceeded
9040	Date prescribed is invalid or missing
9070	Prescribing provider's license number is not on file
9071	Prescribing provider's license number is inactive
9080	Date dispensed is prior to date prescribed
9110	Refill number exceeds refills allowed for NDC

Rejection Code	Description
9111	Refill indicator not numeric
9270	OTC drug not covered for LTC recipient
9300	Medical necessity (DAW) indicator is invalid
9301	Medical necessity (DAW) indicator is not numeric
9310	M/I Service Provider ID Qualifier
9320	M/I Insurance Segment
9330	M/I Claim Segment
9340	Product/Service not covered
9350	M/I Product/Service ID Qualifier
9360	M/I Prescriber Segment
9370	M/I Prescriber ID Qualifier
9380	M/I Pricing Segment
9390	M/I Other Payer Amount Paid Qualifier
9400	M/I Segment Identification
9410	Criteria for pregnancy copay exemption not met
9500	DUR conflict code is invalid
9501	DUR intervention code invalid
9502	DUR outcome code invalid
9510	Previous DUR alerted claim cannot be found
9511	Claim to cancel cannot be found
9520	Previously alerted claim cannot be overridden – corresponding alert not found
9521	Previously alerted claim cannot be overridden – outcome indicates no change, DUR fields changed
9522	Previously alerted claim cannot be overridden – outcome indicates change, DUR fields not changed
9523	Previously alerted claim cannot be overridden – alert requires a PA override
A030	Max quantity exceeded for 30-day period
Z110	Detail DOS not within the header DOS
Z111	Calculated TDOS not within header DOS
Z140	Admission hour is invalid
Z141	Admission minute is invalid
Z160	Discharge hour is invalid
Z161	Discharge minute is invalid
Z170	Non-Covered days are invalid
Z171	Non-Covered days exceeds 366 days
Z191	Occurrence Date 1 is invalid
Z192	Occurrence Date 2 is invalid
Z193	Occurrence Date 3 is invalid
Z194	Occurrence Date 4 is invalid
Z195	Occurrence Date 5 is invalid
Z211	Condition code 1 is invalid
Z212	Condition code 2 is invalid
Z213	Condition code 3 is invalid
Z214	Condition code 4 is invalid

Rejection Code	Description
Z215	Condition code 5 is invalid
Z220	Invalid TPL indicator
Z221	TPL amount must be numeric
Z225	Third party amount (TPL) exceeds total billed
Z229	Other coverage amount is unsigned
Z230	Surgery count missing or invalid
Z231	Occurrence count missing or invalid
Z232	Condition count missing or invalid
Z233	Diagnosis count missing or invalid
Z310	Social Security number not found
Z311	No recipient found that matches request
Z312	Multiple recipients found, resubmit with additional and/or corrected information, or
Z313	Last name does not match SSN
Z314	First name does not match SSN
Z315	Middle initial does not match SSN
Z316	Date of birth does not match SSN
Z800	Claim has already been reversed.
Z801	RX number not found on claim
Z803	RX number is not numeric.
Z804	Non-matched NDC number
Z810	Invalid ICN
Z811	ICN not found on claim file.
Z812	Invalid ICN for claim type.
Z813	Claim has already been reversed.
Z820	Recipient id/claim record mismatch
Z830	Provider id/claim record mismatch
Z840	Claim can only be reversed the same day as submitted
Z980	Non-covered charge is invalid (Header)
Z981	Net amount is invalid (Header)
Z982	Error Count is invalid (Header)
Z983	Location count is invalid (Header)
Z984	Location detail number is invalid (Location – Header)
Z985	Location date is invalid (Location – Header)
Z986	Location age is invalid (Location – Header)
Z987	Detail number is invalid (Detail)
Z988	Manual amount is invalid (Detail)
Z990	Detail count missing or invalid

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K Top 200 Third Party Carrier Codes

This appendix lists the top 200 insurance companies that may be a third-party resource for payment of claims. The company name and carrier codes are listed numerically in Section K.1, Numerical Listing by Company Code, and alphabetically in Section K.2, Alphabetical Listing by Company Name.

Because federal Medicaid regulations require that any resources currently available to a recipient be considered in determining liability for payments of medical services, providers have an obligation to investigate and report the existence of other insurance or liability to Medicaid. When you identify a third party resource, you should submit the claim to that resource.

Refer to Section 3.3.6, Third Party Liability, for more information about how to file a claim when another insurance company may be responsible for all or part of the cost of the medical care.

K.1 Numerical Listing by Company Code

Company Code	***Company Name***	***City, State***
00002	AARP Insurance Plan	Philadelphia, PA
00007	Aetna Life and Casualty Company	Tampa, FL
00020	Amalgamated Life Insurance Company	New York, NY
00031	American Family Life Insurance	Columbus, GA
00039	American Heritage Life	Jacksonville, FL
00067	Assoc Doctors Health and Life	Longhorne, PA
00073	Atlantic American Life	Atlanta, GA
00081	Bankers Life and Casualty Company	Chicago, IL
00128	Colonial Life and Accident	Columbia, SC
00143	Connecticut General Life Insurance Company	Atlanta, GA
00231	Globe Life and Accident	Oklahoma City, OK
00253	American General Gulf Life	Mobile, AL
00272	Independent Life and Accident	Nashville, TN
00291	John Hancock Mutual Life	Greensboro, NC
00306	Liberty National	Birmingham, AL
00310	Life Insurance Company of Alabama	Gadsden, AL
00314	Life Insurance Company of Georgia	Atlanta, GA
00337	Unicare	Springfield, MA
00341	Metropolitan Life	Tampa, FL
00358	Mutual of Omaha Insurance	Omaha, NE
00360	Mutual Savings Life	Decatur, AL
00366	National Home Life Assurance	Valley Forge, PA
00370	American General Life	Nashville, TN
00376	National Security	Elba, AL
00388	New Southland National	Tuscaloosa, AL
00439	Physicians Mutual	Omaha, NE
00445	Pioneer Life Insurance Company	Rockford, IL
00453	Professional Insurance Corporation	Raleigh, NC
00454	Protective Industrial	Birmingham, AL

Company Code	***Company Name***	***City, State***
00455	Protective Life Insurance Company	Birmingham, AL
00461	Prudential Insurance Company	Jacksonville, FL
00474	Ret/Wholesale O Store International	Birmingham, AL
00514	State Farm Insurance Company	Birmingham, AL
00531	Time Insurance Company	Milwaukee, WI
00544	Union Bakers Insurance Company	Dallas, TX
00546	Union Fidelity Life Insurance	Trevose, PA
00550	Union National Life Insurance Company	Baton Rouge, LA
00553	United American Insurance Company	McKinney, TX
00606	New York Life Insurance Company	Atlanta, GA
00614	Boilermakers National	Kansas City, KS
00624	Goodyear	Gadsden, AL
00626	Great West Life Assurance	Atlanta, GA
00633	Life Investors Insurance Company	Cedar Rapids, IA
00640	National Association of Letter Carriers	Ashburn, VA
00706	Provident Life and Accident	Chattanooga, TN
00779	Unicare	Fort Scott, KS
00881	Provident Life Insurance	Greenville, SC
00906	AETNA Life and Casualty	Arlington, TX
00929	Prudential Ins Co.	Jacksonville, FL
01002	United of Omaha	Omaha, NE
01045	KANWHA Ins Co.	Lancaster, SC
01046	Wausau Ins. Co.	Wausau, WI
01085	Provident Life & ACC	Bristol, TN
01110	Combined Ins. Co. of America	Chicago, IL
01114	Mail Handlers Benefit Plan	Rockville, MD
01119	Aetna Life & Casualty	Minneapolis, MN
01158	Aetna Life & Casualty	Memphis, TN
01165	Aetna Life & Casualty	Greensboro, SC
01174	John Alden Life Ins. Co.	Miami, FL
01200	Golden Rule Ins. Co.	Indianapolis, IN
01234	Aetna Insurance Co.	Peoria, IL
01248	Aetna Life & Casualty	Allentown, PA
01264	United Ins. Of America	Baton Rouge, LA
01303	Metropolitan	Utica, NY
01395	Aetna Insurance Co.	Tyler, TX
01427	Metrahealth Travellers	Salt Lake City, UT
01460	Grp Resource Inc.	Duluth, GA
01476	Prime Health	Mobile, AL
01523	Southeast Health Plan Ins.	Birmingham, AL
01582	United Health Care	Birmingham, AL
01613	Prime Health ADM	Mobile, AL
01626	Hilb, Rogal, & Hamilton	Birmingham, AL
01650	Metropolitan Life Insurance	Pittsburgh, PA
01676	National Foundation Life	Ft. Worth, TX
01718	Principal Financial Group	Springfield, MO
01723	Metropolitan Life	Greenville, SC
01740	United Food and Com Workers	Atlanta, GA
01828	Capitol American Life	Cleveland, OH
01894	Delta Dental Plan of Ohio	Columbus, OH
01924	PCS Drug Plan	Phoenix, AZ
01928	Employers Health Insurance	Green Bay, WI
01930	Paid Prescription Plan	Fair Lawn, NJ
01934	Wal-Mart Group Health Plan	Bentonville, AR

Company Code	*Company Name*	*City, State*
01954	Cigna Health Care/Provident	Houston, TX
02001	Federal Employee Program, BCA/BSA	Birmingham, AL
02005	BC/BS of Florida, Incorporated	Jacksonville, AL
02010	BC/BS of Georgia/Columbus	Columbus, GA
02091	BC/BS of Alabama	Birmingham, AL
02092	BC/BS of Georgia/Atlanta	Atlanta, GA
02094	BC/BS of Michigan	Detroit, MI
02095	BC/BS of Mississippi	Jackson, MS
02097	BC/BS of Tennessee	Chattanooga, TN
02106	BC/BS of Virginia	Richmond, VA
02118	BC of Illinois	Chicago, IL
02123	BC/BS of Kentucky, Inc.	Louisville, KY
02137	BC/BS of Greater New York	New York, NY
02171	BC/BS of W PA	Pittsburgh, PA
02198	BC/BS of Alabama	Birmingham, AL
02201	BellSouth D E D Service Center	Birmingham, AL
03035	Health Partners A D M Services	Birmingham, AL
03036	Partners National Health Plans	Birmingham, AL
03256	Guardian Life	Appleton, WI
03261	Eldercare Plus	Fairfield, AL
03308	Freedom Life	Louisville, KY
03382	Southern Administrative Services	Columbus, GA
03427	SIMA	Chattanooga, TN
03478	United Medical Resources	Cincinnati, OH
03485	W H Shepherd Company	Birmingham, AL
03576	AL Hospitals Association Employee Benefit Trust.	Jackson, MS
03584	Principal Mutual Life	Overland Park, KS
03591	Prudential Insurance	High Point, NC
03628	Group Administrators	Birmingham, AL
03712	Senior Partners	Birmingham, AL
03718	Tennessee Laborers Health & Welfare Trust Fund	Goodlettsville, TN
03737	Alabama Health Network	Birmingham, AL
03745	Amer Med Security	Green Bay, WI
03798	Delta Dental Plan	N. Little Rock, AR
03996	Corporate Benefit Service	Minnetonka, MN
04011	Palmetto G B A	Camden, SC
04012	BC/BS of South Carolina	Florence, SC
05001	United Mine Workers	Van Nuys, CA
05018	United Mine Workers	Duluth, MN
10014	Central Reserve Life Insurance	Arlington, TX
10040	United Insurance Co. Of Amer.	Baton Rouge, LA
10049	Prime Care/Prime Health	Mobile, AL
10158	Jefferson Pilot	Lake City, FL
10170	Insurance Claims Service	Birmingham, AL
10172	Employers Health Insurance	Madison, WI
10196	S R C Service I N C C	Columbia, SC
10275	Great West Life	Atlanta, GA
10292	Southern Benefits Service	Birmingham, AL
10349	Great West Life insurance	Detroit, MI
10377	Corporate Benefit Service	Hopkins, MN
10397	Commercial Travelers	Utica, NY
10465	Insurance Benefit Service	Houston, TX

Company Code	***Company Name***	***City, State***
10501	U S A Health Plan	Mobile, AL
10571	Travelers	Charlotte, NC
10579	Great West Life	Atlanta, GA
10655	New E R A	Houston, TX
10689	Health Strategies Insurance	Birmingham, AL
10716	Administrative Enterprise	Phoenix, AR
10730	Advantage Health	Montgomery, AL
10763	Third Party Claims Mgt.	Youngstown, OH
10794	John Hancock Mutual	Greensboro, NC
10807	Premier Health Plans	Huntsville, AL
10878	First Health	Houston, TX
10879	Employee Benefit Consultants	Birmingham, AL
10880	AETNA	Greensboro, NC
10932	Health Partners of Alabama	Birmingham, AL
10942	Value RX	Bloomfield Hills, MI
10950	Prudential Insurance Company	Matteson, IL
11103	First Health	Maitland, FL
11232	NAMCI	Huntsville, AL
11363	CIGNA	Pittsburgh, PA
12389	National RX	Dallas, TX
12431	Benefit Support	Gainesville, GA
12439	Caremark	San Antonio, TX
12452	CACH Administrative Services	Birmingham, AL
12474	Express Scripts	St. Louis, MO
12482	Alascript	Northport, AL
12492	Strategic Resource Company	Columbia, SC
12494	Seniors First	Birmingham, AL
12517	Med. Net	Huntsville, AL
12526	Health Network	Birmingham, AL
12594	Diversified Pharmaceuticals	International Falls, MN
12843	First Health	London, KY
12847	Fountainhead Administrative	Austin, TX
12885	Health Risk Management	Minneapolis, MN
12886	PCA Health Plans	Birmingham, AL
12960	New E R A	Houston, TX
13237	First Community Health	Huntsville, AL
13286	Paid Prescriptions	Fairlawn, NJ
13297	Viva Health	Birmingham, AL
13301	Third Party Management	Oklahoma City, OK
13451	Merit Health	Birmingham, AL
97220	Webb Wheel Products	Cullman, AL
97288	Sunshine Homes	Red Bay, AL
97446	Sanders Employee Benefits	Troy, AL
97460	Tyson Foods	Boaz, AL
97501	Shaw Industries	Dalton, GA
97896	City of Montgomery	Montgomery, AL
97985	Southern Alum Castings	Bay Minette, AL
98142	Phifer Wire Products, Inc.	Tuscaloosa, AL
98174	Goodyear Tire and Rubber Company	Akron, OH
98403	ITPE - NMU Health & Welfare	Savannah, GA
98485	Columbus Mills	Eufaula, AL
98756	Tyson Foods	Gadsden, AL
98790	Tyson Foods	Oxford, AL
98876	Utility Trailer Corporation	Enterprise, AL

Company Code	Company Name	City, State
98907	Tyson Foods	Ashland, AL
98928	Tyson Foods	Heflin, AL
98929	Tyson Foods	Blountsville, AL
98930	Tyson Foods	Ashland, AL
99225	Bush Hog	Selma, AL
99362	Fieldcrest Mills Inc.	Charlotte, NC
99601	Scotch Lumber Co.	Fulton, AL
99684	Wayne Poultry Co.	Decatur, AL
99685	Wayne Poultry Co.	Union Springs, AL
99844	Goldkist Inc.	Trussville, AL
99998	Martin Industries	Florence, AL

K.2 Alphabetical Listing by Company Name

Company Code	Company Name	City, State
00002	A A R P Insurance Plan	Philadelphia, PA
10716	Administrative Enterprise	Phoenix, AR
10730	Advantage Health	Montgomery, AL
10880	AETNA	Greensboro, NC
01234	Aetna Insurance Co.	Peoria, IL
01395	Aetna Insurance Co.	Tyler, TX
01119	Aetna Life & Casualty	Minneapolis, MN
01158	Aetna Life & Casualty	Memphis, TN
01165	Aetna Life & Casualty	Greensboro, SC
01248	Aetna Life & Casualty	Allentown, PA
00906	AETNA Life and Casualty	Arlington, TX
00007	Aetna Life and Casualty Company	Tampa, FL
03576	AL Hospitals Association Employee Benefit Trust.	Jackson, MS
03737	Alabama Health Network	Birmingham, AL
12482	Alascript	Northport, AL
00020	Amalgamated Life Insurance Company	New York, NY
03745	Amer Med Security	Green Bay, WI
00031	American Family Life Insurance	Columbus, GA
00253	American General Gulf Life	Mobile, AL
00370	American General Life	Nashville, TN
00039	American Heritage Life	Jacksonville, FL
00067	Assoc Doctors Health and Life	Longhorne, PA
00073	Atlantic American Life	Atlanta, GA
00081	Bankers Life and Casualty Company	Chicago, IL
02118	BC of Illinois	Chicago, IL
02091	BC/BS of Alabama	Birmingham, AL
02198	BC/BS of Alabama	Birmingham, AL
02005	BC/BS of Florida, Incorporated	Jacksonville, AL
02092	BC/BS of Georgia/Atlanta	Atlanta, GA
02010	BC/BS of Georgia/Columbus	Columbus, GA
02137	BC/BS of Greater New York	New York, NY
02123	BC/BS of Kentucky, Inc.	Louisville, KY
02094	BC/BS of Michigan	Detroit, MI
02095	BC/BS of Mississippi	Jackson, MS
04012	BC/BS of South Carolina	Florence, SC
02097	BC/BS of Tennessee	Chattanooga, TN
02106	BC/BS of Virginia	Richmond, VA

Company Code	***Company Name***	***City, State***
02171	BC/BS of W PA	Pittsburgh, PA
02201	BellSouth D E D Service Center	Birmingham, AL
12431	Benefit Support	Gainesville, GA
00614	Boilermakers National	Kansas City, KS
99225	Bush Hog	Selma, AL
12452	CACH Administrative Services	Birmingham, AL
01828	Capitol American Life	Cleveland, OH
12439	Caremark	San Antonio, TX
10014	Central Reserve Life Insurance	Arlington, TX
11363	CIGNA	Pittsburgh, PA
01954	Cigna Health Care/Provident	Houston, TX
97896	City of Montgomery	Montgomery, AL
00128	Colonial Life and Accident	Columbia, SC
98485	Columbus Mills	Eufaula, AL
01110	Combined Ins. Co. of America	Chicago, IL
10397	Commercial Travelers	Utica, NY
00143	Connecticut General Life Insurance Company	Atlanta, GA
03996	Corporate Benefit Service	Minnetonka, MN
10377	Corporate Benefit Service	Hopkins, MN
03798	Delta Dental Plan	N. Little Rock, AR
01894	Delta Dental Plan of Ohio	Columbus, OH
12594	Diversified Pharmaceuticals	International Falls, MN
03261	Eldercare Plus	Fairfield, AL
10879	Employee Benefit Consultants	Birmingham, AL
01928	Employers Health Insurance	Green Bay, WI
10172	Employers Health Insurance	Madison, WI
12474	Express Scripts	St. Louis, MO
02001	Federal Employee Program, BCA/BSA	Birmingham, AL
99362	Fieldcrest Mills Inc.	Charlotte, NC
13237	First Community Health	Huntsville, AL
10878	First Health	Houston, TX
11103	First Health	Maitland, FL
12843	First Health	London, KY
12847	Fountainhead Administrative	Austin, TX
03308	Freedom Life	Louisville, KY
00231	Globe Life and Accident	Oklahoma City, OK
01200	Golden Rule Ins. Co.	Indianapolis, IN
99844	Goldkist Inc.	Trussville, AL
00624	Goodyear	Gadsden, AL
98174	Goodyear Tire and Rubber Company	Akron, OH
10275	Great West Life	Atlanta, GA
10579	Great West Life	Atlanta, GA
00626	Great West Life Assurance	Atlanta, GA
10349	Great West Life insurance	Detroit, MI
03628	Group Administrators	Birmingham, AL
01460	Grp Resource Inc.	Duluth, GA
03256	Guardian Life	Appleton, WI
12526	Health Network	Birmingham, AL
03035	Health Partners A D M Services	Birmingham, AL
10932	Health Partners of Alabama	Birmingham, AL
12885	Health Risk Management	Minneapolis, MN
10689	Health Strategies Insurance	Birmingham, AL

Company Code	*Company Name*	*City, State*
01626	Hilb, Rogal, & Hamilton	Birmingham, AL
00272	Independent Life and Accident	Nashville, TN
10465	Insurance Benefit Service	Houston, TX
10170	Insurance Claims Service	Birmingham, AL
98403	ITPE - NMU Health & Welfare	Savannah, GA
10158	Jefferson Pilot	Lake City, FL
01174	John Alden Life Ins. Co.	Miami, FL
10794	John Hancock Mutual	Greensboro, NC
00291	John Hancock Mutual Life	Greensboro, NC
01045	KANWHA Ins Co.	Lancaster, SC
00306	Liberty National	Birmingham, AL
00310	Life Insurance Company of Alabama	Gadsden, AL
00314	Life Insurance Company of Georgia	Atlanta, GA
00633	Life Investors Insurance Company	Cedar Rapids, IA
01114	Mail Handlers Benefit Plan	Rockville, MD
99998	Martin Industries	Florence, AL
12517	Med. Net	Huntsville, AL
13451	Merit Health	Birmingham, AL
01427	Metrahealth Travellers	Salt Lake City, UT
01303	Metropolitan	Utica, NY
00341	Metropolitan Life	Tampa, FL
01723	Metropolitan Life	Greenville, SC
01650	Metropolitan Life Insurance	Pittsburgh, PA
00358	Mutual of Omaha Insurance	Omaha, NE
00360	Mutual Savings Life	Decatur, AL
11232	NAMCI	Huntsville, AL
00640	National Association of Letter Carriers	Ashburn, VA
01676	National Foundation Life	Ft. Worth, TX
00366	National Home Life Assurance	Valley Forge, PA
12389	National RX	Dallas, TX
00376	National Security	Elba, AL
10655	New E R A	Houston, TX
12960	New E R A	Houston, TX
00388	New Southland National	Tuscaloosa, AL
00606	New York Life Insurance Company	Atlanta, GA
01930	Paid Prescription Plan	Fair Lawn, NJ
13286	Paid Prescriptions	Fairlawn, NJ
04011	Palmetto G B A	Camden, SC
03036	Partners National Health Plans	Birmingham, AL
12886	PCA Health Plans	Birmingham, AL
01924	PCS Drug Plan	Phoenix, AZ
98142	Phifer Wire Products, Inc.	Tuscaloosa, AL
00439	Physicians Mutual	Omaha, NE
00445	Pioneer Life Insurance Company	Rockford, IL
10807	Premier Health Plans	Huntsville, AL
10049	Prime Care/Prime Health	Mobile, AL
01476	Prime Health	Mobile, AL
01613	Prime Health ADM	Mobile, AL
01718	Principal Financial Group	Springfield, MO
03584	Principal Mutual Life	Overland Park, KS
00453	Professional Insurance Corporation	Raleigh, NC
00454	Protective Industrial	Birmingham, AL
00455	Protective Life Insurance Company	Birmingham, AL

Company Code	***Company Name***	***City, State***
01085	Provident Life & ACC	Bristol, TN
00706	Provident Life and Accident	Chattanooga, TN
00881	Provident Life Insurance	Greenville, SC
00929	Prudential Ins Co.	Jacksonville, FL
03591	Prudential Insurance	High Point, NC
00461	Prudential Insurance Company	Jacksonville, FL
10950	Prudential Insurance Company	Matteson, IL
00474	Ret/Wholesale O Store International	Birmingham, AL
10196	S R C Service I N C C	Columbia, SC
97446	Sanders Employee Benefits	Troy, AL
99601	Scotch Lumber Co.	Fulton, AL
03712	Senior Partners	Birmingham, AL
12494	Seniors First	Birmingham, AL
97501	Shaw Industries	Dalton, GA
03427	SIMA	Chattanooga, TN
01523	Southeast Health Plan Ins.	Birmingham, AL
03382	Southern Administrative Services	Columbus, GA
97985	Southern Alum Castings	Bay Minette, AL
10292	Southern Benefits Service	Birmingham, AL
00514	State Farm Insurance Company	Birmingham, AL
12492	Strategic Resource Company	Columbia, SC
97288	Sunshine Homes	Red Bay, AL
03718	Tennessee Laborers Health & Welfare Trust Fund	Goodlettsville, TN
10763	Third Party Claims Mgt.	Youngstown, OH
13301	Third Party Management	Oklahoma City, OK
00531	Time Insurance Company	Milwaukee, WI
10571	Travelers	Charlotte, NC
97460	Tyson Foods	Boaz, AL
98756	Tyson Foods	Gadsden, AL
98790	Tyson Foods	Oxford, AL
98907	Tyson Foods	Ashland, AL
98928	Tyson Foods	Heflin, AL
98929	Tyson Foods	Blountsville, AL
98930	Tyson Foods	Ashland, AL
10501	U S A Health Plan	Mobile, AL
00337	Unicare	Springfield, MA
00779	Unicare	Fort Scott, KS
00544	Union Bakers Insurance Company	Dallas, TX
00546	Union Fidelity Life Insurance	Trevose, PA
00550	Union National Life Insurance Company	Baton Rouge, LA
00553	United American Insurance Company	McKinney, TX
01740	United Food and Com Workers	Atlanta, GA
01582	United Health Care	Birmingham, AL
01264	United Ins. Of America	Baton Rouge, LA
10040	United Insurance Co. Of Amer.	Baton Rouge, LA
03478	United Medical Resources	Cincinnati, OH
05001	United Mine Workers	Van Nuys, CA
05018	United Mine Workers	Duluth, MN
01002	United of Omaha	Omaha, NE
98876	Utility Trailer Corporation	Enterprise, AL
10942	Value RX	Bloomfield Hills, MI

Company Code	***Company Name***	***City, State***
13297	Viva Health	Birmingham, AL
03485	W H Shepherd Company	Birmingham, AL
01934	Wal-Mart Group Health Plan	Bentonville, AR
01046	Wausau Ins. Co.	Wausau, WI
99684	Wayne Poultry Co.	Decatur, AL
99685	Wayne Poultry Co.	Union Springs, AL
97220	Webb Wheel Products	Cullman, AL

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L AVRS Quick Reference Guide

The Alabama Medicaid Automated Voice Response System (AVRS) enables providers to access information regarding check amount, claim status, recipient eligibility, third party resources, drug and procedure code pricing, and prior authorization requirements. When you dial 1(800) 727-7848, you can access this information 18-20 hours per day, seven days a week. This guide is intended to help you use AVRS quickly, accurately, and efficiently.

