ALABAMA MEDICAID

October 2014 Provider Manual

Provider Alerts

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ALERT

To: Dental Providers, Oral Surgeons, FQHCs, Health Departments, and Children Specialty Clinics

RE: Dental Program Changes/Dental Meeting

An open forum for Alabama Medicaid dental providers has been rescheduled for 1 p.m. on Friday, February 26, 2010, at the Alabama Medicaid Agency, 501 Dexter Avenue in Montgomery. Directions and a map are available on the Agency's web site at http://www.medicaid.alabama.gov/contact/index_contact.aspx?tab=8

The meeting will be in the fourth floor boardroom for those who would like to attend in person and also will be available by conference call and web conference. To participate in the conference call or web conference and to receive future notices and information regarding the Medicaid Dental Program, please contact Nancy Rawlinson at (334) 353-4099 or by e-mail at nancy.rawlinson@medicaid.alabama.gov

February 19, 2010

ALERT

To: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, and Nursing Homes

RE: Preferred Drug List (PDL) Update

Effective April 1, 2010, the Alabama Medicaid Agency will:

1. Remove from the Preferred Drug List and no longer cover, even with prior authorization, all **Brand** Benzodiazepines **with the exception of Diastat**, and
2. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*
Daytrana-Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting	**Amerge**- Pain Management/Antimigraine Agents
	Mycostatin-Anti-infective Agents/Antifungals
	Relpax-Pain Management/Antimigraine Agents

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

March 09, 2010

ALERT

To: In-state and Border Hospital Providers

RE: InterQual ® and Adverse Events Policy and Billing Workshop

Medicaid will be requiring hospitals to capture non-covered days per InterQual® Adult and Pediatric Medical criteria with Alabama Medicaid Local Policy and Adverse Events on all inpatient hospital claims for dates of service beginning July 1, 2010. Sessions for Quality Assurance staff, as well as billing staff, will be offered on the following dates:

- **Monday, April 19, 2010**, 10 a.m.-12 p.m., Decatur General Hospital, 1201 7th Street SE, Decatur, AL. Meeting will be held in the Camp Bluebird room. **Registration deadline for this session is Monday, April 12, 2010.**

- **Tuesday, April 20, 2010**, 10 a.m.-12 p.m., Children's Hospital campus, 1600 7th Avenue S, Birmingham, AL. Meeting will be held at the Bradley Lecture Center, 4th Floor of the Children's Harbor building on the campus of Children's Hospital, 6th Avenue S at 16th Street. Please park in the Park Place parking deck. (Limited seating—no more than 65). **Registration deadline for this session is Tuesday, April 13, 2010.**

- **Monday, April 26, 2010,** 10 a.m.-12 p.m., USA Children's and Women's Hospital Mobile, 1700 Center Street, Mobile, AL. Meeting will be held in the Atlantis Room. **Registration deadline for this session is Monday, April 19, 2010.**

- **Tuesday, May 4, 2010,** 10 a.m.-12 p.m., Alabama Hospital Association office, 500 N Eastern Blvd, Montgomery, AL. The meeting will be held in the Boardroom. (Limited seating—no more than 60) **Registration deadline for this session is Tuesday, April 27, 2010. A web conference will also be provided during this session in which registration is required. Registration deadline for the web conference is Friday, April 16, 2010. A personal link will be sent to you upon registration completion and prior to the date of the conference.**

- **Thursday, April 22, 2010,** 10 a.m.-12 p.m. (Web Conference Only). A personal link will be sent to you one week prior to the date of the conference. This web conference will be limited to 100 recipients. **Registration deadline for this session is Monday, April 12, 2010.**

A registration form is attached to this alert. This form must be completed and faxed or e-mailed to Karen Smith. Seating is limited; you may be contacted if seating is not available. For any questions, contact Karen Smith via e-mail at karen.watkins-smith@medicaid.alabama.gov or by phone at 334-353-4945.