This quick reference guide consists of the following sections:

In This Section	***You Can Find Out About***
AVRS Basics	General information, such as hours of operations and the type of information available on AVRS; AVRS spoken requests and responses; function keys; and time-outs, invalid data, and errors. **Please note the alphabetic table in Section L.1.3, Special Function Keys, which provides a number combination for each letter of the alphabet. Providers who must enter alphabetic characters in AVRS should refer to this section for instructions.**
Accessing AVRS	Using the main menu and entering a valid provider number. **You must enter a valid provider number to access any AVRS information. Only Option 0, the Provider Assistance Center, will be available to callers who do not enter a valid provider number.**
Verifying Check Amount	Selecting the appropriate main menu option and entering valid data to verify check amounts.
Accessing Claims Status	Selecting the appropriate main menu option and entering valid data to verify claims status.
Verifying Recipient Eligibility	Selecting the appropriate main menu option and entering valid data to verify recipient eligibility. **Providers have the option of receiving the eligibility response via fax. The instructions are included in this section.**
Accessing Pricing Information	Selecting the appropriate menu options and entering valid data to access pricing information for NDCs or procedure codes.
Accessing Prior Authorization Information	Selecting the appropriate menu option and entering valid data to access information about approved prior authorizations.
Accessing Household Information	Selecting the appropriate menu options and entering valid data to access information for recipient household members.

NOTE:

All AVRS responses are based on the information entered by the caller. Data is provided for informational purposes and is current only as of the inquiry date. This information is not a guarantee of payment. Claims submitted for payment are subject to system audits (medical policy), edits, and applicable limitations.

L.1 AVRS Basics

This section provides general information about AVRS that will help you use AVRS more efficiently and effectively. It provides general information on how to access AVRS and what information is provided and describes AVRS spoken requests and responses, special function keys, and global messages. Of particular importance is the alphabetic table, described in Section L.1.2, Special Function Keys, providing number combinations corresponding to the letters of the alphabet. Providers who must enter data that contains both numbers and letters should read this section.

L.1.1 General Information

AVRS is available approximately 18-20 hours per day, 7 days per week. Scheduled down times usually occur during off-peak hours, such as late at night or very early in the morning.

To access AVRS, you must use a touch tone phone. Providers with rotary dial phones should contact the EDS Provider Assistance Center, from 8:00 a.m. until 5:00 p.m., Monday through Friday. For Pharmacy Providers only, the Pharmacy Help Desk is also available on Saturdays, 9:00 AM to 5:00 PM and can be accessed by dialing 1(800) 456-1242. Please refer to the Alabama Medicaid Provider Insider, a quarterly bulletin sent to Alabama Medicaid providers, for holiday schedules.

NOTE:

It is important to have all necessary information on hand prior to calling AVRS. AVRS is designed to give callers several chances to enter or correct data; however, the system will terminate the call if you fail to enter correct data within the allowed number of attempts, or if you cause the system to time-out. Please refer to Section L.1.4, Time-outs, Invalid Data, and Errors, for more information.

AVRS enables callers to access the following data:

Press Menu Option	*To Retrieve Information About*
1	Check amount, including check amount for the current checkwrite, and the number of suspended claims and total pending billed amount for the current checkwrite.
2	Claim status, including the following information for pharmacy, Medicare-related, and non-Medicare related claims: • Paid amount and checkwrite date for paid claims • Message that the claim is in process for suspended claims • EOB codes and EOP date for claim denials • Procedure code that denied (for non-pharmacy claims, as appropriate) • ICN and date the claim was voided for voided claims • ICN and date the claim was refunded for refunded claims

Press Menu Option	*To Retrieve Information About*
3	Recipient eligibility verification, including the following eligibility information: • Check digit for recipient number entered • Recipient last and first names • Current recipient number and check digit • Issue number for recipient ID card • Recipient date of birth and sex • Eligibility start and stop dates corresponding to the month of eligibility entered • Screening information • County code
3 (cont.)	Message to indicate whether recipient has other insurance (if recipient has other insurance, providers should access the Other Insurance menu option that follows the eligibility response) Maternity Care information, if applicable • Recipient aid category • Lock-in, lock-out, Long Term Care, and waiver information • Managed care information, including plan, PMP name, phone number, and 24-hour phone number; includes Medicare HMO information. At the end of the verification response, you may also retrieve the following recipient information using the recipient sub-menu: • **Benefit limits** (option 2 on the sub-menu), including inpatient, outpatient, and physician counts; eyeglass limitation counts; and other counts • **Other insurance** (option 3 on the sub-menu), including Medicare information, HIC number, and the following third party policy information (for up to three policies): – Policy number – Company code – Subscriber name and SSN – Coverage dates – Policy coverage information – Coverage limitation (values are No restriction; Accident; Cancer; Medicare Supplement; and Managed Care) – Health Insurance Premium (HIP) information
4	Drug pricing information for the dispense date entered
5	Procedure code pricing information, including prior authorization requirements
6	Prior authorization verification, including recipient number, procedure code or NDC, start date, stop date, units authorized, and units used for the PA number entered
7	Recipient household members. Allows the user to find a recipient Medicaid number for a member of the recipient's household. Information returned includes the following: - recipient number - name - date of birth - sex - race - certifying program.

L.1.2 AVRS Spoken Requests and Responses

AVRS provides a spoken response to queries entered using a touch tone phone. Based on the information you enter, or the menu options you select, AVRS will provide a custom response. AVRS does this by translating responses to the data you enter into speech patterns.

Messages are spoken as recorded, because these do not change. However, other words, such as names, are spelled out. For instance, AVRS translates the last name “Doe” as D-O-E.

Likewise, AVRS speaks number values one number at a time. For example, the number ‘155’ is spoken as ‘one-five-five’, rather than ‘one hundred fifty-five’.

If the response represents a dollar amount, AVRS provides the response in a monetary format. For example, the dollar value ‘128432’ is represented as ‘one thousand, two hundred eighty-four dollars and thirty-two cents’.

AVRS translates date responses in a Gregorian format (the manner in which most of us express dates). For instance, the date ‘05/14/99’ is spoken as ‘May fourteenth, nineteen ninety-nine’.

L.1.3 Special Function Keys

You will receive better, faster results using AVRS if you understand how to use the following special function keys.

End of Data

Because the length of data you enter may vary (for instance, most providers have nine-digit numbers, but some have eight-digit numbers), you must signal AVRS when you have finished entering data. The pound sign (#) is the symbol you use to do this. You should always enter the pound sign key to mark the end of the data you have just entered. The following examples illustrate how to use the pound sign (#) to mark the end of data:

To enter provider number 123456789	Press 123456789#
To enter procedure code 11111	Press 11111#

Repeat Response or Prompt

AVRS is designed to provide you the information you need by using a series of prompts and responses. The system ‘speaks’ requests to you, such as available menu options, or a request to enter data. If you want AVRS to repeat the message, press the asterisk (*) key on your touch tone phone.

Alphabetic Data

AVRS uses information keyed on a touch tone phone, which does not provide a key for each letter of the alphabet. Sometimes, you will have to enter data that contains letters as well as numbers (for instance, some provider numbers contain letters and numbers). To do this, you must use a combination of the asterisk (*) key and **two** numbers to represent a particular letter.

The table below describes the number combinations that represent the letters of the alphabet:

A - *21	G - *41	M - *61	S - *73	Y - *93
B - *22	H - *42	N - *62	T - *81	Z - *12
C - *23	I - *43	O - *63	U - *82	
D - *31	J - *51	P - *71	V- *83	
E - *32	K - *52	Q - *11	W - *91	
F - *33	L - *53	R - *72	X - *92	

Using this table as a guide, enter data with a combination of letters and number in the following way:

Actual Provider Number	ABC0099D
Enter the following in AVRS	*21 *22 *23 0099 *31
AVRS reads back this number	ABC0099D

Void Data

If you enter a string of data (for instance, a provider number or recipient number), and make a mistake, enter two asterisks (**) to indicate that all the data you have entered in the current field should be deleted, and the data following the asterisk should be used in its place. This does not delete any data you entered as a result of a previous AVRS prompt. The following example demonstrates this functionality:

You enter	1245**123456789
AVRS reads back this number	123456789
You enter	*21224***22224
AVRS reads back this number	B224

Cancel Function

To cancel a transaction, press *99# at any prompt. AVRS will return to the main menu.

L.1.4 Time-outs, Invalid Data, and Errors

AVRS can respond only to what is entered by you, the caller. To receive information from AVRS, you must enter valid data in the correct format. When you make an error or fail to enter information when prompted, AVRS gives you another chance to correct the mistake. If you do not correct the error or respond in a timely fashion, AVRS will end the call.

Maximum Errors Exceeded

You have three chances to enter correct data when prompted. If you exceed the limit, AVRS plays the following message:

> *We're sorry – the data you entered is invalid. If you would like assistance from the Provider Assistance Center, press 0.*

If you press 0, AVRS transfers you to the Provider Assistance Center, which will assist you during normal business hours. If you do not press 0 within 10 seconds, AVRS ends the call.

Maximum Time-outs Exceeded

You have ten seconds to enter requested data. The first time you exceed this limit, AVRS prompts you to enter the data. If you exceed the limit a second time, AVRS plays the following message:

> *You have not responded with the requested information. If you would like assistance from the Provider Assistance Center, press 0.*

If you press 0, AVRS transfers you to the Provider Assistance Center, which will assist you during normal business hours. If you do not press 0 within 10 seconds, AVRS ends the call.

Invalid Data

If you enter a value that is not described as a menu option (for instance, if you press '9' after listening to the main menu, when '9' is not a valid option), AVRS plays the following:

> *Invalid option. Please re-enter.*

AVRS then replays the menu options.

Maximum Transactions Exceeded

To ensure AVRS is available to all providers, you are limited to ten (10) transactions per phone call. For each main menu item, AVRS counts **one** transaction using the following criteria:

- For 'Check Amount,' (Option 1), each time you enter a different provider number
- For 'Claims Status' (Option 2), each time you check another claim for the same recipient, or each time you check a claim for a different recipient
- For 'Recipient Eligibility Verification' (Option 3), each time you verify eligibility for a recipient
- For 'Drug Pricing Information' (Option 4), each time you enter an NDC
- For 'Procedure Code Pricing Information' (Option 5), each time you enter a procedure code
- For 'Prior Authorization Verification' (Option 6), each time you enter a prior authorization number
- For 'Household Inquiry' (Option 7), each time you request an inquiry for recipient household information

When you exceed the ten transaction limit, AVRS ends the call after playing the following message:

> *In order to serve as many callers as possible, we must limit the number of inquiries per call. Please call again for any additional inquiries you may have.*

L.2 Accessing the AVRS Main Menu

When you dial 1 (800) 727-7848 to access AVRS, the system supplies the following greeting:

> *Good morning (good afternoon, or good evening). Welcome to the Alabama Medicaid Voice Response Inquiry System.*

If the system is unavailable, the following message plays:

> *The Alabama Medicaid Voice Response Inquiry System is currently unavailable. Please call back later or call the Provider Assistance Center at 1 (800) 392-5741 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.*

If AVRS is available, the system provides the main menu. Callers may choose from the following menu options:

- Check amount (press 1)
- Claims status (press 2)
- Recipient eligibility verification (press 3)
- Drug pricing information (press 4)
- Procedure code pricing information (press 5)
- Prior authorization verification (press 6)
- Recipient Household Information (press 7)
- Provider Assistance Center (press 0)

Providers calling from a rotary phone are instructed to hold for the provider unit during normal business hours, or to call back during normal business hours to speak with a representative of the Provider Assistance Center.

L.3 Verifying a Check Amount

To verify a check amount, press 1 (the number one) from the Main Menu. AVRS prompts you to enter your Alabama Medicaid provider number. After AVRS verifies your provider number, the system returns the following information:

- Check amount for the current checkwrite
- Number of suspended claims and total pending billed amount for the current checkwrite

Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the checkwrite response
- Press 2 to obtain checkwrite information for another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

NOTE:

AVRS returns check amount information based on the payee, or billing provider number. You must have a valid payee provider number in order to complete a successful query. For group practices where several providers receive a single check, the check amount given will be for the entire group.

L.4 Accessing Claims Status

To access claims status, press 2 (the number two) from the Main Menu. AVRS prompts you for your billing provider number and the Alabama Medicaid recipient ID number entered on the claim form. Once you have entered this data, you may choose from the following options, as prompted by AVRS:

- Press 1 for pharmacy claims
- Press 2 for non-Medicare related claims
- Press 3 for Medicare related claims
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

L.4.1 Pharmacy Claim Status

To access claims status for pharmacy claims, you must enter the following data:

- Eleven-digit NDC, followed by the pound sign
- Dispensed date in MMDDCCYY format, followed by the pound sign
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and EOP date for claim denials

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.2 Non-Medicare Claim Status

To access claims status for non-Medicare claims, you must enter the following data:

- From date of service in MMDDCCYY format, followed by the pound sign.
- Through date of service in MMDDCCYY format, followed by the pound sign.
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one or more of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and EOP date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Paid amount, checkwrite date, and ICN for partially paid claims
- Line item, procedure or revenue code, and paid amount for each paid detail on a partially paid claim
- Line item, procedure or revenue code, and EOB code for each denied detail on a partially paid claim

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.3 Medicare Claim Status

To access claims status for non-Medicare claims, you must enter the following data:

- From date of service in MMDDCCYY format, followed by the pound sign.
- Through date of service in MMDDCCYY format, followed by the pound sign.
- Allowed amount, from your Explanation of Medicare Benefits, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one or more of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and EOP date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Message that claim has been voided, and the ICN for voided claim
- Message that claim has been partially refunded and ICN for partially refunded claim
- Message that claim has been fully refunded, and ICN for previous paid claim

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.4 Verifying Recipient Eligibility

To verify recipient eligibility, press 3 (the number three) from the Main Menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- A valid Alabama Medicaid recipient number, followed by the pound sign
- Eligibility date, either for the current month (simply press the pound (#) sign) or for a previous month for which you must enter the date in mmccyy format, followed by the pound sign
- Patient account number, if applicable (to bypass this, simply press the pound (#) sign)

NOTE:

The patient account number is an optional field. It reflects your internal patient account number. You may find it helpful to enter this number if you wish to receive a fax response and would like the number to display on the response. You may enter a maximum of 15 digits.

AVRS verifies the data you entered (except for the patient account number) and returns a message if the recipient is not eligible for the eligibility dates entered. If the recipient is eligible, you may choose from the following options, as prompted by AVRS:

- Press 1 for eligibility information
- Press 2 for benefit limits
- Press 3 for other insurance
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

L.4.5 General Eligibility Information

You can receive a faxed copy of the eligibility response. Instructions are provided below. AVRS provides the following eligibility information for the recipient number entered:

- Check digit for recipient number entered
- Recipient last and first names
- Current recipient number and check digit
- Issue number for recipient ID card
- Recipient date of birth and sex
- Eligibility start and stop dates corresponding to the month of eligibility entered
- County code
- Message to indicate whether recipient has other insurance (if recipient has other insurance, providers should access the Other Insurance menu option that follows the eligibility response)
- Maternity Care information, if applicable
- Recipient aid category
- Lock-in, lock-out, Long Term Care, and waiver information
- Managed care information, including plan name, PMP name, PMP phone number, and 24-hour phone number; includes Medicare HMO coverage.

Once the response has played, you may choose from the following options, prompted by AVRS:

- Press 1 to repeat the message
- Press 2 to receive a fax of the eligibility information
- Press 3 to continue

Receiving a Fax

When you select Option 2, AVRS prompts you to enter your ten-digit fax number (three-digit area code plus the seven-digit number), followed by the pound (#) sign. The system will send a fax transmission to the number you entered and will repeat the menu options listed above.

Selecting Option 3 to Continue

Option 3 accesses a menu that enables you to do the following:

- Press 1 to continue researching eligibility, such as benefit limits or other insurance, for the same recipient
- Press 2 to verify eligibility for another recipient
- Press 3 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

If you select Option 1, AVRS allows you to check benefit limits or other insurance for the recipient number you entered.

L.4.6 Benefit Limits

To access benefit limits for the recipient number you entered, choose from the following options:

- Press 1 for inpatient, outpatient, and physician counts
- Press 2 for eyeglass limitation counts
- Press 3 for dental limits
- Press 4 for other counts
- Press 5 to repeat the message
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

If you choose options 1-4, AVRS responds with the applicable limitation information, then prompts you to select from the following:

- Press 1 to repeat the response
- Press 2 to receive a fax
- Press 3 to inquire on other limits for the recipient you entered
- Press 4 to continue

To receive a fax, select the appropriate option and enter your ten-digit fax number (three-digit area code plus seven-digit number), followed by the pound sign. If you select Option 4 (to continue), AVRS allows you to request another type of recipient information for the same recipient; check eligibility for another recipient; enter another provider number; return to the Main Menu; speak with a Provider Assistance Center representative; or end the call.

Inpatient, Outpatient, and Physician Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Inpatient hospital days
- Outpatient hospital days
- Physician office visits

Eyeglass Limitation Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Eyeglass frames
- Eyeglass lenses
- Eyeglass fitting exams
- Eyeglass exams

Other Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Home health visits
- Ambulatory surgery center visits
- Dialysis services

Screening Information

AVRS provides the last EPSDT screening date for the following screening types:

- Medical screening
- Dental screening
- Hearing screening

Please note that EPSDT screenings for recipients under three years of age occur more frequently than yearly. Please refer to Appendix A, EPSDT, for screening schedules.

L.4.7 Other Insurance

AVRS provides Medicare and non-Medicare related information when you select the Other Insurance option. First, AVRS will identify whether the recipient you entered has no Medicare coverage, Medicare Part A, Medicare Part B, or both A and B. If the recipient has Medicare coverage, AVRS provides the Medicare HIC number.

AVRS then indicates the number of third party policies on file for the recipient. AVRS will provide the following information for up to three (3) third party policies:

- Policy number
- Company code
- Subscriber name and SSN
- Coverage dates
- Policy coverage information
- Coverage limitation (values are No restriction; Accident; Cancer; Medicare Supplement; and Managed Care)
- Health Insurance Premium (HIP) information

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the response
- Press 2 to receive a fax
- Press 3 to continue

To receive a fax, select the appropriate option and enter your ten-digit fax number (three-digit area code plus seven-digit number), followed by the pound sign. If you select Option 3 (to continue), AVRS allows you to request another type of recipient information for the same recipient; check eligibility for another recipient; enter another provider number; return to the Main Menu; speak with a Provider Assistance Center representative; or end the call.

L.5 Accessing Pricing Information

AVRS allows you to verify pricing information for NDCs and procedure codes.

L.5.1 Drug Pricing

To verify pricing information for drugs, press 4 (the number 4) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- A valid, 11-digit NDC, followed by the pound sign
- The dispense date in MMDDCCYY format, followed by the pound sign.

AVRS performs a query and responds with the MAC price on file and whether the NDC requires a prior authorization. The system then allows you to choose from the following options:

- Press 1 to repeat the message
- Press 2 to check another NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.5.2 Procedure Code Pricing

To verify pricing information for procedure codes, press 5 (the number 5) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- A valid, five-digit procedure code, followed by the pound sign
- The date of service in MMDDCCYY format, followed by the pound sign.
- The type of service code, followed by the pound sign.

AVRS performs a query and responds with the price on file and whether the procedure code requires a prior authorization. The system then allows you to choose from the following options:

- Press 1 to repeat the message
- Press 2 to check another procedure code for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

NOTE:

A cross-reference table for type of service to procedure codes is included at the end of this Quick Reference Guide. Please ensure that your selection matches the procedure code for which you are requesting pricing information.

L.6 Inquiring About Prior Authorization Information

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- The ten-digit prior authorization number, followed by the pound sign

AVRS performs a query and responds with the following information for the PA:

- Recipient number
- Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)
- Start and stop dates
- Units authorized
- Dollars Authorized
- Units used
- Dollars Used

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another Procedure Code or NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.7 Recipient Household Inquiry

To request information about recipient household members, press 7 (the number 7) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- The parent/guardian's 12-digit recipient Medicaid number or the parent/guardian's 9-digit Social Security Number, followed by the pound sign
- The household member's date of birth

AVRS performs a query and responds with the following information for the household inquiry:

- Recipient Number
- Recipient Name
- Recipient Date of Birth
- Recipient Race
- Recipient Sex
- Certifying Program

When the response concludes, AVRS provides you with the following options:

- To continue, press 1.
- To repeat the message just heard, press 2.
- To hear the previous recipient's information, press 3.
- To repeat this recipient's information, press 4.
- To enter another provider number, press 5.
- To perform another transaction with a different recipient, press 6.
- To enter another Date of Birth for the same parent/guardian, press 7.
- To return to the main menu, press 9.
- To speak to a Provider Assistance Center representative, press 0.

L.8 Type of Service Cross Reference Table

Inclusion or exclusion of a procedure, supply, product, or service does not imply Medicaid coverage or reimbursement. The pricing file must be verified to determine coverage and reimbursement amounts.

If you bill on a CMS-1500 or Medical Medicaid/Medicare-related Claim Form, use the TOS identified for the procedure on the TOS Cross Reference Table below, except for Medical Medicaid/Medicare-related claims for Ambulatory Surgical Centers, use TOS S.

To verify coverage and reimbursement for the professional component (Modifier 26) of a procedure, use TOS X.

To verify coverage and reimbursement for the technical component (Modifier TC) of a procedure, use TOS S.

To verify coverage and reimbursement for the rental (Modifier RR) of a Durable Medical Equipment procedure, use TOS R.

To verify coverage and reimbursement for maintenance (Modifier MS) of a Durable Medical Equipment procedure, use TOS R.

To compute reimbursement for the surgical assistant fees (Modifiers 80, 81, or 82) of a procedure, use the TOS given on the table for the procedure to determine the reimbursement rate for the procedure, then multiple the rate for the procedure by 16%.

The administrative fee for the Vaccine for Children program is $8.00 for all procedures. The price listed for TOS 1 is not applicable for VFC.

If you bill on a UB-92 or Institutional Medicaid/Medicare-related Claim Form, use TOS “S” for all procedures except for:

- Injectable drugs use TOS given on the table
- Home health providers use TOS given on the table

If you bill on the dental claim, use TOS D.

FROM PROCEDURE	TO PROCEDURE	TOS
0001F	0011F	9
0500F	0500F	9
0501F	0503F	1
1000F	1008F	1
2000F	2004F	1
3000F	3002F	1
4000F	4003F	1
4006F	4006F	1
4009F	4009F	1
4011F	4011F	2
4012F	4012F	1
4014F	4018F	1
0001T	0002T	2
0003T	0003T	9
0005T	0009T	2
0010T	0010T	5
0012T	0020T	2
0021T	0021T	1
0023T	0023T	5
0024T	0024T	2
0025T	0026T	9
0027T	0027T	4
0028T	0028T	9
0029T	0029T	9
0030T	0030T	5
0031T	0041T	2

FROM PROCEDURE	TO PROCEDURE	TOS
0042T	0042T	4
0043T	0043T	9
0044T	0044T	9
0045T	0057T	2
0058T	0058T	5
0059T	0063T	2
0064T	0064T	1
0065T	0065T	2
0066T	0072T	4
0073T	0073T	1
0074T	0076T	6
0077T	0080T	2
0081T	0083T	6
0084T	0084T	5
0085T	0085T	1
0086T	0086T	5
0087T	0088T	6
0089T	0102T	2
0103T	0117T	9
0120T	0124T	2
0126T	0126T	9
0130T	0130T	9
0133T	0133T	2
0135T	0135T	2
0137T	0137T	2
0140T	0144T	2
0145T	0153T	4
0154T	0154T	9
00100	01999	7
10000	36414	2
36415	36415	5
36416	63689	2
63690	63691	5
63692	69979	2
69990	69990	2
70010	75893	4
75894	75896	6
75897	75898	4
75900	75900	6
75901	75901	4
75902	75955	6
75956	75958	4
75959	75969	6
75970	75971	4
75978	75990	6
75992	76081	4
76082	76083	1
76084	76091	4
76092	76092	C
76093	76935	4
76936	76943	6

FROM PROCEDURE	TO PROCEDURE	TOS
76945	76945	4
76946	76965	6
76970	77260	4
77261	77799	6
78000	78999	4
79000	79999	6
80002	80440	5
80500	80502	3
81000	88319	5
88321	88334	3
88342	89399	5
90000	90654	1
90655	90660	V
90665	90665	1
90669	90669	V
90675	90723	1
90724	90724	V
90725	90731	1
90732	90732	V
90733	90749	1
90760	90761	1
90765	90768	1
90772	90775	1
90779	90779	1
90780	90799	1
90801	90899	1
90901	90911	1
90918	90921	M
90922	90999	1
91000	91021	2
91022	91022	1
91023	91033	2
91034	91038	1
91040	91040	5
91052	91110	2
91120	91120	5
91122	91299	2
92002	92510	1
92511	92511	2
92512	92534	1
92541	92596	5
92597	92598	1
92599	92599	5
92601	92610	1
92611	92616	2
92617	92617	1
92620	92621	1
92625	92627	1
92630	92630	1
92633	92633	1
92700	92700	1

FROM PROCEDURE	TO PROCEDURE	TOS
92950	92974	1
92975	92998	2
93000	93350	5
93501	93612	2
93613	93613	5
93614	93659	2
93660	93661	5
93662	93667	2
93668	93668	9
93669	93726	5
93727	93727	1
93728	93740	5
93741	93744	1
93745	94621	5
94640	94668	1
94680	94799	5
95000	95199	1
95250	95250	1
95251	95251	5
95805	96004	5
96100	96117	1
96118	96120	5
96150	96155	1
96400	96912	1
96913	96913	5
96920	96921	2
96922	96922	1
96999	97804	1
97810	97814	1
98925	99069	1
99070	99071	9
99075	99091	1
99100	99145	7
99148	99150	7
99170	99170	5
99172	99173	Q
99175	99199	1
99201	99239	1
99241	99275	3
99281	99440	1
99450	99456	9
99499	99539	1
99551	99569	9
99600	99600	1
99601	99602	9
A0010	A0999	9
A1344	A1344	9
A2000	A2000	1
A4035	A4035	9
A4190	A4205	9
A4206	A4212	P

FROM PROCEDURE	TO PROCEDURE	TOS
A4213	A4213	9
A4214	A4214	P
A4215	A4222	9
A4223	A4223	P
A4230	A4300	9
A4301	A4457	P
A4458	A4458	S
A4459	A4460	P
A4462	A4462	P
A4464	A4519	P
A4520	A4538	9
A4539	A4595	P
A4605	A4605	9
A4606	A4608	P
A4610	A4610	9
A4611	A4613	P
A4614	A4614	9
A4615	A4641	P
A4642	A4643	9
A4644	A4649	P
A4650	A4930	L
A4931	A4931	9
A4932	A4932	P
A5051	A5507	P
A5508	A5513	J
A6000	A6000	P
A6010	A6024	S
A6025	A6025	9
A6154	A6407	S
A6410	A6410	S
A6411	A6411	Q
A6412	A6412	S
A6421	A6422	S
A6424	A6424	S
A6426	A6426	S
A6428	A6428	S
A6430	A6430	S
A6432	A6432	S
A6434	A6434	S
A6436	A6436	S
A6438	A6438	S
A6440	A6457	S
A6501	A6511	S
A6512	A6513	P
A6530	A6544	P
A6549	A6549	P
A6550	A6551	P
A7000	A7020	P
A7025	A7026	P
A7030	A7046	P
A7501	A7509	P

FROM PROCEDURE	TO PROCEDURE	TOS
A7520	A7525	P
A7526	A7526	9
A9150	A9190	9
A9270	A9300	9
A9500	A9521	4
A9522	A9522	6
A9523	A9523	4
A9524	A9524	6
A9525	A9533	4
A9534	A9534	6
A9535	A9561	4
A9562	A9563	4
A9564	A9567	4
A9698	A9698	4
A9600	A9605	6
A9699	A9699	9
A9700	A9700	4
A9900	A9901	9
A9999	A9999	E
ATP02	ATP22	5
B4034	B4099	P
B4100	B4104	E
B4149	B4149	E
B4150	B4156	P
B4157	B4162	E
B4164	B5200	P
B9000	B9999	9
C0001	C9999	S
D0110	D9999	D (see *)
E0100	E0143	P
E0144	E0144	R
E0145	E0326	P
E0350	E0352	9
E0370	E0373	P
E0424	E0435	P
E0439	E0445	P
E0450	E0455	P
E0457	E0550	P
E0555	E0565	P
E0570	E0589	P
E0590	E0590	R
E0591	E0601	P
E0602	E0602	9
E0603	E0616	P
E0617	E0617	9
E0618	E0731	P
E0740	E0740	9
E0744	E0783	P
E0784	E0786	9
E0787	E1389	P
E1390	E1390	R

FROM PROCEDURE	TO PROCEDURE	TOS
E1391	E1499	P
E1500	E1500	L
E1501	E1636	P
E1637	E1639	L
E1640	E1702	P
E1800	E1841	P
E1900	E1900	P
E1902	E1902	9
E2000	E2599	P
E2601	E2621	P
E8000	E8002	P
GV263	GV263	9
G0001	G0001	5
G0002	G0002	2
G0004	G0007	5
G0008	G0009	V
G0010	G0010	1
G0015	G0016	5
G0025	G0025	P
G0026	G0027	5
G0030	G0050	4
G0051	G0053	2
G0054	G0060	5
G0061	G0061	2
G0062	G0063	4
G0064	G0066	1
G0071	G0094	1
G0095	G0098	5
G0100	G0100	5
G0101	G0102	1
G0103	G0103	5
G0104	G0105	2
G0106	G0106	4
G0107	G0107	5
G0108	G0113	1
G0114	G0114	3
G0115	G0118	1
G0120	G0120	4
G0121	G0121	2
G0122	G0122	4
G0123	G0124	5
G0125	G0126	4
G0127	G0127	2
G0128	G0128	1
G0129	G0129	9
G0130	G0132	4
G0133	G0133	9
G0141	G0148	5
G0151	G0156	1
G0159	G0160	2
G0161	G0161	6

FROM PROCEDURE	TO PROCEDURE	TOS
G0163	G0165	4
G0166	G0169	1
G0170	G0171	2
G0172	G0172	9
G0173	G0174	2
G0175	G0175	1
G0176	G0179	U
G0180	G0182	1
G0183	G0188	2
G0190	G0202	1
G0204	G0236	4
G0237	G0241	1
G0242	G0243	2
G0244	G0247	1
G0248	G0248	S
G0249	G0249	1
G0250	G0254	4
G0255	G0255	2
G0256	G0259	1
G0260	G0260	2
G0261	G0261	4
G0262	G0263	1
G0264	G0266	5
G0267	G0271	1
G0272	G0273	6
G0274	G0275	2
G0278	G0279	5
G0280	G0283	1
G0288	G0290	2
G0291	G0291	1
G0292	G0293	2
G0294	G0295	1
G0296	G0299	2
G0300	G0304	1
G0305	G0306	5
G0307	G0327	1
G0328	G0328	5
G0329	G0329	4
G0336	G0337	1
G0341	G0343	2
G0344	G0363	1
G0364	G0364	2
G0365	G0367	5
G0368	G0372	1
G0374	G0379	1
G3001	G3001	1
G8000	G8199	1
G9001	G9036	1
G9041	G9044	1
G9050	G9130	1
H0001	H0048	9

FROM PROCEDURE	TO PROCEDURE	TOS
H1000	H1005	9
H1010	H1011	9
H2000	H2000	9
H2001	H2001	1
H2002	H2099	9
H5010	H5010	P
H5030	H5030	1
H5060	H5060	1
H5300	H5300	U
J0110	J0110	1
J0120	J7508	1
J7509	J7510	G
J7511	J7511	1
J7512	J7599	G
J7608	J7617	1
J7618	J7619	1
J7620	J7627	9
J7628	J7629	1
J7630	J7630	9
J7631	J7631	1
J7632	J7634	9
J7635	J7639	1
J7640	J7641	9
J7642	J7644	1
J7645	J7647	9
J7648	J7649	1
J7650	J7657	9
J7658	J7659	1
J7668	J7669	1
J7670	J7670	9
J7674	J7674	1
J7675	J7679	9
J7680	J7684	1
J7685	J7799	9
J8499	J9999	1
KOO16	KOO16	P
KOO53	KOO53	P
K0001	K0009	P
K0010	K0045	P
K0047	K0118	P
K0119	K0125	G
K0126	K0165	P
K0166	K0167	G
K0168	K0284	P
K0285	K0285	9
K0400	K0400	P
K0401	K0401	J
K0402	K0406	S
K0407	K0412	P
K0417	K0452	P
K0453	K0453	1

FROM PROCEDURE	TO PROCEDURE	TOS
K0455	K0455	R
K0456	K0461	P
K0462	K0462	9
K0501	K0530	P
K0531	K0534	R
K0538	K0559	P
K0581	K0597	P
K0601	K0608	P
K0609	K0609	L
K0615	K0618	P
K0619	K0620	S
K0627	K0669	P
K0730	K0732	P
L0100	L8699	P
L9900	L9900	9
M0005	M0101	1
M0300	M0301	2
M0302	M0302	5
M0702	M0702	1
P0023	P2025	5
P2028	P7001	5
P9010	P9040	0
P9041	P9052	9
P9053	P9053	0
P9054	P9054	9
P9055	P9057	0
P9058	P9060	9
P9603	P9615	5
Q0005	Q0009	1
Q0020	Q0034	1
Q0035	Q0035	5
Q0036	Q0047	1
Q0059	Q0062	2
Q0068	Q0068	5
Q0081	Q0086	1
Q0091	Q0091	1
Q0092	Q0092	4
Q0093	Q0094	1
Q0095	Q0102	5
Q0103	Q0104	1
Q0105	Q0107	P
Q0108	Q0110	1
Q0111	Q0116	5
Q0117	Q0123	1
Q0124	Q0124	V
Q0125	Q0125	1
Q0126	Q0126	5
Q0132	Q0132	1
Q0134	Q0134	P
Q0136	Q0137	1
Q0144	Q0144	1

FROM PROCEDURE	TO PROCEDURE	TOS
Q0156	Q0158	1
Q0160	Q0161	1
Q0163	Q0181	1
Q0182	Q0185	S
Q0186	Q0187	1
Q0480	Q0499	P
Q0500	Q0505	P
Q0510	Q0510	1
Q0511	Q0515	1
Q1001	Q1005	F
Q2001	Q2022	1
Q3000	Q3012	4
Q3014	Q3020	9
Q3021	Q3026	1
Q3031	Q3031	S
Q4001	Q4051	S
Q4052	Q4055	1
Q4075	Q4079	1
Q4080	Q4099	1
Q9920	Q9964	1
R0070	R0076	4
S0016	S0077	1
S0079	S0087	1
S0088	S0107	9
S0108	S0108	1
S0109	S0111	9
S0112	S0112	1
S0113	S0113	9
S0114	S0115	1
S0116	S0116	9
S0117	S0118	1
S0122	S0135	1
S0136	S0155	9
S0158	S0169	1
S0170	S0170	1
S0171	S0187	9
S0189	S0189	1
S0190	S0194	1
S0195	S0195	9
S0196	S0199	1
S0201	S0201	9
S0206	S0206	2
S0207	S0395	9
S0400	S0400	Q
S0500	S0622	9
S0625	S0625	9
S0812	S0812	Q
S1001	S1002	P
S1025	S1025	1
S1030	S1031	P
S1040	S1040	9

Deleted: ~~Q4080~~
Added: Q4099

Deleted: ~~S2065~~
Added: S2067

Added: S3800, S3800, 5

FROM PROCEDURE	TO PROCEDURE	TOS
S2065	S2067	2
S2068	S2068	2
S2078	S2079	2
S2070	S2070	9
S2075	S2077	9
S2080	S2080	9
S2082	S2083	2
S2085	S2085	9
S2090	S2091	9
S2095	S2095	9
S2107	S2107	9
S2112	S2112	2
S2113	S2117	9
S2115	S2115	9
S2130	S2130	9
S2131	S2131	2
S2135	S2135	9
S2150	S2261	9
S2262	S2262	2
S2263	S2264	9
S2265	S2267	2
S2268	S2363	9
S2400	S2411	2
S2900	S2900	2
S3000	S3000	9
S3005	S3005	1
S3600	S3701	9
S3800	S3800	5
S3818	S3819	5
S3820	S3889	9
S3890	S3890	5
S3891	S7049	9
S7050	S7050	S
S7051	S8030	9
S8037	S8037	4
S8042	S8042	9
S8055	S8264	9
S8265	S8265	S
S8266	S8432	9
S8433	S8433	P
S8434	S9119	9
S9120	S9120	P
S9121	S9561	9
S9562	S9562	1
S9563	S9589	9
S9590	S9590	1
S9591	S9801	9
S9802	S9802	1
S9803	S9904	9
S9905	S9908	S
S9909	S9989	9

FROM PROCEDURE	TO PROCEDURE	TOS
T1000	T1014	9
T1015	T1015	1
T1016	T1031	9
T1500	T1503	9
T1999	T2099	9
T2101	T2101	9
T4521	T4542	9
T5001	T5001	9
T5999	T5999	9
V0100	V0105	1
V2020	V2025	9
V2100	V2118	9
V2121	V2121	9
V2199	V2221	9
V2299	V2321	9
V2399	V2399	9
V2410	V2410	9
V2430	V2430	9
V2499	V2513	9
V2520	V2523	9
V2530	V2531	9
V2599	V2600	9
V2610	V2615	9
V2623	V2628	P
V2629	V2799	9
V5008	V5020	K
V5030	V5094	9
V5095	V5095	K
V5096	V5220	9
V5230	V5299	K
V5336	V5336	1
V5362	V5364	1
WW002	WW094	1
W0200	W4165	9
W9200	W9210	9
W9220	W9840	9
X0285	X0285	9
X1015	X1745	1
X2000	X2015	P
X2035	X2073	9
X2074	X2074	P
X2091	X2095	9
X2098	X2098	P
X2780	X2780	9
X2920	X2920	9
X4100	X4100	P
X4120	X4120	P
X4310	X4310	9
X5140	X5146	9
X6200	X6200	P
X6202	X6202	9

Deleted: ~~T1502~~
Added: T1503

FROM PROCEDURE	TO PROCEDURE	TOS
X6205	X6215	P
X6218	X6218	P
X6220	X6222	9
X6224	X6224	9
X6226	X6233	9
Y4100	Y8172	9
Z0001	Z4999	1
Z5015	Z5015	2
Z5027	Z5027	2
Z5061	Z5062	9
Z5064	Z5074	9
Z5076	Z5109	5
Z5114	Z5116	1
Z5117	Z5117	P
Z5119	Z5122	P
Z5124	Z5134	P
Z5135	Z5144	9
Z5145	Z5149	1
Z5150	Z5152	9
Z5153	Z5155	1
Z5158	Z5158	S
Z5159	Z5172	9
Z5173	Z5178	1
Z5179	Z5180	9
Z5181	Z5191	1
Z5192	Z5192	2
Z5193	Z5193	9
Z5194	Z5195	1
Z5196	Z5198	9
Z5199	Z5219	1
Z5220	Z5223	P
Z5225	Z5226	2
Z5227	Z5254	1
Z5255	Z5255	5
Z5256	Z5263	S
Z5264	Z5264	1
Z5265	Z5266	S
Z5267	Z5272	1
Z5273	Z5293	9
Z5294	Z5295	S
Z5296	Z5298	1
Z5299	Z5301	S
Z5302	Z5310	1
Z5311	Z5315	P
Z5316	Z5320	1
Z5321	Z5321	9
Z5322	Z5358	1
Z5363	Z5363	S
Z5365	Z5365	1
Z5367	Z5369	1
Z5370	Z5370	9

FROM PROCEDURE	TO PROCEDURE	TOS
Z5371	Z5371	1
Z5373	Z5381	1
Z5382	Z5382	2
Z5383	Z5391	1
Z5392	Z5392	9
Z5393	Z5396	1
Z5397	Z5399	9
Z5400	Z5400	P
Z5401	Z5410	1
Z5411	Z5411	S
Z5412	Z5413	1
Z5414	Z5430	S
Z5431	Z5438	1
Z5439	Z5439	P
Z5440	Z5442	1
Z5443	Z5448	9
Z5449	Z5475	1
Z5476	Z5476	9
Z5562	Z5562	2
Z7000	Z9501	9

*Only four dental procedure codes (D8080, D8680, D9310 and D9430) can be billed on a CMS claim form.

Modifier 26 – autoplug TOS X
Modifier TC – autoplug TOS S
Modifier RR – autoplug TOS R
Modifier MS – autoplug TOS R
Modifier SC – autoplug TOS Y -- do not convert to TOS Y for dates of service 01/01/04 and thereafter, use the value assigned on the grid.
Modifier UE – autoplug TOS A
Modifier 80, 81, or 82 – pay 16%
Modifier ZN – pay 155%

For UB-92 claims, autoplug TOS S, except for:

1) Injectable drugs, autoplug the TOS on the autoplug grid for the procedures in the following ranges:

2) Home Health providers, autoplug the TOS on the autoplug grid for the procedure

For dental claims, autoplug TOS D
For medical crossover claims for provider type 28, auto plug TOS S.
all dental codes were added to ensure we autoplugged a “D” for the 1st value of the procedure code. However, only four dental procedure codes can be billed on a HCFA claim form. They are: D8080, D8680, D9310 and D9430.

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N Alabama Medicaid Contact Information

N.1 Important Telephone Numbers for the Alabama Medicaid Agency

Dental Services 1-800-362-1504

Durable Medical Equipment

Administration 1-800-362-1504

Hospital, psychiatric, admission

Children/Adolescent 334-242-5196

Geriatric Inpatient 334-242-5196

Long Term Care 1-800-362-1504

- Home Health Services
- Hospice Services
- Personal Care (for children under 21 only)
- Private Duty Nursing (for children under 21 only)

Medical Services Customer Service 1-800-362-1504

- Adolescent Pregnancy Prevention
- Ambulatory Surgical Centers
- EPSDT (Early and periodic screening, diagnosis, and treatment/Child Health Checkups)
- Eye Care
- Family Planning
- Federally Qualified Heath Centers
- Hearing Services
- Hospital Program
- Laboratory Services

- Maternity Care Program
- Mental Health Services
- Partnership Hospital Program (PHP)
- Patient 1st
- Pharmacy Program
- Physician's Program
- Prenatal Care
- Prenatal Education
- Radiology Services
- Renal Dialysis
- Residential Treatment Facilities
- Rural Health Clinics
- Therapist, in home (for children under 21 only)
- Transplants
- Transportation, air (for children under 21 only)

Nursing Home Care

Administration of Program..... 1-800-362-1504

Admissions 334-242-5684

Prior Authorization ……..334-242-5441

Durable Medical Equipment 334-242-5949

Dental 334-353-4771

Eye Care 334-353-4650

Pharmacy Services (prior approval of drugs)..... 1-800-748-0130

Private Duty Nursing (for children under 21 only) 334-242-2366

Therapies, in home (for children under 21 only) 334-242-5196

Third Party Division 334-242-5314

Health Insurance Updates for last names A-G……334-242-5280

Health Insurance Updates for last names H-P……334-242-5254

Health Insurance Updates for last names Q-Z……334-242-5279

N.2 General Information

For anyone to call 334-242-5000

For Medicaid recipients only 1-800-362-1504

For Medicaid providers regarding policies, procedures and/or administrative reviews 1-800-362-1504 for all other information 1-800-688-7989

N.3 Important Telephone Numbers for EDS

Automated Voice Response System (AVRS) 1-800-727-7848

Electronic Media Claims (EMC) 1-800-456-1242

Provider Assistance Center 1-800-688-7989

Provider Enrollment 1-888-223-3630

Provider Relations Representatives 1-800-688-7989

EDS Operator 334-215-0111

N.4 Mailing Addresses

Alabama Medicaid Agency ..... 501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

For mailing claims:

Pharmacy, Dental, and UB-92 Claims ..... EDS
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

CMS-1500 Claims ..... EDS
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

Inquiries, Provider Enrollment Information, Provider Relations
..... EDS
..... Post Office Box 241685
..... Montgomery, AL 36124-1685

Medicare-related Claims ..... EDS
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

Medical Prior Authorization ..... EDS
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

Pharmacy Prior Authorization ..... HID
..... Post Office Box 3210
..... Auburn, AL 36823-3210
..... FAX: 1-800-748-0116

Adjustments..... EDS
Post Office Box 241684
..... Montgomery, AL 36124-1684

N.5 Web Site Address

Refer to the Alabama Medicaid Agency's web site at http://www.medicaid.alabama.gov for the following resources:

- Forms
- Manuals
- Bulletins
- Provider Notices
- Schedule of Events
- Billing and Eligibility Software

O CRNP and PA Services

CRNP and PA services are **limited** to the injectable drug codes found in Appendix H, Alabama Medicaid Physician Drug Listing, all laboratory services, which are CLIA certified, and the following CPT codes or HCPCS codes.

The Evaluation and Management codes that Nurse Practitioners/Physician Assistants may bill have been expanded. The following list does not include all procedure codes covered for CRNP's and PA's. For more specific information on coverage, you may call the Provider Assistance Center at 1(800) 688-7989.

Procedure Codes	Description
99201-99205	Office/Outpatient visit for E & M of a new patient
99211-99215	Office/Outpatient visit for E & M of an established patient
99241-99245	Office consultation for a new or established patient
99271-99275	Confirmatory consultation for a new or established patient
99281-99285	Emergency department visit for E & M
99301-99303	E & M of a new or established patient-nursing facility assessment
99311-99316	Subsequent nursing facility care-E & M of new/established patient
99321-99323	Domiciliary or rest home visit for E & M of a new patient
99331-99333	Domiciliary or rest home visit-E & M of established patient
99341-99345	Home visit for E & M of a new patient
99347-99350	Home visit for E & M of established patient
99354-99357	Prolonged physician service in the office or outpatient setting
99360	Physician standby service
99377	Physician supervision of a hospice patient
99432-99433	Normal newborn care-other than hospital or birthing room
99381-99385-EP	EPSDT periodic screening (with EP modifier), new patient
99381-99385	EPSDT interperiodic screening (w/o EP modifier) new patient
99391-99395-EP	EPSDT periodic screening (w/EP modifier), established patient
99391-99395	EPSDT interperiodic screening (w/o EP modifier) established patient

Nurse Practitioners may be reimbursed at 100% for lab and injectable drugs. Lab codes allowed are based on CLIA certification.

In order to bill for the administration fee for vaccines for children, providers must be enrolled as a VFC provider.

O.1 First Assistant CPT Codes for Physician Employed CRNP/PAs.

CRNP's and Physician Assistants who perform as 1st assistant at surgery, must bill modifier 80, 81, or 82 along with the appropriate procedure code. The surgical codes are not an all-inclusive list. For more specific information on coverage, you may call the Provider Assistance Center at 1-800-688-7989.