ALERT

InterQual ® and Adverse Events Policy and Billing Workshop

Registration Form

Registration Information is required to attend any of the workshops**

Check ONLY one date:

Meeting workshops: ☐ **4/19/10** ☐ **4/20/10** ☐ **4/26/10** ☐ **5/4/10**

OR

Web conference workshops: ☐**4/22/10** ☐ **5/4/10**

Name and title: _____

Hospital or Company: _____

Address:
_____

City: _____ State _____ Zip: _____

Contact Information

Office Phone: _____Office Fax: _____

Email Address: _____

Office Contact Person: _____

Fax this registration form to: 334-353-4818

E-mail this registration form to: karen.watkins-smith@medicaid.alabama.gov.

****Please note that there are limited spaces in each workshop. Please limit your facility to no more than two attendees per session. You may be asked to attend another session or take part in the web conference if space is not available.**

March 22, 2010

ALERT

To: All Pharmacy Providers, Pharmacy Associations, and Vendors

RE: Usual & Customary Amount on Electronic Drug Claims

Effective April 13, 2010, Alabama Medicaid will accept the Usual & Customary (U & C = charge to the general public) amount in Field 426-DQ on Electronic Drug claims. Currently, the Agency requires the total amount due on a drug claim in the "Gross Amount Due" Field 430-DU while the U & C amount in Field 426-DQ is not captured.

Effective April 13, 2010, the Agency will accept the U & C amount in Field 426-DQ in the "lower of" reimbursement methodology. Pharmacies should submit their U & C amounts in Field 426-DQ, and must continue to submit the 'Total Amount Due' in the Gross Amount Due field. The Alabama Medicaid Companion Guide to the NCPDP 5.1 Specifications has been updated on the Medicaid website (www.medicaid.alabama.gov) to reflect this change. Questions related to electronic billing should be directed to HP at 1-800-456-1242 in state, and 1-334-215-0111 out of state.

March 31, 2010

ALERT

To: All Hospital Providers

RE: Third Party Release of Information Policy

This notice is to clarify Alabama Medicaid's requirement of providers to notify the Agency's Third Party Division prior to releasing medical records. As indicated in the Alabama Administrative Code, Rule No. 560-X-20-.05(3), it is not the Agency's intention to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Division.

Providers are to ensure that all HIPAA Privacy and Security rules are met regarding an individual's "right of access to inspect and obtain a copy of protected health information about the individual" (as stated in 45 C.F.R. §164.524).

Medicaid's rule is also designed to ensure that Medicaid is informed of potential circumstances in which Medicaid may have a subrogation interest pertaining to the medical records being requested.

It does not permit providers to deny individuals access to their records. **Providers should not cite Medicaid's rule as cause for not meeting the HIPAA Privacy rule, nor should they attempt to place the responsibility for notifying the Medicaid Agency on the recipient.**

The "Request for Medical Records" form will still be available for use by providers to document that Medicaid has been notified of a medical record request on a Medicaid recipient. The form is available on the Agency's Web site at http://www.medicaid.alabama.gov/billing/release_info.aspx?tab=6

While Medicaid will continue to send a return response to the form, **a provider should not deny the release of medical information to an individual because the provider has not received a response back from Medicaid.**

To determine if Medicaid should be notified, the provider should inquire as to the purpose of the medical information and who is in need of the information. If the request meets any of the circumstances in Rule No. 560-X-20-.05(1) [attached], then the provider is not required to send Medicaid notification of the request. Otherwise, the provider should notify Medicaid of the request and provide the information to the requestor (if all other provisions have been met).

In addition, the Alabama Medicaid Agency has contracted with Health Management Systems (HMS) to handle the processing of requests for medical records. "Request for Medical Records" forms should be faxed to HMS at 866-274-5974. Other notifications to Medicaid regarding medical record releases should be provided to HMS by phone at 877-252-8949.

If you should have any questions regarding this notice, please contact Keith Thompson, Director, Third Party Division, at (334) 242-5248.

May 17, 2010

Rule No. 560-X-20-.05. Release of Information - All Providers

(1) Information pertaining to a patient's treatment (including billing statement, itemized bills, etc.) may be routinely released ONLY UNDER THE FOLLOWING CIRCUMSTANCES AND/OR TO THE FOLLOWING AGENCIES if Medicaid has been billed or is expected to be billed:

(a) The Medicaid Fiscal Agent,

(b) The Social Security Administration,

(c) The Alabama Vocational Rehabilitation Agency,

(d) The Alabama Medicaid Agency,

(e) Requests from insurance companies for information pertaining to a claim filed by the provider in accordance with Medicaid Regulations and for which an assignment of benefits to the provider was furnished the insurance company.