22612	23490	24516	25575	27217	27422	27620	27870
22614	23491	24545	25620	27218	27424	27625	27871
22800	23515	24546	25628	27226	27425	27626	27880
22802	23530	24575	25645	27227	27427	27637	27881
22804	23532	24579	25670	27228	27428	27638	27882
22808	23550	24586	25676	27236	27429	27640	27886
22810	23552	24587	25685	27244	27438	27641	27888
22812	23585	24615	25695	27245	27440	27645	28515
22830	23615	24635	25800	27248	27441	27646	28420
22840	23616	24665	25805	27253	27442	27647	28445
22841	23630	24666	25810	27254	27443	27650	28465
22842	23660	24685	25820	27258	27445	27652	28485
22843	23670	24802	25825	27259	27446	27654	28505
22844	23680	25135	25830	27280	27447	27676	28525
22845	23800	25136	26992	27282	27448	27695	28531
22846	23802	25170	27036	27284	27450	27696	28555
22847	23935	25210	27050	27286	27454	27698	28585
22849	24006	25215	27052	27290	27455	27702	28615
22850	24130	25230	27054	27295	27457	27703	28645
22852	24134	25240	27067	27303	27465	27705	28675
22855	24136	25274	27070	27310	27466	27707	28705
20930	24138	25320	27071	27329	27468	27709	28715
20937	24140	25332	27075	27331	27470	27712	28725
20936	24145	25370	27076	27332	27472	27715	28730
32900	24147	25375	27077	27333	27475	27720	28735
23101	24149	25390	27078	27334	27477	27722	28737
23130	24150	25391	27079	27335	27479	27724	28740
23140	24151	25393	27090	27340	27485	27725	28750
23145	24152	25405	27091	27345	27486	27730	28755
23150	24153	25420	27122	27347	27487	27732	28760
23155	24155	25425	27125	27350	27488	27734	28800
23170	24341	25426	27130	27356	27495	27740	28805
23172	24242	25440	27132	27357	27506	27742	28810
23174	24350	25441	27134	27358	27507	27745	28820
23180	24351	25442	27137	27360	27511	27758	28825
23182	24352	25443	27138	27365	27513	27759	
23184	24356	25444	27140	27380	27514	27766	
23410	24361	25445	27146	27381	27519	27784	
23412	24362	25446	27147	27385	27524	27792	
23420	24363	25447	27151	27386	27535	27814	
23440	24366	25455	27156	27396	27536	27822	
23450	24400	25490	27158	27397	27540	27823	
23455	24410	25491	27161	27400	27556	27826	
23460	24420	25492	26165	27403	27557	27827	
23462	24430	25515	27170	27405	27558	27828	
23465	24435	25525	27181	27407	27566	27829	
23470	24470	25526	27185	27409	27590	27832	

23480	24498	25545	27187	27418	27610	27846
23485	24515	25574	27215	27420	27612	27848

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P

P Durable Medical Equipment (DME) Procedure Codes and Modifiers

The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

NOTE:

Some EPSDT rental equipment codes must be billed with the appropriate procedure code with modifier **RR**. These codes are listed in appendix P and are denoted with the appropriate modifier. IF **RR modifier** is not indicated on the prior authorization request do not use the **RR** modifier when billing the claim.

The following procedure codes apply when filing claims for DME services.

Ambulation Devices

Procedure Code	*Description of Item*	*PA Required*
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip (limited to one every two years)	No
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips (limited to one every two years)	No
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and hand grips (limited to one every two years)	No
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and hand grips (limited to one every two years)	No
E0130	Walker, rigid (pickup), adjustable or fixed height (limited to one every two years)	No
E0135	Walker, folding (pickup), adjustable or fixed height (limited to one every two years)	No
E0143	Walker, folding, wheeled, adjustable or fixed height	No
E0148	Walker, heavy duty, without wheels, rigid or folding, any type	No
E0149	Walker, heavy duty, wheeled , rigid for folding, any type, each (accommodate weight capacities 300lbs and above) (limited to one every two years) **We will use the established prior authorization process for the walker but will add weight specifications.** **Reimbursement will be paid at invoice plus 20%**	Yes

Deleted to E0148: ~~Yes~~
Added to E0148: No

NOTE:

Procedure codes for the ambulation devices listed above may not be billed at the same time.

Ambulation Devices, continued

Procedure Code	*Description of Item*	*PA Required*
L1900	Ankle-Foot Orthosis (AFO), spring wire, dorsiflexion assist calf band	No
L1930	AFO, plastic	No
L1940	AFO, molded to recipient, plastic	No
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar `BK' orthosis)	No

Catheters

Procedure Code	*Description of Item*	*PA Required*
A4338	Indwelling catheter, Foley type, two-way, latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic), (limited to two per month)	No
A4344	Indwelling catheter, Foley type, two-way, all silicone (limited to two per month)	No
A4349	Male external catheter, with or without adhesive, (limited to 30 per month for adults age 21 and over). I**f an EPSDT recipient uses catheters beyond the 30 per month limit, the recipient must be referred through the EPSDT program and the EPSDT referral information must be included on the CMS-1500 claim form when billing - A4349**. Not to exceed 150.	No
A4351	Intermittent urinary catheter; straight tip, with or without coating (teflon, silicon, silicone elastomer, or hydrophilic, etc.) each limited to 31 per month per recipient. **If an EPSDT recipient uses catheters beyond the 31 per month limit , the recipient must be referred through the EPSDT program and EPSDT referral information must be included on the CMS-1500 claim form when billing - A4349**. Not to exceed 150.	No

Catheter Supplies

Procedure Code	*Description of Item*	*PA Required*
A4213	Syringe, sterile, 10cc or greater, each	No
A4217	Sterile water/saline, 500 ML	No
A4354	Insertion tray with drainage bag, without catheter (limited to two per month)	No
A4357	Bedside drainage bag, day or night, with or without antireflux device, with or without tube, each (limited to two per month)	No
A4358	Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each (limited to two per month)	No

Commode Chairs

Procedure Code	*Description of Item*	*PA Required*
E0163	Commode chair, stationary, with fixed arms (limited to one every two years)	No
E0165	Commode chair, stationary, with detachable arms (limited to one every two years)	No

Procedure Code	Description of Item	PA Required
E0168	Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each (limited to one every two years) We will use the established prior authorization process for this item, but will add weight, depth, and width specifications (limited to one every two years)	Yes

Suction Equipment/Supplies

Procedure Code	Description of Item	PA Required
E0600	Suction pump, home model portable (limited to one every five years)	Yes
A7000	Cannister, disposable, used with suction pump (limited to 4 per year or 1 every 3 months)	No
A7001	Cannister, non-disposable, used with suction pump (limited to 1 per year)	No
A7002	Tubing , used with suction pump (12 per year)	No

Heat Application Appliance

Procedure Code	Description of Item	PA Required
E0210	Electric heat pad, standard	No

Oxygen

Procedure Code	Description of Item	PA Required
E0424	Stationary compressed gaseous oxygen system, rental; includes contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes
E0431	Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask, tubing	Yes
E0441	Oxygen contents, gaseous, (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)	Yes
E0443	Portable oxygen contents, gaseous, per unit for use only with portable gaseous systems when no stationary gas or liquid system is used. (Limited to 4 refills per month per recipient with medical justification)	Yes
E1390	Oxygen concentrator capable of delivering 85% or greater oxygen concentration at the prescribed flow rate	Yes

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form must be filled out, signed and dated by the ordering physician.

Home Glucose Monitor and Supplies

Procedure Code	***Description of Item***	***PA Required***
A4250	Urine test or reagent strips or tablets, per 50 (limited to 100 strips or tablets, two bottles per month)	No
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 (limited to three boxes per month)	No
A4259	Lancets, per box of 100 (limited to two boxes per month)	No
E0607	Home blood glucose monitor (limited to one every five years)	Yes
A4256	Normal, low and high calibrator solution/chips	No
A4258	Spring-powered device for lancet, each	No
A4233	Replacement battery, alkaline, (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each	No
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each	No
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	No
A4236	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each	No

Home IV Therapy Only

Procedure Code	***Description of Item***	***PA Required***
A4208	Syringe with needle, sterile 3cc, each (billed with IV therapy only)	No
A4215	Needle, sterile, any size**,** (in-site IV catheter) limited to 100 per month	No
A4245	Alcohol wipes, per box (limited to 3 boxes per month)	No
A4247	Betadine or iodine swabs/wipes, per box (limited to 2 boxes per month)	No
A4927	Gloves, non-sterile, per pair, 100 gloves per box (limited to two boxes per month)	No
B9004	Parenteral nutrition infusion pump, portable, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
B9006	Parenteral nutrition infusion pump, stationary, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
E0776	IV pole	No
E0781	Ambulatory infusion pump, single or multiple channels, with administrative equipment, worn by recipient (monthly rental but must be prorated on a daily basis if pump is used less than one month)	Yes
A9999	Miscellaneous DME supply not otherwise specified (IV Administration start kit includes tubing, filters, Y connector, transparent dressing.) **Procedure code A9999 is to be used for supplies in the IV Administration kit. Recipient's file should have an itemized listing of all supplies used with usual and customary charges billed for each supply. This will be used as a Medicaid auditing tool.** (Limited to 70 per month)	No

Hospital Beds

Procedure Code	***Description of Item***	***PA Required***
E0250	Hospital bed, with side rails, fixed height, with mattress	Yes
E0255	Hospital bed, with side rails, variable height, Hi-Lo, with mattress	Yes
E0260	Hospital bed, semi-electric (head and foot adjustment) with any type side rails, with mattress	Yes

Procedure Code	Description of Item	PA Required
E0280	Bed Cradle any type	Yes
E0303	Hospital bed heavy duty, extra wide with weight capacity greater than 350 pounds but less than 600 pounds with any type side rails with mattress	Yes
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Yes

Hospital Bed Accessories

Procedure Code	Description of Item	PA Required
E0181	Powered Pressure Reducing mattress overlay/pad, alternating, with pump, includes heavy duty (limited to one every three years)	Yes
E0182	Pump for alternating pressure pad, replacement only	Yes
E0185	Gel or gel like pressure pad for mattress, standard mattress length and width (limited to one every two years)	Yes
E0271	Mattress, innerspring (replacement for medically necessary hospital bed owned by recipient)	Yes
E0310	Bed side rails, full length	Yes
E0621	Sling or seat, recipient lift, canvas or nylon	No
E0630	Recipient lift, hydraulic, with seat or sling	Yes
E0910	Trapeze bars, AKA recipient helper, attached to bed, with grab bar	Yes
E0911	Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	Yes

Nebulizer

Procedure Code	Description of Item	PA Required
E0570	Nebulizer, with compressor (limited to one every four years)	No
A7003	Administration set, small volume non-filtered pneumatic nebulizer (limited to 3 sets per month)	No
A7005	Administration set, small volume non-filtered pneumatic nebulizer, non-disposable (limited to two per year)	No
A7015	Aerosol mask, used with DME Nebulizer (limited to 15 per month)	No

Supplies

Procedure Code	Description of Item	PA Required
A4362	Skin barrier; solid, 4 x 4 or equivalent; each (limited to 20 per month)	No
A4365	Adhesive remover wipes any type, per 50	No
A4367	Ostomy belts, each	No
A4400	Ostomy irrigation set	No
A4404	Ostomy rings	No
A4414 *	Ostomy skin barrier, with flange (solid, flexible or accordion) extended wear, without built-in convexity, 4 x 4 inches or smaller, each (limited to 31 per month)	No
A4415*	Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4x4 inches or smaller, each	No
A4450	Tape, non-waterproof, per 18 square inches = 1 unit (limited to 60 units per month)	No
A4452	Tape, waterproof, per 18 square inches = 1 unit (limited to 60 units per month)	No

Procedure Code	*Description of Item*	*PA Required*
A5052	Pouch, closed; without barrier attached (one piece), per bag (limited to 60 per month)	No
A5054	Pouch closed; for use on barrier with flange (two piece)	No
A5061	Pouch drainable with barrier attached (one piece), per bag (limited to 31 per month)	No
A5063	Pouch, open; without barrier attached (two piece), per bag (limited to 31 per month)	No
A5071	Pouch, urinary; with barrier attached; (one piece), limited to 40 per month.	No
A5121	Skin barrier; solid, 6 x 6 or equivalent, each (limited to 20 per month)	No

Deleted: ~~A5123~~
Added: A4414 or A4415

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A4414 or A4415. Procedure code A5063 may not be billed on the same date of service as A5052.

Supplies, continued

Procedure Code	*Description of Item*	*PA Required*
A6216	Gauze pad, non-impregnated, non-sterile; pad size 16 sq. in. or less 4x4 (limited to 1000 Units)	No
A6217	Gauze pad, non-impregnated, non-sterile; pad size more than 16 sq. in. (limited to 700 per month)	No
A6402	Gauze pad, non-impregnated, sterile; pad size 16 sq. in. or less **(used only on areas requiring sterile pads)** (limited to 400 per month)	No
A6403	Gauze pad, non-impregnated, sterile; pad size more than 16 sq. In. (limited to 100 per month) **(used only on areas requiring sterile pads)** (limited to 400 per month)	No
B4081	Nasogastric tubing with stylet	No
B4082	Nasogastric tubing without stylet	No
B4086	Gastrostomy/jejunostomy tube, any material, any type, (standard or low profile), each	No
E0188	Synthetic sheepskin pad	No
E0191	Heel or elbow protector, each	No
E0210	Electric heat pad, standard	No
E0275	Bedpan, standard, metal or plastic	No
E0276	Bedpan, fracture, metal or plastic	No
A6530	Gradient compression stocking, below knee, 18-30 MMHG, each; limited to eight (8) stockings per year (4 pairs)	No
A6533	Gradient compression stockings, thigh length, 18-30 MMHG, each; limited to eight (8) stockings per year (4 pairs)	No
A7520	Tracheostomy or laryngectomy tube, non-cuffed, polyvinyl chloride (PVC). Silicone or equal, ach (Limited to 5 per month)	No
A7526	Tracheostomy/tube collar/holder, each (4 per month)	No
A4623	Tracheostomy, inner cannula (limited to 20 per month)	No
A4624	Tracheal suction catheter, any type other than closed system, each (500 per month)	No
A4625	Tracheostomy care kit for new tracheostomy (90 per month)	No
A4628	Oropharyngeal suction catheter, each (50 per month)	No
A4629	Tracheostomy care kit for established tracheostomy (31 per month)	No

Added: A4623

Iron Chelation Therapy

Procedure Code	*Description of Item*	*PA Required*
E0779	Ambulatory infusion pump mechanical, reusable for infusion 8 hours or greater. For repairs to the Ambulatory Infusion Pump use DME repair codes in DME Repair section (E1340 & E1399).	Yes
A4222	Supplies for external infusion pump, per cassette or bag (list drugs separately). **Procedure code A4222 is to be used for infusion tubing for iron chelation therapy**. (Limited to 31 per month)	No

Deleted: ~~A4632~~

External Breast Prosthesis

Procedure Code	*Description of Item*	*PA Required*
L8000	Breast prosthesis, mastectomy bra (limited to 6 per year **MAXIMUM OF 4 ON INITIAL REQUEST**) Per breast mastectomy	Yes
L8015	External breast prosthesis garment, with mastectomy form (camisole) limited to 2 of L8030 per year or 1 of L8030 and 1 of L8020 **NOT 2 OF EACH CODE**) Per breast mastectomy	Yes
L8020	Breast prosthesis, mastectomy form (limited to 2 of L8030 per year or 1 of L8030 and 1 of L8020 **NOT 2 OF EACH CODE**) Per breast mastectomy	Yes
L8030	Breast prosthesis, silicone or equal (limited to 2 of L8030 per year or 1 of L8030 and 1 of L8020 **NOT 2 OF EACH CODE**) Per breast mastectomy	Yes
*L8035	Custom breast prosthesis, post mastectomy, molded to patient model	Yes
*L8039	Breast prosthesis, not otherwise classified	Yes

Added to L8015: (camisole)

NOTE:

* Evaluated on a case-by-case basis with submission of pricing information and medical documentation.

Augmentative Communication Devices

Procedure Code	*Description of Item*	*PA Required*
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to eight minutes recording time	Yes
E2502	Speech generating device, digitized speech using pre-recorded messages greater than 8 minutes, but less than or equal to 20 minutes recording time	Yes
E2504	Speech generating device, digitized speech using pre-recorded messages greater than 20 minutes, but less than or equal to 40 minutes recording time	Yes
E2506	Speech generating device, digitized speech using pre-recorded messages greater than 40 minutes recording time	Yes
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	Yes
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Yes
E2511	Speech generating software program, for personal computer or personal digital assistant.	Yes

Procedure Code	***Description of Item***	***PA Required***
E2512	Accessory for speech generating device, mounting system	Yes
E2599	Accessory for speech generating device not otherwise classified (This code may be used to bill batteries for Acd devices)	Yes
V5336	Repair/modification of augumentative communication system or device (excluding adaptive hearing aid))	Yes

Wheelchairs

Procedure Code	***Description of Item***	***PA Required***
E1050	Fully-reclining wheelchair, fixed full-length arms, swing away detachable elevating leg rests	Yes
E1060	Fully reclining wheelchair, detachable arms, (desk or full length) swing away detachable elevating leg rests	Yes
E1070	Fully-reclining wheelchair, detachable arms (desk or full length), swing away detachable footrest	Yes
E1091	Youth Wheelchair; any type	Yes
E1088	High strength lightweight wheelchair, detachable arms, desk or full length swing away detachable elevating leg rests	Yes
E1092	Wide, heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1093	Wide heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1110	Semi-reclining wheelchair, detachable arms, (desk or full length), elevating leg rests	Yes
E1037	Transport Chair; pediatric size	Yes
E1130	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	Yes
E1140	Standard wheelchair, detachable arms, (desk or full length), swing away detachable footrests	Yes
E1150	Wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1160	Standard wheelchair, fixed full length arms, swing away detachable elevating leg rests	Yes
E1180	Amputee wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1190	Amputee wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1200	Amputee wheelchair, fixed full length arms, swing away detachable footrest	Yes
E1240	Lightweight wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1280	Heavy duty wheelchair, detachable arms (desk or full length), elevating leg rests	Yes
E1285	Heavy duty wheelchair, fixed full length arms, swing away detachable footrests	Yes
E1290	Heavy duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
K0007	Extra Heavy Duty Wheelchair	Yes
K0009	Other manual wheelchair/base	Yes
K0813	Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds patient weight capacity up to and including 300 pounds	Yes
K0814	Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	Yes
K0815	Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds	Yes
K0816	Power wheelchair, group 1 standard, captains chair patient weight capacity up to and including 300 pounds	Yes

Procedure Code	***Description of Item***	***PA Required***
K0820	Power wheelchair, group 2 standard, portable, sling/solid seat/ back, patient weight capacity up to and including 300 pounds patient weight capacity up to and including 300 pounds	Yes
K0821	Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds	Yes
K0822	Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0823	Power wheelchair, group 2 standard, captains chair patient weight capacity up to and including 300 pounds	Yes
K0824	Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 pounds to 450 pounds	Yes
K0825	Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds	Yes
K0826	Power wheelchair, group 2 very heavy duty, sling/solid seat back, patient weight capacity 451 to 600 pounds	Yes
K0827	Power wheelchair, group 2 very heavy duty, captains chair patient weight capacity 45 to 600 pounds	Yes
K0828	Power wheelchair, group 2 extra heavy duty, sling/solid seat back, patient weight capacity 601 pounds or more	Yes
K0829	Power wheelchair, group 2 extra heavy duty, captains chair patient weight capacity 601 pounds or more	Yes
K0830	Power wheelchair, group 2 standard, seat elevator, sling/solid Seat/back, patient weight capacity up to and including 300 pounds	Yes
K0831	Power wheelchair, group 2 standard, seat elevator, captains Chair, patient weight capacity up to and including 300 pounds	Yes
K0835	Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0836	Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	Yes
K0837	Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 pounds to 450 pounds	Yes
K0838	Power wheelchair, group 2 heavy duty, single power option, captains chair patient weight capacity 301 pounds to 450 pounds	Yes
K0839	Power wheelchair, group 2 very heavy duty, single power option, Sling/back seat/ solid patient weight capacity 451 pounds to 600 pounds	Yes
K0840	Power wheelchair, group 2 heavy duty, single power option, Sling/solid seat back patient weight capacity 601 pounds or more	Yes
K0841	Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0842	Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds	Yes
K0843	Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 pounds to 450 pounds	Yes
K0848	Power wheelchair, group 3 standard, sling/back, patient weight Capacity up to and including 300 pounds	Yes
K0849	Power wheelchair, group 3 standard, captains chair, patient Weight capacity up to and including 300 pounds	Yes
K0850	Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 pounds to 450 pounds	Yes
K0851	Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 pounds to 450 pounds	Yes
K0852	Power wheelchair, group 3 very heavy duty, Sling/solid seat/ back, patient weight capacity 451 pounds to 600 pounds	Yes

Procedure Code	***Description of Item***	***PA Required***
K0853	Power wheelchair, group 3 very heavy duty, captains chair patient weight capacity 451 pounds to 600 pounds	Yes
K0854	Power wheelchair, group 3 extra heavy duty, sling/solid seat back, patient weight capacity 601 pounds or more	Yes
K0855	Power wheelchair, group 3 extra heavy duty, captains chair patient weight capacity 601 pounds or more	Yes
K0856	Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0857	Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	Yes
K0858	Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301pounds to 450 pounds	Yes
K0859	Power wheelchair, group 3 heavy duty, single power option, captains chair patient weight capacity 301 pounds to 450 pounds	Yes
K0860	Power wheelchair, group 3 very heavy duty, single power option, Sling/solid seat/ back patient weight capacity pounds to 451 pounds to 600 pounds	Yes
K0861	Power wheelchair, group 3 standard, multiple power option, sling/solid, seat/back, patient weight capacity up to and including 300 pounds	Yes
K0862	Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 pounds to 450 pounds	Yes
K0863	Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 pounds to 600 pounds	Yes
K0864	Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more	Yes
K0868	Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0869	Power wheelchair, group 4 standard, captains chair, patient Weight capacity up to and including 300 pounds	Yes
K0870	Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds	Yes
K0871	Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 pounds to 600 pounds	Yes
K0877	Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0878	Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds	Yes
K0879	Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 pounds to 450 pounds	Yes
K0880	Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 pounds 600 pounds	Yes
K0884	Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds	Yes
K0885	Power wheelchair, group 4 standard, multiple power option, captains chair patient weight capacity up to and including 300 pounds	Yes
K0886	Power wheelchair, group 4 heavy duty ,multiple power option, sling/solid seat/back patient weight capacity 301 pounds to 450 pounds	Yes
K0890	Power wheelchair , group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	Yes

Procedure Code	*Description of Item*	*PA Required*
K0891	Power wheelchair , group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds	Yes
K0898	Power wheelchair, not otherwise classified	Yes

NOTE:

Wheelchairs are limited to one every five years per recipient.

Wheelchair Accessories

Procedure Code	*Description of Item*	*PA Required*
E0951*	Loop heel, each	Yes
E0952	Toe Loop / holder each	Yes
E0955	Wheelchair accessory, headrest, cushioned, prefabricated	Yes
E0956	Wheelchair accessory, lateral trunk support, prefabricated including fixed mounting hardware	Yes
E0957	Wheelchair accessory, medial thigh support, prefabricated, including fixed mounting hardware	Yes
E0958*	Manual wheelchair accessory to convert any wheelchair to one arm drive	Yes
E0959	Manual wheelchair accessory, adapter for amputee	Yes
E0960	Wheelchair accessory, shoulder harness/ straps or chest strap including any type mounting hardware.	Yes
E0961	Manual wheelchair accessory, wheel lock brake extension (handle) each	Yes
E0966	Manual wheelchair accessory, rest extension , each	Yes
E0967	Manual wheelchair accessory, hand rim with projections, each	Yes
E0971*	Manual wheelchair accessory, anti-tipping device, each	Yes
E0972	Wheelchair accessory, transfer board or device, each	Yes
E0973	Wheelchair Accessory, adjustable height, detachable armrest, complete assembly, each	Yes
E0974	Manual wheelchair accessory, anti-rollback device, each	Yes
E0978	Wheelchair accessory safety belt / pelvic strap each	Yes
E0980	Safety Vest, Wheelchair	Yes
E0981	Wheelchair accessory, seat upholstery replacement only, each	Yes
E0982	Wheelchair accessory, back upholstery, replacement only, each	Yes
E0983	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair	Yes
E0984	Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair	Yes
E0985	Wheelchair accessory, seat lift mechanism	Yes
E0986	Manual Wheelchair accessory, push-rim activated power assist, each	Yes
E0990	Wheelchair accessory, elevating leg rest, complete assembly, each	Yes
E0992	Manual Wheelchair accessory, solid insert	Yes
E0994	Armrest, each	Yes
E0995	Wheelchair accessory, calf rest/ pad, each	Yes
E1002	Wheelchair accessory, power seating system, tilt only	Yes
E1003	Wheelchair accessory, power seating system, recline only Without shear reduction	Yes

Procedure Code	***Description of Item***	***PA Required***
E1004	Wheelchair accessory , power seating system, recline only with Mechanical shear reduction	Yes
E1005	Wheelchair accessory, power seating system, recline only with power shear reduction	Yes
E1006	Wheelchair accessory , power seating system, combination tilt and recline without shear reduction	Yes
E1007	Wheelchair accessory , power seating system, combination tilt and recline with mechanical shear reduction	Yes
E1008	Wheelchair accessory , power seating system, combination tilt and recline with power shear reduction	Yes
E1009	Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including push rod and leg rest	Yes
E1010	Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair	Yes
E1011	Modification to pediatric wheelchair, width adjustable package (not to be dispensed with initial chair)	Yes
E1014	Reclining back, addition to pediatric wheelchair	Yes
E1015	Shock absorber for manual wheelchair, each	Yes
E1016	Shock absorber for power wheelchair, each	Yes
E1017	Heavy duty shock absorber for heavy duty or extra heavy duty Manual wheelchair	Yes
E1018	Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each	Yes
E1020	Residual Limb Support System for wheelchair	Yes
E1028	Wheelchair accessory, manual swing away retractable or removable mounting hardware for joystick	Yes
E1029	Wheelchair accessory, ventilator tray, fixed	Yes
E1030	Manual wheelchair accessory, ventilator tray, gimbaled	Yes
E2201	Manual wheelchair accessory, nonstandard seat frame width greater than or equal to 20 inches	Yes
E2202	Manual wheelchair accessory, nonstandard seat frame width 24-27 inches	Yes
E2203	Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches	Yes
E2204	Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches	Yes
E2205	Manual wheelchair accessory, handrim without projections, any type, replacement only, each	Yes
E2206	Manual wheelchair accessory, wheellock assembly, complete, each	Yes
E2210	Wheelchair accessory, bearings, any type, replacement only	Yes
E2211	Manual wheelchair accessory, pneumatic propulsion tire, any size, each	Yes
E2212	Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	Yes
E2213	Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	Yes
E2314	Manual wheelchair accessory, pneumatic caster tire, any size, each	Yes
E2215	Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	Yes
E2216	Manual wheelchair accessory, foam filled propulsion tire, any size, each	Yes
E2217	Manual wheelchair accessory, foam filled caster tire, any size, each	Yes
E2218	Manual Wheelchair accessory, foam propulsion tire, any size, each	Yes
E2219	Manual wheelchair accessory, foam caster tire, any size, each	Yes

Procedure Code	***Description of Item***	***PA Required***
E2220	Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	Yes
E2221	Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), each	Yes
E2222	Manual wheelchair accessory, solid (rubber/plastic) caster tire with intergrated wheel, any size, each	Yes
E2223	Manual wheelchair accessory, valve, any type, replacement only, each	Yes
E2224	Manual wheelchair accessory, propulsion wheel excludes tire, any size, each	Yes
E2225	Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each	Yes
E2226	Manual wheelchair accessory, caster fork, any size, replacement only, each	Yes
E2300	Power wheelchair accessory, power seat elevation system	Yes
E2301	Power wheelchair accessory, power standing system	Yes
E2310	Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics	Yes
E2311	Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating systems motor, including all related electronics	Yes
E2321	Power wheelchair accessory, hand control interface, remote joystick, non-proportional, inc	Yes
E2322	Power wheelchair accessory, hand control interface, multiple mechanical switches, non-proportional	Yes
E2323	Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated	Yes
E2324	Power wheelchair accessory, chin cup for chin control interface	Yes
E2325	Power wheelchair accessory, sip and puff interface non-proportional, including all related electronics	Yes
E2326	Power wheelchair accessory, breath tube kit for sip and puff interface	Yes
E2327	Power wheelchair accessory, head control interface, mechanical proportional, including all related electronics	Yes
E2328	Power wheelchair accessory, head control or extremity control interface, electronic proportional	Yes
E2329	Power wheelchair accessory, head control interface, switch mechanism, non-proportional inc	Yes
E2330	Power wheelchair accessory, head control interface, proximity switch mechanism, non-proportional inc	Yes
E2331	Power wheelchair accessory, attendant control interface, proportional including all related electronics	Yes
E2340	Power wheelchair accessory, nonstandard seat frame width, 20-23 inches	Yes
E2341	Power wheelchair accessory, nonstandard seat frame width, 24-27 inches	Yes
E2342	Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches	Yes
E2343	Power wheelchair accessory, nonstandard seat frame depth, 22 -25 inches	Yes
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair	Yes
E2360	Power wheelchair accessory, 22 NF non-sealed lead acid battery, each	Yes
E2361	Power wheelchair accessory, 22 NF sealed lead acid battery, each, (e.g. gel cell, absorbed glass	Yes
E2362	Power wheelchair accessory, group 24 non-sealed lead acid battery, each	Yes
E2363	Power wheelchair accessory, group 24 NF sealed lead acid battery, each, (e.g. gel cell, absorbed glass	Yes
E2364	Power wheelchair accessory, U-1 non-sealed lead acid battery each	Yes

Procedure Code	***Description of Item***	***PA Required***
E2365	Power wheelchair accessory, u-1 sealed lead acid battery, each (e.g. gel cell, absorbed glassma)	Yes
E2366	Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed	Yes
E2367	Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each	Yes
E2368	Power wheelchair component, replacement only	Yes
E2369	Power wheelchair component, gear box, replacement only	Yes
E2370	Power wheelchair component, motor and gearbox combination, replacement only	Yes
E2371	Power Wheelchair accessory, group 27 sealed acid battery, (e.g. gel cel, absorbed glassmat), each	Yes
E2372	Power Wheelchair accessory, group 27 non-sealed lead acid battery, each	Yes
E2395	Power wheelchair accessory, caster wheel excludes tire, any size replacement only	Yes
E2399*	Power wheelchair accessory, not otherwise classified interface, and including all related electronics and any type mounting hardware.	Yes
E2601*	General use wheelchair cushion, width less than 232 inches , any depth	Yes
E2602	General, use wheelchair seat cushion, width 2 inches or greater, any depth	Yes
E2603	Skin protection wheelchair seat cushion, width less than 22 inches, any depth (replaced E0192)	Yes
E2604	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth (replaced E0192)	Yes
E2605	Positioning wheelchair seat cushion, width less than 22 inches, any depth	Yes
E2606	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	Yes
E2607	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	Yes
E2608	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	Yes
E2609	Custom fabricated wheelchair seat cushion, any size	Yes
E2611	General use wheelchair back cushion, width less than 22 inches, any weight, including any type mounting hardware	Yes
E2612	General use wheelchair back cushion, width greater than 22 inches, any weight, including any type mounting hardware	Yes
E2613	Positioning wheelchair back cushion, Posterior, width less than 22 inches, any height, including any type mounting hardware	Yes
E2614	Positioning wheelchair back cushion, Posterior, width 22 inches or greater, any height, including any type mounting hardware	Yes
E2615	Positioning wheelchair back cushion, posterior or lateral, width less than 22 inches, any height, including any type mounting hardware	Yes
E2616	Positioning wheelchair back cushion, posterior or lateral, width less than 22 inches or greater, any height, including any type mounting hardware	Yes
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting system	Yes
E2618	Wheelchair accessory, solid seat support base (replaced sling seat) for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware	Yes
E2619	Replacement cover for wheelchair seat cushion or back cushion, each	Yes
E2620	Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches , any height, including any type mounting hardware	Yes
E2621	Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware	Yes

Procedure Code	***Description of Item***	***PA Required***
E2399	Power wheelchair accessory, not otherwise classified interface, including all related electronics	Yes
E8000	Gait trainer, pediatric size, posteria support, includes all accessories and components	Yes
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components	Yes
E8002	Gait trainer, pediatric size, anteriort support, includes all accessories and components	Yes
K0007*	Extra wide Heavy Duty Wheelchair	Yes
K0015*	Detachable , nonadjustable height armrest, each	Yes
K0017	Detachable, adjustable height armrest, base, each	Yes
K0018*	Detachable, adjustable	Yes
K0019*	Arm Pad, each	Yes
K0020*	Fixed, adjustable height armrest, pair	Yes
K0037*	High mount flip-up footrest, each	Yes
K0038*	Leg strap, each	Yes
K0039*	Leg strap, h style, each	Yes
K0040*	Adjustable angle footplate, each	Yes
K0041*	Large size footplate, each	Yes
K0042*	Standard size footplate, each	Yes
K0043*	Footrest, lower extension tube, each	Yes
K0044*	Footrest, upper hanger bracket, each	Yes
K0045*	Footrest, complete assembly	Yes
K0046*	Elevating leg rest, lower extension tube, each	Yes
K0047*	Elevating leg rest, upper hanger bracket, each	Yes
K0050*	Ratchet assembly	Yes
K0051*	Cam release assembly, footrest or leg rest, each	Yes
K0052*	Swing away, detachable footrests, each	Yes
K0053*	Elevating footrests, articulating (telescoping), each	Yes
K0056*	Seat height less than 17" or equal to or greater than 21" for a High strength, lightweight, or ultra lightweight wheelchair	Yes
K0065*	Spoke protectors, each	Yes
K0068*	Pneumatic tire .tube, each	Yes
K0069*	Rear wheel assembly, complete, with solid tire, pokes or molded, Each	Yes
K0070*	Rear wheel assembly, complete, with pneumatic tire, spokes or Molded, each	Yes
K0071*	Front caster assembly, complete, with pneumatic tire, each	Yes
K0072*	Front caster assembly, complete, with semi- pneumatic tire, each	Yes
K0073*	Caster pin lock, each	Yes
K0077*	Front caster assembly, complete, with solid tire, each	Yes
K0105*	IV hanger, each	Yes
K0108*	Wheelchair component or accessory, not otherwise specified	Yes
K0195*	Elevating leg rests, pair (for use with capped rental wheelchair base)	Yes
K0462	Temporary replacement for patient owned equipment being repaired, any type	Yes
K0734	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Yes

Procedure Code	***Description of Item***	***PA Required***
K0735	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Yes
K0736	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth	Yes
K0737	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	Yes
L3964*	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment	Yes
L3965*	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable rancho type, prefabricated, includes fitting and adjustment	Yes
L3966*	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, reclining fabricated for attachment to wheelchair base	Yes
L3968*	Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, includes fitting and adjustment	Yes
L3969*	Shoulder elbow orthosis, mobile arm support, monosuspension arm and hand support, overhand elbow forearm hand sling support, yoke type suspension support, prefabricated, includes fitting and adjustment	Yes
L3970*	See, addition to mobile arm support, elevating proximal arm	Yes
L3972*	See, addition to mobile arm support, offset or lateral rocker arm With elastic balance control	Yes
L3974*	See, addition to mobile arm support, supinator	Yes

DME Repair

Procedure Code	***Description of Item***	***PA Required***
E1340*	Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes	Yes
E1399	Durable medical equipment, miscellaneous	Yes

EPSDT Referred Services

The following procedure codes identified with an asterisk are available for all Medicaid recipients. However, if these procedure codes exceed Medicaid established limits or program guidelines, a current EPSDT screening, Patient 1st referral (if applicable) and prior authorization would be required. A prior authorization may be required before Medicaid would make reimbursement for service provided beyond the limitations.

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
A4206		1cc syringe with needle	No
A4208 *		3cc syringe w/needle (HOME IV ONLY)	No
A4209		Syringe with needle, sterile 5 cc or greater	No
A4210		Needle-free injection device – inj. cap with luer lock, monojector	No
A4213 *		Syringe, sterile, 20cc or greater (for catheter or wound irrigation or bolus feeds)	No
A4215 *		Needles, sterile, any size each (HOME IV ONLY)	No
A4216		Sterile water/saline and /or dextrose (diluent), 10 ML	No
A4217		Sterile water, saline 500ml	No
A4221		Supplies for maintenance of drug infusion catheter, per week	No

Procedure Code	*Modifier*	*Description of Item*	*PA Required*
A4232		Syringe with needle for External Insulin Pump, sterile, 3cc	No
A4233 *		Replacement battery, Alkaline, other than J cell	No
A4234 *		Replacement battery, Alkaline, J cell	No
A4235 *		Replacement battery, Lithium	No
A4236 *		Replacement battery, Silver Oxide	No
A4256 *		Normal, Low and High Calibrator Solution/Chips	No
A4258 *		Spring-powered device for lancet	No
A4244		Alcohol or peroxide	No
A4245 *		Alcohol wipes, per 100	No
A4246		Betadine or Phisohex solution	No
A4247 *		Betadine or iodine swabs/wipes (home IV only), per box of 100	No
A4250 *		Urine test or reagent strips or tablets, per 50	No
A4253 *		Blood glucose test or reagent strips for home blood glucose monitor, per box of 50	No
A4259 *		Lancets, per box of 100	No
A4335		Incontinence supply; miscellaneous (replaced Z5311)	No
A4338 *		Indwelling catheter, Foley type, two-way, latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	No
A4340		Indwelling catheter; specialty type (for enteral feeding)	No
A4344 *		Indwelling catheter, Foley type, two-way, all silicone	No
A4349 *		Male external catheter with or w/out adhesive, disposable, each (limited to 30 per month for adults age 21 and above). **If an EPSDT recipient uses catheters beyond the 30 per month limit, the A4349 code should be used. The recipient must be referred through the EPSDT program and this information must be included on the billing claim form when billing - A4349**. Not to exceed 150.	No
A4351*		**Intermittent urinary catheter, straight tip, with or without coating (Teflon, silicon, silicon elastomer, or hydrophilic, etc) each limited to 30 per month for adults age 21 and over)** If an EPSDT recipient uses catheters beyond the 30 per month limit, the **A4351** code should be used. The recipient must be referred through the EPSDT program and this information must be included on the billing claim form when billing **A4351** Not to exceed 150.	No
A4352		Intermittent urinary catheter, coude (curved) tip, 60 per month	No
A4354 *		Insertion tray with drainage bag, without catheter	No
A4357 *		Bedside drainage bag, day or night, with or without antireflux device, with or without tube, each	No
A4358 *		Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps each.	No
A4362 *		Skin barrier; solid, 4 x 4 or equivalent; each	No
A4364 *		Adhesive for Ostomy or catheter; liquid (spray, brush, etc.), cement, powder or paste; any composition (e.g. silicone, latex, etc.)	No
A4365		Adhesive remover wipes, any type per 50	No
A4367 *		Ostomy Belt (each)	No
A4400 *		Ostomy Irrigation Set	No
A4402		Lubricant, per ounce	No
A4404 *		Ostomy Ring	No

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
A4414 *		Skin barrier; with flange (solid, flexible or accordion) without built-in convexity, 4x4 inches or smaller, each (limited to 30 per month)	No
A4450 *		Tape, non-waterproof, per 18 square inches (limited to six rolls per month)	No
A4452 *		Tape, waterproof, per 18 square inches (limited to six rolls per month)	No
T4521		Adult-sized incontinence product, diaper, small (limited up to 180 diapers per month)	Yes
T4522		Adult-sized Incontinence product ,Medium (limited up to 180 diapers per month)	Yes
T4523		Adult-sized incontinence product, diaper large (limited up to 150 diapers per month)	Yes
T4524		Adult-sized incontinence product, diaper, extra large (limited to up 150 diapers per month)	Yes
T4529		Child-sized incontinence product, diaper small/medium (limited up to 210 diapers per month)	Yes
T4530		Child-sized incontinence product, large (limited up to 210 diapers per month)	Yes
A4611		Battery, heavy duty; replacement for recipient owned ventilator	No
A4614		Peak flow meter	Yes
A4615		Cannula, nasal	No
A4618		Breathing circuits, permanent ventilator circuits	No
A4624*		Tracheal suction catheter, any type	No
A4625		Tracheostomy care kit for new tracheostomy	No
A4627		Spacer, bag or reservoir, with or without mask	No
A4628 *		Oropharyngeal suction catheter, each	No
A4629*		Tracheostomy care kit for established tracheostomy	No
A4714		Treated water (deionized, distilled, reverse osmosis) for use in dialysis system	No
A4927 *		Gloves, sterile or non-sterile, per pair, 100 gloves per box	No
A5052 *		Pouch, closed; without barrier attached (one piece), per bag	No
A5054 *		Pouch closed; for use on barrier with flange (two piece)	No
A5061 *		Pouch, closed; without barrier attached, one piece (Ostomy)	No
A5063 *		Pouch, open; without barrier attached (two piece), per bag	No
A5071 *		Pouch, urinary, with barrier attached; (one piece) limited to 40 per month)	No
A5121 *		Skin barrier; solid, 6 x 6 or equivalent, each	No
A6216 *		Gauze pad, non-impregnated, non-sterile; pad size 16 sq. in. or less	No
A6217 *		Gauze pad, non-impregnated, non-sterile; pad size more than 16 sq. in. (limited to 100 per month)	No
A6402 *		Gauze pad, non-impregnated, sterile; pad size 16 sq. in. or less (used only in areas requiring sterile pads)	No
A6403 *		Gauze pad, non-impregnated, sterile; pad size more than 16 sq. in. (limited to 100 per month) (used only in areas requiring sterile pads)	No
A6501		Compression burn garment, body suit (head to foot), custom fabricated	Yes
A6502		Compress burn garment, chin strap. Custom fabricated	Yes
A6503		Compression burn garment, facial hood custom fabricated	Yes

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
A6504		Compression burn garment, glove to wrist, custom fabricated	Yes
A6505		Compression burn garment, glove to elbow, custom fabricated	Yes
A6507		Compression burn garment, foot to knee length, Custom fabricated	Yes
A6508		Compression burn garment, foot to thigh length, Custom fabricated	Yes
A6509		Compression burn garment, upper trunk to waist Including arm openings (vest),custom fabricated	Yes
A6511		Compression burn garment, lower trunk including Openings (pantry), custom fabricated	Yes
A6512		Compression burn garment, not otherwise classified	Yes
A6513		Compression burn mask, face and /or neck, Plastic or equal, custom fabricated	Yes
A7003 *****		Administration set, small volume non-filtered pneumatic nebulizer (limited to 3 sets per month)	No
A7005 *****		Administration set, small volume non-filtered pneumatic nebulizer, non-disposable (limited to 2 per year)	No
A7015		Aerosol mask, used with DME Bebulizer	No
A7520		Tacheostomy or laryngectomty tube, non-cuffed, polyvinyl chloride (PVC). Silicone or equal each	No
A7525		Tracheostomy mask, each	No
A7526		Tracheostomy tube collar/holder, each	No
A9999*		Miscellaneous DME supply not otherwise specified (IV administration kit) (A9999 is to be used for supplies in the IV administration start kit only.) (limited to 70 per month)	No
B4034		Enteral feeding supply kit; per day	Yes
B4035		Enteral feeding supply kit; pump fed (1 set per day) kit includes tubing & bags	Yes
B4036		Enteral feeding supply kit; gravity fed 1 set per day)	Yes
B4081 *****		N/G Tubing with stylet	No
B4082 *****		N/G Tubing without stylet	No
B4086 *		Gastrostomy/jejunostomy tube, any material, any type (standard or low profile)	No
B9002	RR	Enteral nutrition infusion pump w/alarm, per day	Yes
B9004 *****	RR	Parenteral nutrition infusion pump, portable, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
B9006 *****	RR	Parenteral nutrition infusion pump, stationary, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
B9998	EP	Not otherwise classified for enteral supplies • Catheter plug adapter • Enteral feeding adapter, “Y” • GT button adapter 18 fr cont. and/or bolus • GT button decompression tube 24 fr 1.7 • R angle adapter	Yes
E0100 *****		Cane, includes canes of all materials, adjustable or fixed, with tip	No
E0105 *****		Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	No
E0110 *****		Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	No
E0112 *****		Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	No
E0130 *****		Walker, rigid (pickup), adjustable/fixed height	No

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E0135 *		Walker, folding (pickup), adjustable or fixed height	No
E0146 *		Walker, wheeled with seat	No
E0153		Platform attachment, forearm crutch	Yes
E0163 *		Commode chair, stationary with fixed arms	No
E0165 *		Commode chair, stationary with detachable arms	No
E0178		Gel pressure pad or cushion, non-positioning	Yes
E0181 *		Pressure pad, alternating with pump, Heavy Duty	Yes
E0184		Dry pressure mattress	No
E0185 *		Gel or gel-like pressure pad for mattress (limited to one every two years)	Yes
E0188 *		Synthetic sheep skin pad	No
E0191 *		Heel or elbow protector, each	No
E0192 *		Low pressure and positioning equalization pad for wheelchair	Yes
E0202		Phototherapy (bilirubin) light with photometer	Yes
E0210 *		Electric heat pad, standard	No
E0250 *		Hospital bed, with side rails, fixed height, with mattress	Yes
E0255 *		Hospital bed, with side rails, variable height, HI-LO, with mattress	Yes
E0260 *		Semi electric hospital bed	Yes
E0271 *		Mattress, inner-spring (replacement for medically necessary hospital bed owned by recipient)	Yes
E0275 *		Bedpan, standard, metal or plastic	No
E0276 *		Bedpan, fracture, metal or plastic	No
E0277	RR	Power pressure reducing air mattress	Yes
E0280		Bed cradle, any type	Yes
E0310 *		Bed side rails (full length)	Yes
E0445		Pulse oximeter machine (Note: load specific number of units)	Yes
E0450		Volume ventilator; portable (includes battery, battery charger, & battery cables) (E0451ZN)	Yes
E0455		Oxygen tent, excluding croup or pediatric tents	Yes
E0461		Volume control ventilator, without pressure support mode, may include pressure control mode, used with non-invasive interface (e.g., mask)	Yes
E0463		Pressure support ventilator, with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)	Yes
E0470	RR	Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with noninvasive interface, e.g.,nasal or facial mask	Yes
E0471		Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, e.g.,nasal or facial mask	Yes
E0472	RR	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with invasive interface,e.g., tracheostomy tube (intermittent	Yes
E0480		Percussor, electric or pneumatic, home model	No
E0483		High Frequency Chest Wall Oscillation Air Pulse Generator System (includes Hoses and Vest)	Yes
E0550		Humidifier, durable, for extensive supplemental humidification during IPPB treatment or oxygen delivery.	Yes
E0561	RR	Humidifier, non-heated, used with positive airway pressure device	Yes
E0562	RR	Humidifier, heated, used with positive airway pressure device	Yes

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E0565		Compressor	Yes
E0565		Compressor; air power source for equipment not self-contained or cylinder driven; large volume air compressor	Yes
E0570 *		Nebulizer, with compressor (limited to one every four years)	No
E0575		Nebulizer, self-contained, ultrasonic	Yes
E0585		Nebulizer with compressor & heater	Yes
E0600 *		Suction Pump, home model, portable	Yes
E0601	RR	Continuous airway pressure (CPAP) device	Yes
E0607 *		Home blood glucose monitor	Yes
E0619		Apnea monitor with recording feature	Yes
E0621 *		Sling or seat for patient lift, canvas or nylon	No
E0630 *		Patient lift, hydraulic, with seat or sling	Yes
E0650		Pneumatic compressor, non segmental home model	Yes
E0667		Pneumatic appliance for use with segmental pneumatic compressor, leg	Yes
E0668		Arm appliance for linear pump	Yes
E0776 *		IV Pole (HOME IV ONLY)	No
E0781 *	RR	Ambulatory Pump (HOME IV ONLY)	Yes
E0784		External Ambulatory Infusion Pump, Insulin	Yes
E0791		Parenteral infusion pump, stationary, single or multi-channel (for chemotherapy or morphine)	Yes
E0850		Traction stand, free standing, simple cervical traction	Yes
E0890		Traction frame, attached to footboard, simple pelvic traction	Yes
E0910 *		Trapeze bars, AKA patient helper, attached to bed, with grab bar	Yes
E0953		Pneumatic tire	Yes
E0958		Manual wheelchair accessory to convert any wheelchair to one arm drive	Yes
E0963 *		2” cushion for wheelchair	Yes
E0964 *		3” cushion for wheelchair	Yes
E0965 *		4” cushion for wheelchair	Yes
E0972		Transfer bench	Yes
E0978		Wheelchair accessory safety belt / pelvic strap each	Yes
E0980		Safety Vest, Wheelchair	Yes
E0996		Tire, solid	Yes
E0999		Pneumatic tire	Yes
E1000		Tire, pneumatic caster	Yes
E1037		Transport chair pediactric size	Yes
E1050		Fully reclining wheelchair, fixed full length arms, swing away detachable elevating legrest	Yes
E1050 *		Fully-reclining wheelchair, fixed full-length arms, swing away detachable elevating leg rests	Yes
E1060 *		Fully reclining wheelchair, detachable arms, (desk or full length) swing away detachable elevating leg rests	Yes
E1070 *		Fully-reclining wheelchair, detachable arms (desk or full length), swing away detachable footrest	Yes
E1088*		High strength lightweight wheelchair, detachable arms, desk or full length swing away detachable elevating leg rests	Yes
E1091		Youth wheelchair , any type	Yes
E1093 *		Wide heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1110 *		Semi-reclining wheelchair, detachable arms, (desk or full length), elevating leg rests	Yes

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E1130 *		Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	Yes
E1140 *		Standard wheelchair, detachable arms, (desk or full length), swing away detachable footrests	Yes
E1150 *		Wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1160 *		Standard wheelchair, fixed full length arms, swing away detachable elevating leg rests	Yes
E1180 *		Amputee wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1190 *		Amputee wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1200 *		Amputee wheelchair, fixed full length arms, swing away detachable footrest	Yes
E1220		Wheelchair; specially sized or constructed, (indicate brand name, model number, if any and justification	Yes
E1240 *		Lightweight wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1280 *		Heavy duty wheelchair, detachable arms (desk or full length), elevating leg rests	Yes
E1285 *		Heavy duty wheelchair, fixed full length arms, swing away detachable footrests	Yes
E1290 *		Heavy duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E2602*		General, use wheelchair seat cushion, width 22 inches or greater, any depth (replaced (E0963, E0964)	Yes
E2603*		Skin protection wheelchair seat cushion, width less than 22 inches, any depth (replaced E0192)	Yes
E2604*		Skin protection wheelchair seat cushion, width less than 22 inches or greater, any depth (replaced E0192)	Yes
E1390*		Oxygen concentrator capable of delivering 85% or greater oxygen concentration at the prescribed flow rate	Yes

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E1399	EP	DME, not otherwise classified • Aerosol drainage system • Bubble humidifier • Clinitest kit (includes dropper tubes, & 5 or 6 Clinitest tabs) • Davol mucus specimen trap (Delee) • Disposable jet nebulizer • Drain bag for trach, 750cc • Enviracare model EV-35 with HEPA filter • Exhalation manifold • Enviracare model EV-35 replacement filters 2 per pack • Face masks, 50 count • Filter cabinet • Manual resuscitator with oxygen accumulator • Mushroom valve • Nebulizer adapters with 750 ml sterile water • Nitrazine paper with dispenser • Non-molded pediatric helmet • Padded tub transfer bench • Peep valves for ventilator • Respiguard II • Swan neck splint index finger size 4/1 • Swan neck splint (l) middle size 3 1/2/1 • VOL pump set, pancreatic 78” • Feeder seats • Orthopedic seats	Yes
E1399 *		DME, not otherwise classified • Heat moisture exchanger • Right angle adapter for gastronomy tube • Spring steel catheter clamp • Suction filter (for internal use with suction pump) • 10lb sand weight bag • Twill tape (72' roll)	Yes

NOTE:

Procedure codes E1399 or E1399 (EP) should be entered on a claim as one line item. The money amounts for multiple items approved on a prior authorization request for E1399 or E1399 (EP) should be combined and the total money amount billed as one lump sum. If each approved item on a prior authorization request is billed as a separate line item on the same date of service for the same prior authorization number, the claim will deny as a duplicate.