(f) Requests by insurance companies for information to process an application for insurance, to pay life insurance benefits, or to pay on a loan.

(g) Requests from other providers for medical information needed in the treatment of patient.

(2) If information pertaining to a patient's treatment is requested by any other source, or under any other circumstance, the Alabama Medicaid Agency, Third Party Section, must be contacted PRIOR TO RELEASE OF INFORMATION. The only exception is when a subpoena is received during nonworking hours of the Alabama Medicaid Agency and must be responded to immediately. Should this occur, the provider may respond to the subpoena and must include with the released records a notice that the patient was covered by Medicaid. In addition, the provider must notify the Third Party Section of the subpoena as soon as possible.

(3) It is not the intention to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Section.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

ALERT

To: All Providers

RE: Printing of RAs

The missing RA page issue for the May 21, 2010, check write has now been resolved. RAs can now be downloaded via the Web Portal. There will be two files listed until the erroneous file can be deleted. Please ensure the file you use contains all pages.

Please contact the Electronic Media Claims Help Desk if you have any questions at (800) 456-1242 for Alabama, Florida, Georgia, Mississippi and Tennessee and (334) 215-0111for all other locations.

May 27, 2010

ALERT

To: All Dental Providers

RE: Dental IV Sedation Certification

To ensure the safety of Alabama Medicaid recipients, state dental providers using IV sedation must submit documentation of their certification to the Agency prior to August 1, 2010.

On August 1, 2010, Alabama Medicaid will deny procedure codes D9241 and D9220, if the provider does not submit their IV sedation certification to Medicaid.

To ensure that Medicaid enrollment files are updated prior to the August 1, 2010 start date, providers are asked to complete the form below and return it with a copy of your IV sedation certification by June 21, 2010 to:

Provider Enrollment
HP Enterprise Services
301 Technacenter Dr
Montgomery, AL 36117

Please complete the following:

Provider's Name _____

Provider's NPI _____

Medicaid Numbers (please include Medicaid assigned numbers for all clinics the provider is enrolled to provide services)

_____

_____

_____

_____

_____

ATTACH a copy of Certificate

May 27, 2010

ALERT

To: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes

RE: PDL Update

Effective July 1, 2010, the Alabama Medicaid Agency will: Require prior authorization (PA) for payment of non-preferred brands in the First Generation Antihistamine drug class, and Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*
Besivance-EENT Preparations/Antibacterials	**Optivar**-EENT Preparations/Antiallergic Agents
	Pramox-Skin and Mucous Membrane Agents/Antipruitics and Local Anesthetics

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

June 10, 2010

ALERT

To: All In-State and Border Hospital Providers

RE: Adverse Events Policy

Effective July 1, 2010, Medicaid will require hospitals to report Adverse Events. The following is approved policy that will be a part of Medicaid's Billing Manual and Administrative Code.

Serious Preventable Events, Hospital-Acquired Conditions, and Present on Admission Indicators and Billing

Adverse Events are the events that must be reported to Medicaid by the hospital. To be reportable, these events must meet the following criteria:

- The event must be reasonably preventable as determined by a root cause analysis or some other means.
- The event must be within the control of the hospital.
- The event must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The error or event must result in significant harm. The events for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 0 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability. Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from adverse events.

  Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

Reporting Adverse Events

Adverse events must be reported to Medicaid by encrypted emailing required information to: AdverseEvents@medicaid.alabama.gov. Each hospital will receive a password specifically for e-mail reporting. Reportable "Adverse Events" include:

- Surgery on a wrong body part
- Wrong surgery on a patient
- Surgery on a wrong patient

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type. A sample form is on the Alabama Medicaid Agency website at www.medicaid.alabama.gov under Programs/Hospital Services although hospitals may submit their own form as long as it contains all required information.