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
K0007 *		Extra Heavy Duty Wheelchair (weight capacity up to 600 pounds)	Yes
K0009		Manual wheelchair base (weight capacity 600 lbs and above	Yes
K0108		Wheelchair component or accessory not otherwise specified	Yes
K0549		Hospital bed heavy duty, extra wide with any type side rails, with mattress.	Yes
L1900 *		Ankle-foot orthosis (AFO), spring wire, dorsiflexion assist calf band	No
L1940 *		AFO, molded to patient, plastic	No
L1990 *		AFO, double upright free plantar dorsiflexion, solid, stirrup, calf band/cuff (double bar “BK” orthosis)	No
A6530		Gradient compression stockings, below knee, 18-30 MMHG, each limited to eight (8) stockings per year (4 pairs)	No
A6533		Gradient compression stockings, thigh length, 18-30 MMHG, each limited to eight (8) stockings per year (4 pairs)	No
L8501		Tracheotomy speaking valve	No

Oxygen

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E0424 *		Stationary compressed gaseous oxygen system, rental; includes contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes
E0431 *		Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask, tubing.	Yes
E0441 *		Oxygen contents, gaseous, (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)	Yes
E0443		Portable oxygen contents, gaseous, per unit for use only with portable gaseous systems when no stationary gas or liquid system is used. (limited to 4 refills per month, per recipient with Medicaid justification)	Yes
E1390 *		Oxygen concentrator capable of delivering 85% or greater oxygen concentration at the prescribed flow rate	Yes

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form must be filled out, signed and dated by the ordering physician.

External Ambulatory Infusion Pump & Supplies

Procedure Code	*Modifier*	*Description of Item*	*PA Required*
E0784		External Ambulatory Infusion Pump will be limited to one every five years based on submitted documentation. This procedure code will be a capped rental item with rental payment of $360.00 per month for twelve months. At the end of the twelve month period, the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance/repair cost would be subject to an EPSDT screening and referral and a prior authorization as addressed under current Medicaid policy.	Yes
A4232		Syringe with needle for External Insulin Pump, sterile 3cc (each) will be supplied in quantities prescribed as medically necessary by the physician.	No
A4221		Supplies for maintenance of drug infusion catheter per week will be limited to three supply kits per week; no more than twelve supply kits per month. These supply kits must be prescribed as medically necessary by the recipient's physician. If additional supply kits are needed, an EPSDT screening and referral and a prior authorization must be submitted to Medicaid for review.	No

Deleted: ~~A4632~~

NOTE:

Insulin pumps are limited to one every five years.

Supplies used with BI-PAP and CPAP Machines

A7030 Full mask fused with positive airway pressure device

A7031 Face mask interface, replacement for full facemask, each

A7032 Replacement cushion for nasal application device, each

A7033 Replacement pillows for nasal application device, pair

A7034 Nasal interface (mask or cannula type) used with positive airway pressure device, without head strap

A7035 Headgear used positive airway pressure device

A7036 Chinstrap used with positive airway pressure device

A7037 Tubing used with positive airway pressure device

A7038 Filter, disposable, used with positive airway pressure device

A7039 Filter, non disposable, used with positive airway pressure device

A7044 Oral interface used with positive airway pressure device, each

A7046 Water chamber for humidifier, used with positive airway pressure device, replacement each

Orthotic Devices

All orthotics and prosthetics (L Codes) are covered for children up to the age of 21 through the EPSDT Program with a current screening and referral.

Orthotic - Upper Limb

Added: A8000 and A8001

Procedure Code	***Description***
A8000	Helmet protective, soft, prefabricated, includes all components and accessories
A8001	Helmet protective, hard, pre fabricated, includes all components and accessories
L0120	Cervical, flexible, non-adjustable (foam collar)
L0130	Cervical, flexible, thermoplastic collar, molded to patient
L0140	Cervical, semi-rigid, adjustable (plastic collar)
L0150	Cervical, semi-rigid, adjustable molded chin cup (plastic collar, with mandibular/occipital piece)

Orthotic - Upper Limb

Procedure Code	***Description***
L0160	Cervical, semi-rigid, wire frame occipital/mandibular support
L0170	Cervical, collar, molded to patient model
L0172	Cervical, collar, semi-rigid thermoplastic foam, two piece
L0174	Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension
L0180	Cervical, multiple post collar, occipital/mandibular supports, adjustable
L0190	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (Somi, Guilford, Taylor types)
L0200	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension
L0210	Thoracic rib belt, custom fitted
L0220	Thoracic rib belt, custom fabricated
L0300	Thoracic-lumbar-sacral-orthosis (TLSO), flexible (dorso-lumbar surgical support)
L0310	TLSO, flexible (dorso-lumbar surgical support), custom fabricated
L0315	TLSO, flexible (dorso-lumbar surgical support), elastic type, with rigid posterior panel
L0317	TLSO, flexible (dorso-lumbar surgical support), hyperextension, elastic type, with rigid posterior panel
L0320	TLSO, anterior-posterior control, (Taylor type), with apron front
L0330	TLSO, anterior-posterior-lateral control, (Knight-Taylor type), with apron front
L0340	TLSO, anterior-posterior-lateral-rotary control (Arnold, Magnuson, Steindler types), with apron front
L0350	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, custom fitted
L0360	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, molded to patient model
L0370	TLSO, anterior-posterior-lateral-rotary control, hyperextension, (Jewett, Lennox, Baker, Cash types)
L0380	TLSO, anterior-posterior-lateral-rotary control, with extensions
L0390	TLSO, anterior-posterior-lateral control, molded to patient model
L0400	TLSO, anterior-posterior-lateral control, molded to patient model, with interface material
L0410	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model

Procedure Code	***Description***
L0420	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model, with interface material
L0430	TLSO, anterior-posterior-lateral control, with interface material, custom fitted
L0440	TLSO, anterior-posterior-lateral control, with overlapping front section, spring steel front, custom fitted
L0491	TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0492	TLSO, sagittal-coronal control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment
L0520	LSO, anterior-posterior-lateral control, (Knight, Wilcox types), with apron front
L0530	LSO, anterior-posterior control, (MacAusland type), with apron front
L0621	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
L0622	Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
L0623	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment
L0624	Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated
L0625	Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment
L0626	Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0627	Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0628	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0629	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated

Procedure Code	***Description***
L0630	Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0631	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0632	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated
L0633	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0634	Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated
L0635	Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0636	Lumbar sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated
L0637	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L0638	Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated
L0639	Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment

Procedure Code	Description
L0640	Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated
K0645	Lumbar sacral orthosis, sagittal-coronal control lumbar flexion rigid posterior frame/panels, lateral articulating design to flex the lumbar spine
K0646	Lumbar-sacral orthosis, sagittal-coronal control rigid anterior and posterior frame/panels, posteror extends from sacrococcygeal junction to T-9.
K0649	Lumbar-sacral orthosis, sagittal-coronal control rigid shell (S), posteriaextends from sasroccgeal junctionto T-9 vertebra, anterior
L0700	Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model, (Minerva type)
L0710	CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material, (Minerva type)
L0810	Halo procedure, cervical halo incorporated into jacket vest
L0820	Halo procedure, cervical halo incorporated into plaster body jacket
L0830	Halo procedure, cervical halo incorporated into Milwaukee type orthosis
L0859	Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material
L0860	Addition to halo procedures, magnetic resonance image compatible system

Orthotic - Lower Limb

Procedure Code	Description
L0900	Torso support, ptosis support
L0910	Torso support, ptosis support, custom fabricated
L0920	Torso support, pendulous abdomen support
L0930	Torso support, pendulous abdomen support, custom fabricated
L0940	Torso support, post surgical support
L0950	Torso support, post-surgical support, custom fabricated
L0960	Torso support, post-surgical support, pads for post-surgical support
L0970	TLSO, corset front
L0972	LSO, corset front
L0974	TLSO, full corset
L0976	LSO, full corset
L0978	Axillary crutch extension
L0980	Peroneal straps, pair
L0982	Stocking supporter grips, set of 4
L0984	Protective body sock, each

Orthotic - Upper Limb

Procedure Code	Description
L0999	Addition to spinal orthosis, not otherwise specified
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), inclusive of furnishing initial orthosis, including model
L1001	Cervical thoracic lumbar sacral orthosis immobilizer, infant size, prefabricated, includes fitting and adjustments
L1010	Addition to CTLSO or scoliosis orthosis, axilla sling
L1020	Addition to CTLSO or scoliosis orthosis, kyphosis pad
L1025	Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating
L1030	Addition to CTLSO or scoliosis orthosis, lumbar bolster pad

Procedure Code	***Description***
L1040	Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad
L1050	Addition to CTLSO or scoliosis orthosis, sternal pad
L1060	Addition to CTLSO or scoliosis orthosis, thoracic pad
L1070	Addition to CTLSO or scoliosis orthosis, trapezius sling
L1080	Addition to CTLSO or scoliosis orthosis, outrigger
L1085	Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions
L1090	Addition to CTLSO or scoliosis orthosis, lumbar sling
L1100	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather
L1110	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model
L1120	Addition to CTLSO, scoliosis orthosis, cover for upright, each
L1200	Thoracic-lumbar-sacral orthosis (TLSO), inclusive of furnishing initial orthosis only
L1210	Addition to TLSO, (low profile), lateral thoracic extension
L1220	Addition to TLSO, (low profile), anterior thoracic extension
L1230	Addition to TLSO, (low profile), Milwaukee type superstructure
L1240	Addition to TLSO, (low profile), lumbar derotation pad
L1250	Addition to TLSO, (low profile), anterior asis pad
L1260	Addition to TLSO, (low profile), anterior thoracic derogation pad
L1270	Addition to TLSO, (low profile), abdominal pad
L1280	Addition to TLSO, (low profile), rib gusset (elastic), each
L1290	Addition to TLSO, (low profile), lateral trochanteric pad
L1300	Other scoliosis procedure, body jacket molded to patient model **(REQUIRES PRIOR AUTHORIZATION)**
L1310	Other scoliosis procedure, post-operative body jacket **(REQUIRES PRIOR AUTHORIZATION)**
L1499	Spinal orthosis, not otherwise specified

Orthotic - Lower Limb

Procedure Code	***Description***
L1500	Thoracic-hip-knee-ankle orthosis, (THKAO), mobility frame (Newington, Parapodium types)
L1510	THKAO, standing frame
L1520	THKAO, swivel walker **(REQUIRES PRIOR AUTHORIZATION)**
L1600	Hip orthosis, (HO), abduction control of hip joints, flexible, Frejka type with cover
L1610	HO, abduction control of hip joints, flexible, Frejka cover only
L1620	HO, abduction control of hip joints, flexible, Pavlik harness
L1630	HO, abduction control of hip joints, semi-flexible (Von Rosen type)
L1640	HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs
L1650	HO, abduction control of hip joints, static, adjustable, (Ilfled type)
L1660	HO, abduction control of hip joints, static, plastic
L1680	HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thighcuffs, (Rancho hip action type)
L1685	HO, abduction control of hip joints, post-operative hip abduction type, custom fabricated
L1686	HO, Abduction control of hip joint, post-operative hip abduction type
L1700	Legg Perthes orthosis, (Toronto type)
L1710	Legg Perthes orthosis, (Newington type)
L1720	Legg Perthes orthosis, trilateral, (Tachdijan type)
L1730	Legg Perthes orthosis, (Scottish rite type)
L1750	Legg Perthes orthosis, Legg Perthes sling, (Sam Brown type)

Procedure Code	Description
L1755	Legg Perthes orthosis, (Patten bottom type)
L1800	Knee orthosis, (KO), elastic with stays
L1810	KO, elastic with joints
L1815	KO, elastic or other elastic type material with condylar pad(s)
L1820	KO, elastic or other elastic type material with condylar pads and joints
L1825	KO, elastic knee cap
L1830	KO, immobilizer, canvas longitudinal
L1832	KO, adjustable knee joints, positional orthosis, rigid support
L1834	KO, without knee joint, rigid, molded to patient model
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated to patient model
L1843	KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted
L1844	KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted
L1846	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model

Prosthetic - Lower Limb

Procedure Code	Description
L1850	KO, Swedish type
L1855	KO, molded plastic, thigh and calf sections, with double upright knee joints, molded to patient model
L1858	KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI)
L1860	KO, modification of supracondylar prosthetic socket, molded to patient model,(SK)
L1870	KO, double upright, thigh and calf lacers, molded to patient model, with knee joints
L1880	KO, double upright, non-molded thigh and calf cuffs/lacers, with knee joints
L1885	KO, single or double upright, thigh and calf, with functional active resistance control
L1900 *	Ankle-foot orthosis, (AFO), spring wire, dorsiflexion assist calf band
L1902	AFO, ankle gauntlet, custom fitted
L1904	AFO, molded ankle gauntlet, molded to patient model
L1906	AFO, multiligamentus ankle support
L1907	AFO, Supramalleolar, with or without interface pads, custom fabricated
L1910	AFO, posterior, single bar, clasp attachment to shoe counter
L1920	AFO, single upright with static or adjustable stop, (Phelps or Perlstein type)
L1930 *	AFO, plastic
L1940 *	AFO, molded to patient model, plastic
L1945	AFO, molded to patient model, plastic, rigid interior tibial section (floor reaction)
L1950	AFO, spiral, molded to patient model, (IRM type), plastic
L1960	AFO, posterior solid ankle, molded to patient model, plastic
L1970	AFO, plastic, molded to patient model, with ankle joint
L1980	AFO, single upright, free plantar dorsiflexion, solid stirrup, calf band/cuff, (single bar “BK” orthosis)
L1990 *	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff, (double bar “BK” orthosis)
L2000	Knee-ankle-foot orthosis, (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs, (single bar “AK” orthosis)

Procedure Code	***Description***
L2010	KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (single bar “AK” orthosis), without knee joint
L2020	KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis)
L2030	KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis), without knee joint
L2035	KAFO, full plastic, static, prefabricated (pediatric size)
L2036	KAFO, full plastic, double upright, free knee, molded to patient model
L2037	KAFO, full plastic, single upright, free-knee, molded to patient model
L2038	KAFO, full plastic, without knee joint, multiaxis ankle, molded to patient model (Lively orthosis or equal)
L2039	KAFO, full plastic, single upright, poly-axial hinge, medial lateral rotation control, molded to patient model
L2040	HKAFO, torsion control, bilateral rotation straps, pelvic band/belt
L2050	HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt
L2060	HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt
L2070	HKAFO, torsion control, unilateral rotation straps, pelvic band/belt
L2080	HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt
L2090	HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt
L2102	AFO, fracture orthosis, tibial fracture cast orthosis, plaster type casting material, molded to patient
L2104	AFO, fracture orthosis, tibial fracture cast orthosis, synthetic type casting material, molded to patient
L2106	AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient
L2108	AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid
L2122	KAFO, fracture orthosis, femoral fracture cast orthosis, plaster type casting material, molded to patient
L2124	KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient
L2126	KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, molded to patient
L2128	KAFO, fracture orthosis, femoral fracture cast orthosis, molded to patient model
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid
L2180	Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints
L2182	Addition to lower extremity fracture orthosis, drop lock knee joint
L2184	Addition to lower extremity fracture orthosis, limited motion knee joint
L2186	Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman Type
L2188	Addition to lower extremity fracture orthosis, quadrilateral brim
L2190	Addition to lower extremity fracture orthosis, waist belt
L2192	Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt
L2200	Addition to lower extremity, limited ankle motion, each joint
L2210	Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint
L2220	Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint

Procedure Code	Description
L2230	Addition to lower extremity, split flat caliper stirrups and plate attachment
L2232	Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only
L2240	Addition to lower extremity, round caliper and plate attachment
L2250	Addition to lower extremity, foot plate, molded to patient model, stirrup attachment
L2260	Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)
L2265	Addition to lower extremity, long tongue stirrup
L2270	Addition to lower extremity, varus, vulgus correction (“T”) strap, padded/lined or malleolus pad
L2275	Addition to lower extremity, varus, vulgus correction, plastic modification, padded/lined
L2280	Addition to lower extremity, molded inner boot
L2300	Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable
L2310	Addition to lower extremity, abduction bar, straight
L2320	Addition to lower extremity, non-molded lacer
L2330	Addition to lower extremity, lacer molded to patient model
L2335	Addition to lower extremity, anterior swing band
L2340	Addition to lower extremity, pre-tibial shell, molded to patient model
L2350	Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for “PTB” or “AFO” orthoses)
L2360	Addition to lower extremity, extended steel shank
L2370	Addition to lower extremity, Patten bottom
L2375	Addition to lower extremity, torsion control, ankle joint and half solid stirrup
L2380	Addition to lower extremity, torsion control, straight knee joint, each joint
L2385	Addition to lower extremity, straight knee joint, heavy duty, each joint
L2390	Addition to lower extremity, offset knee joint, each joint
L2395	Addition to lower extremity, offset knee joint, heavy duty, each joint
L2397	Addition to lower extremity orthosis, suspension sleeve
L2405	Addition to knee joint, drop lock, each joint
L2415	Addition to knee joint, cam lock (Swiss, French, Bail types) each joint
L2425	Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint
L2430	Addition to knee joint, ratchet lock for active and progressive knee extension, each joint
L2435	Addition to knee joint, polycentric joint, each joint
L2492	Addition to knee joint, lift loop for drop lock ring
L2500	Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring
L2510	Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model
L2520	Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted
L2525	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model
L2526	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted
L2530	Addition to lower extremity, thigh/weight bearing, lacer, non-molded
L2540	Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model
L2550	Addition to lower extremity, thigh/weight bearing, high roll cuff
L2570	Addition to lower extremity, pelvic control, hip joint, Clevis type, two position joint, each
L2580	Addition to lower extremity, pelvic control, pelvic sling
L2600	Addition to lower extremity, pelvic control, hip joint, Clevis type or thrust bearing, free, each

Added: L2232

Procedure Code	***Description***
L2610	Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each
L2620	Addition to lower extremity, pelvic control, hip joint, heavy duty, each
L2622	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each
L2624	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each
L2627	Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables
L2628	Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables
L2630	Addition to lower extremity, pelvic control, band and belt, unilateral
L2640	Addition to lower extremity, pelvic control, band and belt, bilateral
L2650	Addition to lower extremity, pelvic and thoracic control, gluteal pad, each

Orthotic - Upper Limb

Procedure Code	***Description***
L2660	Addition to lower extremity, thoracic control, thoracic band
L2670	Addition to lower extremity, thoracic control, paraspinal uprights
L2680	Addition to lower extremity, thoracic control, lateral support uprights

Orthotic - Lower Limb

Procedure Code	***Description***
L2750	Addition to lower extremity orthosis, plating chrome or nickel, per bar
L2755	Addition to lower extremity orthosis, carbon graphite lamination
L2760	Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)
L2770	Addition to lower extremity orthosis, stainless steel, per bar or joint
L2780	Addition to lower extremity orthosis, non-corrosive finish, per bar
L2785	Addition to lower extremity orthosis, drop lock retainer, each
L2795	Addition to lower extremity orthosis, knee control, full kneecap
L2800	Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull
L2810	Addition to lower extremity orthosis, knee control, condylar pad
L2820	Addition to lower extremity orthosis, soft interface for molded plastic, below knee section
L2830	Addition to lower extremity orthosis, soft interface for molded plastic, above knee section
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L2860	Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism, each
L2999	Lower extremity orthosis, not otherwise specified
L3000	Foot, insert, removable, molded to patient model, UCBll type, Berkeley Shell, each
L3001	Foot, insert, removable, molded to patient model, Spenco, each
L3002	Foot, insert, removable, molded to patient model, Plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model, silicone gel, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each

Procedure Code	***Description***
L3030	Foot, insert, removable, formed to patient foot, each
L3040	Foot, arch support, removable, pre-molded, longitudinal, each
L3050	Foot, arch support, removable, pre-molded, metatarsal, each
L3060	Foot, arch support, removable, pre-molded, longitudinal/metatarsal, each
L3070	Foot, arch support, non-removable, attached to shoe, longitudinal, each
L3080	Foot, arch support, non-removable, attached to shoe, metatarsal, each
L3090	Foot arch support, non-removable, attached to shoe, longitudinal/metatarsal, each
L3100	Hallus-valgus night dynamic splint
L3140	Foot, abduction rotation bar, including shoes
L3150	Foot, abduction rotation bar, without shoes
L3160	Foot, adjustable shoe-styled positioning device
L3170	Foot, plastic heel stabilizer
L3201	Orthopedic shoe, oxford with supinator or pronator, infant
L3202	Orthopedic shoe, oxford with supinator or pronator, child
L3203	Orthopedic shoe, oxford with supinator or pronator, junior
L3204	Orthopedic shoe, hightop with supinator or pronator, infant
L3206	Orthopedic shoe, hightop with supinator or pronator, child
L3207	Orthopedic shoe, hightop with supinator or pronator, junior
L3208	Surgical boot, each, infant
L3209	Surgical boot, each, child
L3211	Surgical boot, each, junior
L3212	Benesch boot, pair, infant
L3213	Benesch boot, pair, child
L3214	Benesch boot, pair, junior
L3215	Orthopedic footwear, ladies shoes, oxford
L3216	Orthopedic footwear, ladies shoes, depth inlay
L3217	Orthopedic footwear, ladies shoes, hightop, depth inlay
L3218	Orthopedic footwear, ladies surgical boot, each
L3219	Orthopedic footwear, men’s shoes, oxford
L3221	Orthopedic footwear, men’s shoes, depth inlay
L3222	Orthopedic footwear, men’s shoes, hightop, depth inlay
L3223	Orthopedic footwear, men’s surgical boot, each
L3224	Orthopedic footwear, woman’s shoe, oxford, used as an integral part of a brace (orthosis)
L3225	Orthopedic footwear, man’s shoe, oxford, used as an integral part of a brace (orthosis)
L3230	Orthopedic footwear, custom shoes, depth inlay
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each
L3251	Foot, shoe molded to patient model, silicone shoe, each
L3252	Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each
L3253	Foot, molded shoe, plastazote (or similar), custom fitted, each
L3254	Non-standard size or width
L3255	Non-standard size or length
L3257	Orthopedic footwear, additional charge for split size
L3260	Ambulatory surgical boot, each
L3265	Plastazote sandal, each
L3300	Lift, elevation, heel, tapered to metatarsals, per inch
L3310	Lift, elevation, heel and sole, neoprene, per inch
L3320	Lift, elevation, heel and sole, cork, per inch
L3330	Lift, elevation, metal extension, (skate)
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch

Procedure Code	***Description***
L3334	Lift, elevation, heel, per inch
L3340	Heel wedge, Sach
L3350	Heel wedge
L3360	Sole wedge, outside sole
L3370	Sole wedge, between sole
L3380	Clubfoot wedge
L3390	Out flare wedge
L3400	Metatarsal bar wedge, rocker
L3410	Metatarsal bar wedge, between sole
L3420	Full sole and heel wedge, between sole
L3430	Heel, counter, plastic reinforced
L3440	Heel, counter, leather reinforced
L3450	Heel, Sach cushion type
L3455	Heel, new leather, standard
L3460	Heel, new rubber, standard
L3465	Heel, Thomas with wedge
L3470	Heel, Thomas extended to ball
L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur
L3500	Miscellaneous shoe addition, insole, leather
L3510	Miscellaneous shoe addition, insole, rubber
L3520	Miscellaneous shoe addition, insole, felt covered with leather
L3530	Miscellaneous shoe addition, sole, half
L3540	Miscellaneous shoe addition, sole, full
L3550	Miscellaneous shoe addition, toe tap, standard
L3560	Orthopedic shoe addition, toe tap, horseshoe
L3570	Miscellaneous shoe addition, special extension to instep, (leather with eyelets)
L3580	Miscellaneous shoe addition, convert instep to Velcro closure
L3590	Miscellaneous shoe addition, convert firm shoe counter to soft counter
L3595	Miscellaneous shoe addition, March bar
L3600	Transfer of an orthosis from one shoe to another, caliper plate, existing
L3610	Transfer of an orthosis from one shoe to another, caliper plate, new
L3620	Transfer of an orthosis from one shoe to another, solid stirrup, existing
L3630	Transfer of an orthosis from one shoe to another, solid stirrup, new
L3640	Transfer of an orthosis from one shoe to another, Dennis Browns splint (Riveton), both shoes
L3649	Unlisted procedures for foot orthopedic shoes, shoe modifications and transfers
L3650	Shoulder orthosis, (SO), figure 8 design abduction restrainer
L3660	SO, figure 8 design abduction restrainer, canvas and webbing
L3670	SO, acromio/clavicular, (canvas and webbing type)
L3671	Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3672	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3673	Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment

Orthotic - Upper Limb

Procedure Code	*Description*
L3700	Elbow orthoses, (EO), elastic with stays
L3702	Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3710	EO, elastic with metal joints
L3720	EO, double upright, with forearm/arm cuffs, free motion
L3730	EO, double upright, with forearm/arm cuffs, extension/ flexion assist
L3740	EO, double upright, with forearm/arm cuffs, adjustable position lock with active control
L3763	Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3764	Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3765	Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3766	Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3800	Wrist-hand-finger orthoses, (WHFO), short opponens, no attachments
L3805	WHFO, long opponens, no attachment
L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckle, may include soft interface material, straps, custom
L3810	WHFO, addition to short and long opponens, thumb abduction ib Cld bar
L3815	WHFO, addition to short and long opponens, second M.P. abduction assist
L3820	WHFO, addition to short and long opponens, I.P. extension assist, with M.P. extension stop
L3825	WHFO, addition to long and short opponens, M.P. extension stop
L3830	WHFO, addition to short and long opponens, M.P. extension assist
L3835	WHFO, addition to short and long opponens, M.P. spring extension assist
L3840	WHFO, addition to short and long opponens, spring swivel thumb
L3845	WHFO, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop
L3850	WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855	WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.
L3890	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each
L3900	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven
L3901	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion extension, cable driven
L3904	WHFO, external powered, electric
L3905	Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3906	WHFO, wrist, (gauntlet), molded to patient model
L3907	WHFO, wrist gauntlet with thumb spica, molded to patient model
L3908	WHFO, wrist extension control (cock-up), non-molded
L3910	WHFO, Swanson design
L3912	WHFO, flexion glove, with elastic finger control

Procedure Code	***Description***
L3913	Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3916	WHFO, wrist extension (cock-up), with outrigger
L3918	WHFO, knuckle bender
L3919	Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3920	WHFO, knuckle bender, with outrigger
L3921	Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3922	WHFO, knuckle bender, two-segment to flex joints
L3924	WHFO, Oppenheimer
L3926	WHFO, Thomas suspension
L3928	WHFO, finger extension, with clock spring
L3930	WHFO, finger extension, with wrist support
L3932	WHFO, safety pin, spring wire
L3933	Finger orthosis, without joints, may include soft interface, custom fabricated, includes fitting and adjustment
L3934	WHFO, safety pin, modified
L3935	Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment
L3936	WHFO, Palmer
L3938	WHFO, dorsal wrist
L3940	WHFO, dorsal wrist, with outrigger attachment
L3942	WHFO, reverse knuckle bender
L3944	WHFO, reverse knuckle bender, with outrigger
L3946	WHFO, composite elastic
L3948	WHFO, finger knuckle bender
L3950	WHFO, combination Oppenheimer, with knuckle bender, and two attachments
L3952	WHFO, combination Oppenheimer, with reverse knuckle bender and two attachments
L3954	WHFO, spreading hand
L3956	Addition of joint to upper extremity orthosis, any material, per joint
L3960	Shoulder-elbow-wrist-hand orthosis, (SEWHO), abduction positioning, airplane design
L3961	Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3962	SEWHO, abduction positioning, Erbs Palsey design
L3963	SEWHO, molded shoulder, arm, forearm, and wrist, with articulating elbow joint
L3964	SEO, mobile arm support attached to wheelchair, balanced, adjustable 1
L3965	SEO, mobile arm support attached to wheelchair, balanced, adjustable, rancho type 1
L3966	SEO, mobile arm support attached to wheelchair, balanced, reclining 1
L3967	Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3968	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) 1
L3969	SEWHO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support 1
L3970	SEWHO, addition to mobile arm support, elevating proximal arm 1
L3971	Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

Procedure Code	Description
L3972	SEWHO, addition to mobile arm support, offset or lateral rocker arm, with elastic balance control 1
L3973	Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3974	SEWHO, addition to mobile arm support, supinator 1
L3975	Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3976	Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3977	Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3978	Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L3980	Upper extremity fracture orthosis, humeral
L3982	Upper extremity fracture orthosis, radius/ulnar
L3984	Upper extremity fracture orthosis, wrist
L3985	Upper extremity fracture orthosis, forearm, hand with wrist hinge
L3986	Upper extremity fracture orthosis, combination of humeral, radius ulnar, wrist (e.g., Colles fracture)
L3995	Addition to upper extremity orthosis, sock, fracture or equal, each
L3999	Upper extremity orthosis, not otherwise specified
L4000	Replace girdle for Milwaukee orthosis
L4010	Replace trilateral socket brim
L4020	Replace quadrilateral socket brim, molded to patient model
L4030	Replace quadrilateral socket brim, custom fitted

Orthotic - Lower Limb

Procedure Code	Description
L4040	Replace molded thigh lacer
L4045	Replace non-molded thigh lacer
L4050	Replace molded calf lacer
L4055	Replace non-molded calf lacer
L4060	Replace high roll cuff
L4070	Replace proximal and distal upright for KAFO
L4080	Replace metal bands KAFO, proximal thigh
L4090	Replace metal bands KAFO-AFO, calf or distal thigh
L4100	Replace leather cuff KAFO, proximal thigh
L4110	Replace leather cuff KAFO-AFO, calf or distal thigh
L4130	Replace pretibial shell

Repair Codes

Procedure Code	Description
L4205	Repair of orthotic device, labor component, per 15 minutes (Effective 1/1/97 this replaces HCPCS code L4200)
L4210	Repair of orthotic device, repair or replace minor parts

Procedure Code	Description
L4310	Multi-podus or equal orthotic preparatory management system for lower extremities

Orthotic - Lower Limb

Added: L4386

Procedure Code	Description
L4320	Addition to AFO, multi-podus (or equal) orthotic preparatory management system for lower extremities, Flexible foot positioner with soft interface for AFO, with Velcro closure
L4350	Pneumatic ankle control splint (aircast or equal)
L4360	Pneumatic walking splint (aircast or equal)
L4370	Pneumatic full leg splint (aircast or equal)
L4380	Pneumatic knee splint (aircast or equal)
L4386	Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment
L4390	Replace soft interface material, multi-podus type splint (Effective 1/1/97 this replaces HCPCS code K0126)
L4392	Replace soft interface material, ankle contracture splint (Effective 1/1/97 this replaces HCPCS code K0127)
L4394	Replace soft interface material, foot drop, splint (Effective 1/1/97 this replaces HCPCS code K0128)
L4396	Ankle contracture splint (Effective 1/1/97 this replaces HCPCS code K0129)
L4398	Foot drop splint, recumbent positioning device (Effective 1/1/97 this replaces HCPCS code K0130)
L5000	Partial foot, shoe insert, with longitudinal arch, toe filler

Prosthetic - Lower Limb

Procedure Code	Description
L5010	Partial foot, molded socket, ankle height, with toe filler
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler
L5050	Ankle, Symes, molded socket, SACH foot
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
L5100	Below knee, molded socket, shin, SACH foot
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	Above knee, short prosthesis, no knee joint (“stubbies”), with foot blocks, no ankle joints, each
L5220	Above knee, short prosthesis, no knee joint (“stubbies”), with articulated ankle/foot, dynamically aligned, each
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
L5250	Hip disarticulation, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	Hip disarticulation, tilt table type, molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
L5280	Hemipelvectomy, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5300	Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finishing

Procedure Code	Description
L5310	Knee disarticulation (or through knee), molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5320	Above knee, molded socket, open end, SACH foot, single axis knee, endoskeletal system, including soft cover and finishing
L5330	Hip disarticulation, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5340	Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing

Orthotic - Lower Limb

Procedure Code	Description
L5400	Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee
L5410	Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, below knee, each additional cast change and realignment
L5420	Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, and one cast change, “AK” or knee disarticulation
L5430	Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, ”AK” or knee disarticulation, each additional cast change and realignment
L5450	Immediate post-surgical or early fitting, application of non-weight bearing rigid dressing, below knee
L5460	Immediate post-surgical or early fitting, application of non-weight bearing rigid dressing, above knee

Prosthetic - Lower Limb

Procedure Code	Description
L5500	Initial, below knee, “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, direct formed
L5505	Initial, above-knee or knee disarticulation ischial level socket, USMC or equal pylon, no cover, Sach foot, plaster socket, direct formed
L5510	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, molded to model
L5520	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5530	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee in “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, laminated socket, molded to model
L5560	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, molded to model
L5570	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee-knee disarticulation, ischial level socket, “USMC” or equal pylon, no cover, SACH foot, prefabricated adjustable open end socket

Procedure Code	***Description***
L5590	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model
L5600	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient
L5610	Addition to lower extremity, above knee, Hydracadence system
L5611	Addition to lower extremity, above knee-knee disarticulation, 4-bar linkage, with friction swing phase control
L5613	Addition to lower extremity, above knee-knee disarticulation, 4-bar linkage, with hydraulic swing phase control
L5614	Addition to lower extremity, above knee-knee disarticulation, 4-bar linkage, with pneumatic swing phase control
L5616	Addition to lower extremity, above knee, Universal Multiplex system, friction swing phase control
L5617	Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each
L5618	Addition to lower extremity, test socket, Symes
L5620	Addition to lower extremity, test socket, below knee
L5622	Addition to lower extremity, test socket, knee disarticulation
L5624	Addition to lower extremity, test socket, above knee
L5626	Addition to lower extremity, test socket, hip disarticulation
L5628	Addition to lower extremity, test socket, hemipelvectomy
L5629	Addition to lower extremity, below knee, acrylic socket
L5630	Addition to lower extremity, Symes type, expandable wall socket
L5631	Addition to lower extremity, above knee or knee disarticulation, Acrylic socket
L5632	Addition to lower extremity, Symes type, PTBl, brim design socket
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636	Addition to lower extremity, Symes type, medial opening socket
L5637	Addition to lower extremity, below knee, total contact
L5638	Addition to lower extremity, below knee, leather socket
L5639	Addition to lower extremity, below knee, wood socket
L5640	Addition to lower extremity, knee disarticulation, leather socket
L5642	Addition to lower extremity, above knee, leather socket
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	Addition to lower extremity, above knee, wood socket
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	Addition to lower extremity, below knee, air cushion socket
L5647	Addition to lower extremity, below knee suction socket
L5648	Addition to lower extremity, above knee, air cushion socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket
L5654	Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5655	Addition to lower extremity, socket insert, below knee, (Kemblo, Pelite, Aliplast, Plastazote or equal)

Procedure Code	*Description*
L5656	Addition to lower extremity, socket insert, knee disarticulation, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5658	Addition to lower extremity, socket insert, above knee, (Kemblo, Pelite, Aliplast, Plastozote, or equal)
K0556	Addition to lower extremity, socket insert, Symes, silicone gel or equal
K0557	Addition to lower extremity, socket insert, multidurometer symes
K0558	Addition to lower extremity, socket insert, below knee, silicone gel or equal
K0559	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal
L5665	Addition to lower extremity, socket insert, multidurometer, below knee
L5666	Addition to lower extremity, below knee, cuff suspension
L5668	Addition to lower extremity, below knee, molded distal cushion
L5669	Addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism
L5670	Addition to lower extremity, below knee, molded supracondylar suspension (“PTS” or similar)
L5672	Addition to lower extremity, below knee, removable medial brim suspension
L5673	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastometric or
L5674	Addition to lower extremity, below knee, latex sleeve suspension or equal, each
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair
L5677	Additions to lower extremity, below knee, knee joints, polycentric, pair
L5678	Additions to lower extremity, below knee, joint covers, pair

Orthotic - Lower Limb

Procedure Code	*Description*
L5679	Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastometric
L5680	Addition to lower extremity, below knee, thigh lacer, non-molded
L5681	Addition to lower extremity, below knee/above knee, custom fabricated socket for congenital or atypical traumatic amputee, silicone gel elastometric
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5683	Addition to lower extremity, below knee/above knee, custom fabricated socket for other than congenital or atypical traumatic amputee, silicone gel elastometric
L5684	Addition to lower extremity, below knee, fork strap
L5686	Addition to lower extremity, below knee, back check, (extension control)
L5688	Addition to lower extremity, below knee, waist belt, webbing
L5690	Addition to lower extremity, below knee, waist belt, padded and lined
L5692	Addition to lower extremity, above knee, pelvic control belt, light
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint

Procedure Code	***Description***
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	All lower extremity prostheses, shoulder harness

Prosthetic - Lower Limb

Procedure Code	***Description***
L5700	Replacement, socket, below knee, molded to patient model
L5701	Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5704	Replacement, custom shaped protective cover, below knee
L5705	Replacement, custom shaped protective cover, above knee
L5706	Replacement, custom shaped protective cover, knee disarticulation
L5707	Replacement, custom shaped protective cover, hip disarticulation
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	Addition, exoskeletal knee shin system, polycentric, mechanical stance phase lock
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber, or equal)
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control

Procedure Code	Description
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control
L5840	Addition, endoskeletal knee-shin system, multi-axial, pneumatic swing phase control
L5846	Addition, endoskeletal, knee-shin system, microprocessor control feature, swing phase only
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
L5910	Addition, endoskeletal system, below knee, alignable system
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5930	Addition, endoskeletal system, high activity knee control frame
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5970	All lower extremity prostheses, foot, external keel, SACH foot
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)
L5974	All lower extremity prostheses, foot, single axis ankle/foot
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)
L5978	All lower extremity prostheses, foot, multi-axial ankle/foot
L5979	All lower extremity prostheses, multi-axial ankle/foot, dynamic response
L5980	All lower extremity prostheses, flex-foot system
L5982	All exoskeletal lower extremity prostheses, axial rotation unit
L5984	All endoskeletal lower extremity prostheses, axial rotation unit
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986	All lower extremity prostheses, multi-axial rotation unit (ii MCPlt or equal)
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon
L5999	Lower extremity prosthesis, not otherwise specified

Prosthetic - Upper Limb

Procedure Code	Description

Procedure Code	***Description***
L6000	Partial hand, Robin-Aids, thumb remaining, (or equal)
L6010	Partial hand, Robin-Aids, little and/or ring finger remaining, (or equal)
L6020	Partial hand, Robin-Aids, no finger remaining, (or equal)
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110	Below elbow, molded socket, (Muenster or Northwestern suspension types)
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310	Shoulder disarticulation, passive restoration, (complete prosthesis)
L6320	Shoulder disarticulation, passive restoration, (shoulder cap only)
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360	Interscapular thoracic, passive restoration (complete prosthesis)
L6370	Interscapular thoracic, passive restoration, (shoulder cap only)
L6380	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components and one cast change, wrist disarticulation or below elbow
L6382	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components and one cast change, elbow disarticulation or above elbow
L6384	Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic
L6386	Immediate post surgical or early fitting, each additional cast change and realignment
L6388	Immediate post surgical or early fitting, application of rigid dressing only
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control “USMC” or equal pylon, no cover, molded to patient model
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, “USMC” or equal pylon, no cover, direct formed
L6584	Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, “USMC” or equal pylon, no cover, molded to patient model

Procedure Code	***Description***
L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead table control, “USMC” or equal pylon, no cover, direct formed
L6588	Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control “USMC” or equal pylon, no cover, molded to patient model
L6590	Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, “USMC” or equal pylon, no cover, direct formed
L6600	Upper extremity additions, polycentric hinge, pair
L6605	Upper extremity additions, single pivot hinge, pair
L6610	Upper extremity additions, flexible metal hinge, pair
L6615	Upper extremity addition, disconnect locking wrist unit
L6616	Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620	Upper extremity addition, flexion-friction wrist unit
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release
L6625	Upper extremity addition, rotation wrist unit with cable lock
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630	Upper extremity addition, stainless steel, any wrist
L6632	Upper extremity addition, latex suspension sleeve, each
L6635	Upper extremity addition, lift assist for elbow
L6637	Upper extremity addition, nudge control elbow lock
L6640	Upper extremity additions, shoulder abduction joint, pair
L6641	Upper extremity addition, excursion amplifier, pulley type
L6642	Upper extremity addition, excursion amplifier, lever type
L6645	Upper extremity addition, shoulder flexion/abduction joint, each
L6650	Upper extremity addition, shoulder universal joint, each
L6655	Upper extremity addition, standard control cable, extra
L6660	Upper extremity addition, heavy duty control cable
L6665	Upper extremity addition, Teflon or equal, cable lining
L6670	Upper extremity addition, hook to hand, cable adapter
L6672	Upper extremity addition, harness, chest or shoulder, saddle type
L6675	Upper extremity addition, harness, figure-(ib 8lg) eight type, for single control
L6676	Upper extremity addition, harness, figure-(ib 8lg) eight type, for dual control
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686	Upper extremity addition, suction socket
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation
L6688	Upper extremity addition, frame type socket, above elbow or wrist disarticulation
L6689	Upper extremity addition, frame type socket, shoulder disarticulation
L6690	Upper extremity addition, frame type socket, interscapular-thoracic
L6691	Upper extremity addition, removable insert, each
L6692	Upper extremity addition, silicone gel insert or equal, each

Procedure Code	***Description***
L6704	Terminal device, sport/recreational/work attachment, any material, any size
L6706	Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined
L6707	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined
L6708	Terminal device, hand, mechanical, voluntary opening, any material, any size
L6709	Terminal device, hand, mechanical, voluntary, closing, any material, any size
L6890	Terminal device, glove for above hands, production glove
L6895	Terminal device, glove for above hands, custom glove
L6900	Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining
L6905	Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining
L6910	Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining
L6915	Hand restoration (shading and measurements included), replacement glove for above
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device
L6925	Wrist disarticulation, external power, self suspended inner socket, removable forearm shell, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries one charger, myoelectronic control of terminal device
L6960	Shoulder disarticulation, external power, molded innersocket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, switch control of switch device

Procedure Code	Description
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of switch device
L7040	Prehensile actuator, Hosmer or equal, switch controlled
L7045	Electronic hook, child, Michigan or equal, switch controlled
L7170	Electronic elbow, Hosmer or equal, switch controlled
L7180	Electronic elbow, Boston, Utah or equal, myoelectronically controlled
L7185	Electronic elbow, Variety Village or equal, switch controlled
L7186	Electronic elbow, child, variety village or equal, switch controlled
L7190	Electronic elbow, Variety Village or equal, myoelectronically controlled
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled
L7260	Electronic wrist rotator, Otto Bock or equal
L7261	Electronic wrist rotator, for Utah arm
L7266	Servo control, Steeper or equal
L7272	Analogue control, UNB or equal
L7274	Proportional control, 6-12 volt, Liberty, Utah or equal

Battery

Procedure Code	Description
L7360	Six volt battery, Otto Bock or equal
L7362	Battery charger, six volt, Otto Bock or equal
L7364	Twelve volt battery, Utah or equal, each
L7366	Battery charger, twelve volt, Utah or equal
L7499	Upper extremity prosthesis, not otherwise specified

Prosthetic - Upper Limb

Procedure Code	Description
L7500	Repair of prosthetic device, hourly rate (Excludes V5335 repair of oral or laryngeal prosthesis or Artificial larynx)
L7510	Repair of prosthetic device, repair or replace minor parts (Excludes V5335 repair of oral or laryngeal prothesis or artificial larynx)
L7520	Repair prosthetic device, labor component, per 15 minutes (Effective 1/1/97 this replaces HCPCS code K0285)
L7900	Vacuum erection system (Effective 1/1/97 this replaces HCPCS code K0163)

Orthotic - Lower Limb

Procedure Code	Description
L8100	Elastic support, elastic stocking, below knee, medium weight, each
L8110	Elastic support, elastic stocking, below knee, heavy weight, each
L8120	Elastic support, elastic stocking, below knee, surgical weight, (Linton type or equal), each
L8130	Elastic support, elastic stocking, above knee, medium weight, each
L8140	Elastic support, elastic stocking, above knee, heavy weight, each
L8150	Elastic support, elastic stocking, above knee, surgical weight, (Linton type or equal), each
L8160	Elastic support, elastic stocking, full length, medium weight, each Elastic support, elastic stocking, full length, heavy weight, each

Procedure Code	***Description***
L8170	Elastic support, elastic stocking, full length, heavy weight, each
L8180	Elastic support, elastic stocking, full length, heavy surgical weight, (Linton type or equal), each
L8190	Elastic support, elastic stocking, leotards, medium weight, each
L8200	Elastic support, elastic stocking, leotards, surgical weight, (Linton type or equal), each
L8210	Elastic support, elastic stocking, custom made
L8220	Elastic support, elastic stocking, lymphedema
L8230	Elastic support, elastic stocking, garter belt
L8239	Elastic support, not otherwise specified
L8300	Truss, single, with standard pad
L8310	Truss, double, with standard pads
L8320	Truss, addition to standard pad, water pad
L8330	Truss, addition to standard pad, scrotal pad
L8400	Prosthetic sheath, below knee, each

Prosthetic - Lower Limb

Procedure Code	***Description***
L8410	Prosthetic sheath, above knee, each
L8415	Prosthetic sheath, Wool, upper limb, each
L8417	Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each (Effective 1/1/97 this replaces HCPCS code XX015)
L8420	Prosthetic sock, wool, below knee, each
L8430	Prosthetic sock, wool, above knee, each
L8435	Prosthetic sock, wool, upper limb, each
L8440	Prosthetic shrinker, below knee, each
L8460	Prosthetic shrinker, above knee, each
L8465	Prosthetic shrinker, upper limb, each
L8470	Stump sock, single ply, fitting, below knee, each
L8480	Stump sock, single ply, fitting, above knee, each
L8485	Stump sock, single ply, fitting, upper limb, each
L8490	Addition to prosthetic sheath/sock, air seal suction retention system
L8499	Unlisted procedure for miscellaneous prosthetic services

Alabama Medicaid Glossary of Terms

A

ACSW	Academy of Certified Social Workers
ADA	Americans with Disabilities Act, also American Dental Association
ADM	Alcohol, drug or mental disorder
ADS	Alternative delivery system
AEAC	Alabama Estimated Acquisition Cost
AEVCS	Automated Eligibility Verification and Claims Submission System
AFDC	Aid to Families with Dependent Children
AHA	American Hospital Association
AHC	Alternative health care
AMA	American Medical Association
ARC	Adjustment Reason Code
AWP	Average wholesale price
Absent Parent	A parent who is responsible for child's medical payments that Medicaid locates. Used in Third Party Liability.
Access	A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their accessibility to the patient, the location of health care facilities, transportation, hours of operation and cost of care.
Accounts Payable	Money that Medicaid should pay out
Accounts Receivable	Money owed to Medicaid
Adjudication	The process of determining whether a claim (credit or adjustment) is to be paid
Adjustment Reason Code	Codes used to explain the basis for a denial, reduction, or increase in payment for a service.
Adjustments	Changes made on a paid claim to correct an input or payment error. Adjusted claims receive a new internal claim number that begins with 50 and references the original claim.
Administrative costs	The costs incurred by a carrier such as an insurance company or HMO for administrative services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis.
Admits	The number of admissions to a hospital or inpatient facility
Alabama Estimated Acquisition Cost	Medicaid's best estimate of the price providers generally pay for a drug. Medicaid establishes the AEAC for each drug based on the package size providers most frequently purchase.
Alabama Medicaid Management Information System (AMMIS)	The automated system used to process Medicaid claims and support program administration

Alcoholism	A primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.
Allowable costs	Charges for services rendered or supplies furnished by a health provider which qualify as covered expenses
Alternative care	Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home health care and skilled nursing facility care. Also may refer to nontraditional care delivered by providers such as midwives.
American Medical Association	A doctor's group which endorses the development of practice parameters. The AMA's directory of practice parameters includes 1,600 listings of guidelines ranging from prenatal diagnoses to decisions near the end of life.
American National Standards Institute (ANSI) Standards Board	The American National Standards Institute (ANSI) Standards Board coordinates the U.S. voluntary standards system that develops standards for electronic interchange.
Ancillary	A term used to describe additional services performed related to care, such as lab work, x-ray and anesthesia.
Ancillary charge	The fee associated with additional services performed prior to and/or secondary to a significant procedure, such as lab work, x-ray, and anesthesia. Also, a charge in addition to the copayment and deductible amount which the covered person is required to pay to a participating pharmacy for a prescription which, through the request of the covered person or participating prescriber, has been dispensed in non conformance with the plan's maximum allowable cost (MAC) list.
Ancillary services	Health care services conducted by providers other than primary care physicians.
Appeal	A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or an administrative action, with the goal of finding a mutually acceptable solution
Attending Physician/Attending Provider	The physician rendering the major portion of care or having primary responsibility for care of the major condition or diagnosis
Audit	A system check for history validation, comparing a claim to other claims in the client’s file. The system reviews the client’s history and looks for “red flags” — two claims for the same service on the same date, a claim in excess of limitation, expired eligibility, etc. Audits may result in a claim being manually reviewed to determine if a suspended claim should be paid or denied.
Audit Trail	Record of actions performed. In systems operations, it is a record of database updates.
Automated Eligibility Verification and Claims Submission System	This system performs basic edits on claims to ensure data integrity before the claim enters the adjudication cycle.