Reporting Hospital–Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Hospitals should use the POA indicator on claims for these events. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at AdverseEvents@medicaid.alabama.gov. The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form.

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Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) and 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 949-949.5 991-994.9
Catheter-Associated Urinary Tract Infection (UTI)	996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC)
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of poor glycemic control	250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)
Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)	519.2 (MCC) and one of the following procedure codes: 36.10-36.19.
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis code-278.01 OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 81.51-81.52, 81.54.

The hospital may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- **1**-Unreported/Not used. Exempt from POA reporting.

If the value code '81' is indicated; then non-covered days must be present and the amount field must be greater than '0'.

It is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services. Any further questions regarding this notice should be directed to Jerri Jackson at 334-242-5630 or Karen Smith at 334-353-4945.

June 22, 2010

ALERT

To: All In-State and Border Hospital Providers

RE: Utilization Review Policy

Effective for admissions on or after July 1, 2010, Medicaid will require hospitals to report dates that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy on the UB-04 claim form. The following is approved policy that will be a part of Medicaid's Billing Manual and Administrative Code.

Utilization Review for Inpatient Hospital Admissions and Concurrent Stays

Medicaid will utilize Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes.

- It is the hospital's responsibility to utilize its own physician advisor.
- The attending physician and/or resident may change an order up to 30 days after discharge, as long as the patient met criteria for inpatient or observation services.

For admissions and continued stays on or after July 1, 2010, Medicaid will require in-state and border hospital providers to report dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

Dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy must be reported on the UB-04.

- Hospital Providers are required to use Occurrence Span Code 74 to identify days not meeting InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy, and
- Must enter the occurrence span dates for the dates that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

Inpatient psychiatric and rehabilitation services in an acute care facility will be exempt from reporting dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

The Alabama Medicaid Local Policy is available on the Alabama Medicaid website at www.medicaid.alabama.gov under *Programs/Hospital Services.* Hospital providers are to use the 2009 criteria until the 2010 criteria have been reviewed.

A percentage of admissions and concurrent stay charts will be reviewed by the Alabama Medicaid Agency and a Quality Improvement Organization contracted by the Agency.

All in-state and border hospitals must submit Medical Care Evaluation (MCE) Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to the contracted Quality Improvement Organization every year upon request.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services. Questions regarding this notice should be directed to Jerri Jackson at 334-242-5630 or Karen Smith at 334-353-4945.

June 22, 2010

ALERT

To: All Psychologists

RE: Change in Billing for Diagnostic Testing Codes and Use of Modifiers

Based on the support and input of Alabama's psychologists, the Alabama Medicaid Agency will make two changes to Chapter 34 of the Provider Manual, effective July 1, 2010.

1. **The units of measure for Diagnostic Testing Codes 96101 – 96103 and 96118 – 96120 can be billed in 30-minute fractional units.** When billing claims, .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers cannot bill less than a 30-minute increment.

The time started and time ended of service delivery will not include time spent for interpretation of tests at this time.

2. **Service documentation requirements have been further clarified and expounded.**

Modifiers will be appended to procedure codes when services are performed by eligible allied mental health professional staff. The reimbursement rate for services performed and billed with a modifier will be 75% of the allowable rate. Services performed by an allied mental health professional but not billed with the modifier will be subject to recoupment on post payment review. The modifiers are as follows:

- **U6** for a Licensed Professional Counselor (LPC) or Associate Licensed Counselor (ALC)
- **U7** for a Licensed Marriage and Family Therapist (LMFT)
- **AJ** for a Licensed Certified Social Worker (LCSW)
- **HO** for an individual with a masters degree or above, not yet licensed but has successfully completed a practicum as a part of the requirements for the degree or 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.

If you have further questions, you may contact Karen Smith via e-mail at karen.watkins-smith@medicaid.alabama.gov or telephone at 334-353-4945.

June 28, 2010

ALERT

TO: All Providers

RE: Denial 1825 – "COBA Denial-Do Not Crossover"

What does denial 1825 "COBA Denial – Do Not Crossover" Mean?

This denial means HP does not automatically accept for payment your crossover claims from Medicare.