Automated Voice Response System (AVRS)	The automated voice information system available 24 hours a day to Medicaid providers for inquiries of recipient eligibility, lock-in, other insurance, last check information, National Drug Code (NDC) information, procedure code pricing, claim statistics, and PA information.

B

BAY Health Plan	A full-risk HMO operating in Mobile county (This program was terminated effective 10/1/99)
BCBS	Blue Cross/Blue Shield
Beneficiary	A person designated by an insuring organization as eligible to receive insurance benefits
Benefits	Amount payable by an insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy or the available coverage under an insurance plan
Billed claims	The fees or costs for health care services provided to a covered person submitted by a health care provider
Billing Provider	Provider submitting claim and receiving payment
Blue Cross/Blue Shield (BCBS)	A non-profit commercial insurer designed to cover consumers for medical expenses, regardless of risk
Board certified	A physician who had passed an examination given by a medical specialty board and who has been certified as a specialist in that medical area
Board eligible	A physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training, and practiced for a specified amount of time.
Bulletin Board System (BBS)	An electronic medium for posting information. Providers transmit claims in batches to the BBS using Provider Electronic Solutions Software, or vendor supplied software, when performing electronic claims submission.
Buy-in	A monthly premium payment made by the State to the Social Security Administration to enroll eligible clients in Medicare Part B program as a cost-saving measure

C

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT (Current Procedural Terminology) Code	Code used to determine procedures on claim forms, taken from the CPT - 4 Manual, an American Medical Association (AMA) approved listing of medical terms and identifying codes for reporting medical services and procedures performed by providers
Calendar year	The period of time from January 1 of any year through December 31 of the same year, inclusive. Most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year. Also found in provisions outlining benefits in basic hospital, surgical, and medical plans.

Capitation	Method of payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Capitation rates	Payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person
Carrier	The CMS-designated statewide or regional contractor responsible for Medicare Part B claims administration. Also used generically to refer to private third party payers.
Case management	Planned approach to manage service or treatment to an individual with a serious medical problem. Its dual goal is to contain costs and promote more effective intervention to meet patient needs. Often referred to as large case management. Nurses are often case managers.
Case manager	An experienced professional (such as a nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health
Chronic Stable Medical Condition	A condition that has persisted over six months and clinical documentation supports that there has been no significant changes in the past 60 days or in the 60 day period prior to admission.
Civilian Health and Medical Program of Uniformed Services.	The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a federal program providing cost-sharing health benefits for dependents and survivors of active duty personnel and for retirees and their dependents and survivors
Claim	A request for payment for services rendered on a standardized form or electronic record
Claims	Demands to the insurer by or on behalf of an insured person for the payment of benefits under a policy. Information submitted by a provider or a covered person to establish that medical services were provided to a covered person from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.
CMS	Center for Medicare and Medicaid services
Coinsurance	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Often coinsurance applies after first meeting a deductible requirement. Also referred to as a copayment.
Consolidated Omnibus Budget Reconciliation Act	A Federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated

Copayment	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Also referred to as a coinsurance. A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital service. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered. Also called copay.
Cost Effectiveness	A State-run process that determines if paying insurance premiums for a client is less expensive than paying straight Medicaid payments. Medicaid buys insurance coverage for a client when premiums are cheaper than medical costs.
Cost sharing	When there is no financial risk involved, consumers have no incentive to seek the most cost-effective health care. However, for cost sharing methods to be beneficial they must be strong enough for people to conserve, without discouraging them from getting care. Copays and deductibles are examples of cost-sharing methods.
Crossover Claim	Claim for which both Medicare and Medicaid are liable to pay for services rendered to a client entitled to benefits under both programs
Current Procedural Terminology (CPT)	Set of five-digit codes describing medical services delivered that are used for billing by professional providers

D

DME	Durable Medical Equipment
DO	Doctor of osteopathy
DOB	Date of birth
DOS	Date of service
DRG	Diagnosis related group
DSH	Disproportionate Share Hospital Payments
DUR	Drug Utilization Review
DUR Review Board	Agent or unit of the State responsible for Drug Utilization Review activities, such as reviewing clients and providers whose prescriptions set a large number of DUR alerts when pharmacists use the POS system. The board also determines and alerts the EDS pharmacist when updates to DUR criteria are necessary.
Date of Service	The date on which health care services were provided to the covered person
Deductible	Amount of covered expenses that must be incurred and paid by an insured person before benefits become payable by the insurer
Deferred compensation administrator (DCA)	A company that provides services through retirement planning administration, third party administration, self-insured plans, compensation planning, salary survey administration and workers compensation claims administration
Denial of payment	When services are deemed to be inappropriate, unnecessary, or of poor quality, payment may be denied. The insurer or payer will not pay for services that do not conform to benefit standards.

Dependent	An individual who relies on an employee for support or obtains health coverage through a spouse, parent or grandparent who is the covered person. See also eligible dependent and member.
Diagnosis	The identification of a disease or condition through analysis and examination
Diagnosis-related group (DRG)	System of determining specific reimbursement fees based on the medical diagnosis of a patient. System of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.
Disability	Any condition that results in function limitations that interferes with an individual's ability to perform their customary work and which results in substantial limitation in one or more major life activities
Dispensing Fees	Fees set, and periodically reviewed for fairness, by Medicaid. These fees are set considering such factors as inflation and fee studies or surveys. When deemed appropriate by Medicaid, these fees may be adjusted.
Drug price review (DPR)	A weekly updating of drug prices, at average wholesale price (AWP), from the American Druggist Blue Book. Price maximums are subsequently established.
Dual diagnosis	Coexistence of more than one disorder in an individual patient. Commonly refers to a patient who is diagnosed with mental illness in conjunction with substance abuse.
Durable Medical Equipment (DME)	Medical equipment that • can withstand repeated use • generally is not useful to a person in the absence of an illness or injury • generally is not useful to a person in the absence of an illness or injury • is appropriate for use in the home Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

E

ECS	Electronic Claims Submission
EDS	The fiscal agent for the Medicaid program
EFT	Electronic funds transfer
EOB (Explanation of Benefits) Code	Code(s) appearing on the provider's EOP to let them know what action is taken on claims
EOMB	Explanation of Medicare benefits
EOP	Explanation of payment
EOP Message	Message appearing on the top of the remittance advice mailed to providers to address issues and provide information
EOP(Explanation of Payment)	Notice advising Medicaid providers on claim status (paid, denied, returned, or suspended). EDS mails EOPs to providers biweekly.
EPSDT	Early Periodic Screening, Diagnosis, and Treatment

EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Medicaid program for children (until age 21), covering any medically necessary service allowable under Medicaid regulations
Edit	A system run data verification. When the system processes a claim, it runs edits to verify that data on the claim is correct. Examples of edits include: • Match of RID and recipient name • Match of provider name and number
Electronic Claims Submission	A form of electronic submission of claims for services rendered. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.
Eligibility date	The defined date a covered person becomes eligible for benefits under an existing contract

F

FFS	Fee for service
FQHC	Federally Qualified Health Clinic
Fee-for-service	Method of payment for provider services based on each visit or service rendered
Fee-for-service reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment based on billed charges for each service provided
Frequency	The number of times a service was provided

G

GUI	Graphical user interface
Gatekeeper model	A situation in which a primary medical physician, the "gatekeeper" serves as the patient's initial contact for medical care and referrals.
Gatekeepers	Primary medical providers (PMP) are usually the gatekeepers. Role description of the PCP in HMOs who coordinate services and referral of enrollees.
Generic drug	A generic drug is one that has the identical makeup as a brand name drug. A generic is typically less expensive and sold under a common or "generic" name for that drug; for instance, the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.
Generic equivalent	See generic drug.
Generic substitution	Dispensing a generic drug in place of a brand name medication. Substitution guidelines are defined by state regulations.
Graphical user interface (GUI)	The visual interface that characterizes Microsoft Windows and the Macintosh.
Group Practice	Medical practice in which several physicians render and bill for services under a single provider number

H

HCFA	Health Care Financing Administration
HCFA Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS include CPT (Current Procedural Terminology) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by HCFA to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy, and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit is a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.
HCPCS	HCFA Common Procedural Coding System
HHA	Home health agency
HHS	Department of Health and Human Services
HID	Health Information Designs
HIC	Health Insurance Claim Number
HIPC	Health insurance purchasing cooperative
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health maintenance organization
Health Care Financing Administration(HCFA)	A branch of the U.S. Department of Health and Human Services charged with oversight and financial management of government-related health care programs such as Medicare and Medicaid
Health Care Quality Improvement Act	This Act requires health care provider organizations and insurers to report malpractice cases that have been settled or lost. Created in 1986, malpractice suits and other related reference checks can be obtained through the National Practitioner Data Bank.
Health Information Designs (HID)	Organization that provides prior authorization for drugs requiring prior approval
Health Maintenance Organization (HMO)	Organization that provides for a wide range of comprehensive health care services for a specified group of enrollees for a fixed, periodic prepayment. There are several HMO models including: staff model, group model, IPA, and mixed (or network) model. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: An organized system for providing health care or otherwise assuring health care delivery in a geographic area, an agreed upon set of basic and supplemental health maintenance and treatment services, and a voluntarily enrolled group of people.
Home health agency (HHA)	A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide health care services in the home
Home health services	Comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient in the home
Hospice	Concept of care provided to terminally ill patients and their families that emphasizes emotional needs and coping with pain and death.

Hospital privileges	The approved means by which physicians can provide care to their patients who have been hospitalized. A physician without hospital privileges cannot treat patients or be reimbursed for services.
Hospital-based Physician	Physician having an arrangement with a hospital whereby they receive fees for services performed for that hospital

I/J

ICD-9-CM	International Classification of Disease, Ninth Edition, Clinical Modification. A listing used by providers in coding diagnosis on claims.
ICF	Intermediate care facility
ICN (Internal Control Number)	The number assigned to each Medicaid claim that allows tracking in the system. The ICN indicates when the claim was received and whether it was sent by paper or electronic media.
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function such as hearing loss
Inpatient	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours
Intermediate care facility (ICF)	A facility providing a level of care that is less than the degree of care and treatment that a hospital or skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board
International classification of diseases	The International classification of diseases, 9th Edition (Clinical Modification) (ICD-9-CM) is a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded by a two-digit year designation. Example: 93321 is the 321st day of the 93rd year

K/L

LCSW	Licensed clinical social worker
Local Code(s)	A generic term for code values that are defined for a state or other political subdivision, or for a specific payer.
Lock-in	The term used to describe the status of a recipient who may be potentially overusing or misusing Medicaid services and benefits. The recipient is locked in to one physician and/or pharmacy to receive services.
LOS	Length of stay
Length of stay (LOS)	The number of days that a covered person stayed in an inpatient facility
Long Term Care Facility	A nursing facility that provides 24-hour nursing care
Long Term Care	Care that must be provided over a long period of time. Elderly people tend to need long-term care. Nursing home care is a type of long-term care. The goal of Long Term Care is to help people with disabilities be as independent as possible. A person who requires help with the activities of daily living (ADLs) or who suffers from cognitive impairment needs long Term Care.

M

MAC	Maximum allowable cost
MH/CD	Mental health/chemical dependent
MH/SA	Mental health/substance abuse
MMIS	Medicaid Management Information Systems
MSW	Masters in social work
Managed care	The coordination of financing and provision of health care to produce high quality health care for the lowest possible cost
Maximum allowable cost (MAC) list	Specified multi-source prescription medications that will be covered at a generic product cost level established by the plan. This list, distributed to participating pharmacies is subject to periodic review and modification by the plan. The MAC list may require covered persons to pay a cost differential for a brand name product.
Medicaid	A state-run program, with matching federal funds, for public assistance to persons, regardless of age, whose income and resources are insufficient to pay for health care
Medicaid eligible	Recipients in the Alabama Medicaid program. Medicaid reimburses for services rendered while the recipient is eligible for Medicaid benefits.
Medical necessity	Term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted clinical standards
Medical supplies	Items which, due to their therapeutic or diagnostic characteristics are essential in carrying out the care which the physician has ordered for the treatment of the patient's illness or injury. Examples of medical supplies are catheters, needles, syringes, surgical dressings and materials used for dressings, irrigating solutions and intravenous fluids.
Medicare	Federally sponsored program under the Social Security Act that provides hospital benefits, supplementary medical care, and catastrophic coverage to persons age 65 years and older. Includes some younger people who are covered under social security benefits. Medicare covers two parts: Medicare Part A-Covers hospitalization and inpatient costs. Medicare Part B-Covers physician services, ancillary services and outpatient costs.
Mental Health provider	A psychiatrist, licensed consulting psychiatrist, social worker, hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received
Mental health services	Behavioral health care services that may be provided on an inpatient, outpatient, or partial hospitalization basis
Morbidity	An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons

N

NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NHIC	National Heritage Insurance Company
National Council for Prescription Drug Programs Standards	Pharmacy claim telecommunications standards that dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert
National drug code (NDC)	A national classification for identification of drugs. Similar to the Universal Product Code (UPC).
Non-participating provider (non-par)	A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care
Noncovered Services	(1) Services not medically necessary; (2) Services provided for the personal convenience of the client; or (3) Services not covered under the Medicaid Program.
Non-emergency Transportation (NET) Program	Program that provides necessary non-ambulance transportation services to Medicaid recipients

O

OBRA 90	Federal law directing how federal monies are to be expended
OLTP	On-line transaction processing
OSHA	Occupational Safety and Health Administration
OTC	Over-the-counter
Omnibus Budget Reconciliation Act (OBRA)	This Act granted states greater flexibility in structuring managed care arrangements for Medicaid beneficiaries. Also, up to 75 percent of enrollees in an HMO can be a part of Medicaid or Medicare. Waivers of the freedom-of-choice provisions of the Social Security Act permitted states to establish primary care case management and to select Medicaid providers according to their cost-effectiveness.
Optical character recognition (OCR)	A process that recognizes typewritten and handwritten characters by matching them against character templates. Paper claims submitted to EDS are scanned using OCR to enter the data on those claims into the system.
Outpatient	A person who receives health care services without being admitted to a hospital
Over-the-counter (OTC) drug	A drug product that is available to the public without a prescription; however, Medicaid reimbursement requires a prescription.
Override	A code to bypass specific edits or audits
Overutilization	Term used to describe inappropriate or excessive use of medical services that add to health care costs

P

PA Criteria	Criteria that must be present for Medicaid to approve a PA request
PA Denial	A denial of a prior authorization because the services requested by the provider are non-covered services, or non-medically justifiable
Patient 1st	A statewide (with the exception of Mobile county) Primary Care Case Management (PCCM) system
PCCM	Primary Care Case Management
PES	Provider Electronic Solutions software used by providers to submit claims electronically
PRO	Professional (or peer) review organization
Paid claims	The amounts paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any covered person liability for ineligible charges or for deductibles or copayments. If the carrier has preferred payment contracts with providers such as fee schedules or capitation arrangements, lower paid claims liability will usually result.
Participating provider	A provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility, or a physician who has contractually accepted the terms and conditions as set forth by the health plan.
Pay and Chase	A situation where Medicaid pays a claim, knowing that a third party is probably responsible for the payment, then tries to recover the money. Also referred to as postpayment.
Peer review organization(PRO)	An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates and reducing lengths of stay while insuring against inadequate treatment. Also known as professional standards review organization.
Per diem	Literally, per day. Term that is applied to determining costs for a day of care and is an average that does not reflect true cost for each patient.
Pharmaceutical services	Pharmacy management programs help to monitor and control the utilization and cost of prescription drugs. These programs also help with the collection and interpretation of information about the prescribing habits of physicians.
Pharmacy and Therapeutics Committee	An organized panel of physicians from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage, and administer a drug formulary.
Physician	Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received or as defined in the summary plan description

Physician's Current Procedural Terminology	A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.
Place of service	The location where health services are rendered, such as office, home, or hospital
Point of sale (POS) device	Enables the real time electronic transfer of information between two places; the user keys information into the POS device and perhaps swipes a card with a magnetic strip through the device
Prescription medication	A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician
Prevailing charges	Amounts charged by health care providers that are consistent with charges from similar providers for identical or similar services in a given locale
Preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care
Preventive services	Wellness and health promotion services that are part of the basic benefits package of a managed health care plan
Primary Medical Provider (PMP)	Primary deliverers and managers of health care, central to providing appropriate health care. The PMP provides basis care to the enrollee, initiates referrals to specialists, and provides follow-up care. Usually defined as a physician practicing in such areas as internal medicine, family practice, and pediatrics, although an obstetrician/gynecologist may be considered a primary medical physician.
Principal diagnosis	The condition established after study to be mainly responsible for the patient's need for health care services from a provider. Commonly refers to the condition most responsible for a patient's admission to the hospital.
Prior Authorization	Approval provided by Medicaid for specified services for a specific recipient to a specific provider, or the process of obtaining prior approval as to the appropriateness of the service or medication. Prior authorization does not guarantee coverage.
Private Duty Nurse	Service covered by Medicaid that provides hourly nursing care in a home setting
Prospective DUR	Required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include the screening, patient counseling, and patient profiles.
Provider	Any health care professional enrolled with the Medicaid agency who provides or is eligible to provide a covered service to a Medicaid recipient
Provider Assistance Center (PAC)	This center answers your questions about claim status, eligibility, or other claims-related issues
Provider networks	Groups of physicians, or hospitals, who provide health care to enrollees. Some large employers are establishing their own provider networks to ensure their employees a choice.
Provider	A physician, hospital, group practice, nursing home, pharmacy, or any individual group of individuals that provides a health care service

Providers	Medical professionals and service organizations that provide health care services

Q/R

QA	Quality assurance
QMB	Qualified Medicare beneficiary
Qualified Medicare beneficiary (QMB)	A Part A Medicare beneficiary whose verified income does not exceed certain levels. Income may not exceed 100 percent of the federal poverty level plus $20.
Quality assurance (QA)	A set of activities that measures the characteristics of health care services and may include corrective measures
Remittance Advice Code (RAC)	National code set for providing either claim-level or service-level related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice EDI transaction.
R&C	Reasonable and customary
Recipient	Person eligible to receive Medicaid covered services
Recipient Aid Categories	Categories assigned to a recipient used to assign benefits
Recipient Identification Number (RID)	A unique 13-digit number that identifies a Medicaid recipient
Recoupments	Reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills to offset overpayments previously made to the provider. Also, payment made directly to Medicaid by a provider as a settlement for overpayment.
Referral	Primary care provider-directed transfer of a patient to a specialty physician or specialty care
Referral provider	A provider that renders a service to a patient who has been sent to the referral provider by a participating provider in the health plan

S

SNF	Skilled nursing facility
SSI	Social Security Income
Skilled nursing facilities	Institution providing the degree of medical care required from, or under the supervision of, a registered nurse or physician
Social Security Act	Law under which the federal government operates the Old Age, Survivors, Disability, and Health Insurance Program (OSDHI). Includes Medicare and Medicaid.
Specialty	Specialized area of practice for a provider
Specialty HMOs	Those group practices and organizations of providers who contract with managed care organizations to provide non-primary care medical services
Specialty services	Services that are outside of the realm of general practice

Subrogation	A procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured. For example, should a claim and who has received benefits under a state's statutory plan covering disability benefits enter into litigation to make claims against a third parts, the insurance carrier has a right to place a lien against any benefit the third action party may provide.
Suspend	A claim status in which the claim must be reviewed. Claim type needing in-depth investigation to allow EDS adjudicators and provider relations team members to work together to resolve the claim.

T

TPL	Third party liability
Third Party Liability (TPL)	A condition whereby a person or an organization other than the recipient or Medicaid is responsible for all, or some portion of the medical costs for health or medical services incurred by a Medicaid recipient (health or casualty insurance company, or another person in the case of an accident)
Third-party payer	A public or private organization that pays for or underwrites coverage for health care expenses of another entity, usually an employer. Examples of third-party payers are Blue Cross, Blue Shield, and Medicare.
Transaction	Exchange of information between two parties to carry out financial and administrative activities related to health care. Examples include health claims, health care payment, coordination of benefits, health claim status, enrollment or disenrollment, referrals, etc

U

U&C	Usual and customary
UB-92	The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-92, requiring the hospitals to send additional itemized bills. The UB-92 replaced the UB-82 in 1993.
UCR	Usual, customary, and reasonable charge
UR	Utilization review
Underutilization	Underutilization is providing fewer services than are necessary for adequate levels of care
Uniform Billing Code of 1992 (UB-92)	A revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.
Unstable Medical Condition (Long Term Care Admission Criteria)	One in which there is documentation of an episode of acute illness or exacerbation of a diagnosis which requires active treatment in the 60 days prior to the admission date. The provider must have supporting documentation of the acute illness or exacerbation and active treatment.
Usual and Customary Charges	Amount which a provider usually and most frequently charges patients for a specific service in normal medical circumstances

Usual, customary and reasonable (UCR)	See reasonable and customary
Usual, customary, and reasonable fees (UCR)	Charges of health care providers that are consistent with charges from similar providers for identical or similar services in a given locale.
Utilization Control Procedures	These procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by Medicaid.
Utilization Review (UR)	Programs designed to reduce unnecessary medical services, both inpatient and out. URs may be prospective, retrospective, concurrent, or in relation to discharge planning.

V/W

Vaccines for Children (VCF)	Program that offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under insured
Value Added Networks (VANs)	Networks that provide billing services on behalf of an Alabama Medicaid provider
Waiver	Term usually associated with the Medicare or Medicaid programs by which the government waives certain regulations or rules for a managed care or insurance program to operate in a certain geographic area.

X/Y/Z

X12	An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards proposed under HIPAA are X12 standards
X12 270	X12's Health Care Eligibility & Benefit Inquiry EDI transaction
X12 271	X12's Health Care Eligibility & Benefit Response EDI transaction
X12 276	X12's Health Care Claims Status Inquiry EDI transaction
X12 277	X12's Health Care Claim Status Response EDI transaction
X12 834	X12's Benefit Enrollment & Maintenance EDI transaction
X12 820	X12's Payment Order & Remittance Advice EDI transaction
X12 835	X12's Health Care Claim Payment & Remittance Advice EDI transaction
X12 278	The X12 Referral Certification and Authorization transaction
X12 837	The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims

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