Changes to COBA Indicators on Provider File

Effective August 1, 2010, HP will turn all Coordination of Benefits Agreement (COBA) indicators on our provider file from "No" to "Yes". The "Yes" status means all claims will automatically crossover from Medicare to Medicaid and will process according to established Medicaid guidelines, without being denied for error 1825. Claims automatically crossing over from Medicare are identified with ICN beginning with "30".

What to do if you do not want your COBA indicator turned to "Yes"

If you do **not** want your COBA indicator turned to a "Yes" status, please send a letter on official office letterhead to HP Provider Enrollment.

The letter should state: *"I do **not** want my COBA indicator turned on to allow claims to automatically crossover."* Please include your NPI and all associated secondary identifiers.

The letter may be faxed to (334) 215-4298.

EXCEPTION: Providers whose COBA Indicators will remain "No"

The following providers' COBA indicators will **not** be turned on since their claims should never crossover from Medicare to Medicaid because of the difference in billing and reimbursement for services:

- Rural Health Clinics
- Federally Qualified Health Centers
- Renal Dialysis Facilities

Crossover claims from Medicare for these providers will continue to receive error 1825.

July 1, 2010

ALERT

To: All Providers

RE: Identifying Oil-Spill Related Illnesses/Injuries for Medicaid Recipients

In order to track and evaluate health outcomes and costs related to the BP Oil Spill, the Alabama Medicaid Agency will begin use of claims billing indicators to identify services provided to Alabama Medicaid recipients when treated for an oil-spill related illness or injury.

Effective immediately, providers are asked to use the following indicators on applicable claims submitted to Alabama Medicaid:

- Professional Claims (837P, other electronic methods, or CMS-1500) – Enter ***Modifier*** **"U9"** (Disaster-Related Service or Illness) with all appropriate procedure codes. This modifier should follow any other modifiers currently required for claims payment.
- Institutional Claims (837I, other electronic methods, or UB-04) – Enter the ***Condition Code*** **"DR"** (Disaster-Related Service or Illness) as the first condition code with all appropriate services.
- Pharmacy POS Transactions – Enter the NCPDP Field ***Reason for Service Code*** **"RE"** (Suspected Environmental Risk) with all appropriate services. This reason for service code should follow any other reason for service code required for claims payment.

Providers should begin immediately to use these indicators on claims submitted for Medicaid payment. Please contact the Provider Assistance Center at 1-800-688-7989 with any related questions.

July 12, 2010

ALERT

To: All Hospice Providers

RE: Concurrent Care for Children Under the Hospice Election

Effective immediately, Medicaid will no longer require parents with children under the age of 21 receiving hospice care, to waive all rights to Medicaid services covered under Medicaid for the duration of hospice care. Based on the *Patient Protection and Affordable Care Act*, a voluntary election to receive hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payments made for services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made. Children can now receive services related to the treatment of the condition for which a diagnosis of terminal illness was made.

For additional information or further clarification, please contact Samantha McLeod at (334)242-5584 or Samantha.McLeod@medicaid.alabama.gov .

July 19, 2010

ALERT

To: All Providers

RE: Synagis® Criteria for 2010 – 2011 Season

The Alabama Medicaid Agency has updated its prior authorization criteria for Synagis®.

- The approval time frame for Synagis® will begin October 1, 2010 and will be effective through March 31, 2011.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2010 (for an October 1 effective date).
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

Criteria

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. The form and complete updated criteria specific to Synagis® are available on the Agency's website at www.medicaid.alabama.gov under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Pharmacy Forms: 2010-2011 Synagis® Criteria and Forms.

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

July 30, 2010

ALERT

To: All Home Health Providers

RE: Home Health Certification and Re-Certification Forms

Effective immediately, Medicaid will no longer require providers to add information included on Medicaid's Home Health Certification/Re-Certification Forms to the Medicare Home Health Certification and Plan of Care Form.

Currently, there are two approved forms for documenting Medicaid home health certification and re-certification admissions:

A. *Medicaid's* Home Health Certification & Re-Certification Forms (Forms 377 & 378).

B. *Medicare's* Home Health Certification and Plan of Care Form (Form CMS-485).

Formerly, providers using the Medicare Form CMS-485 were required to add all missing information from Medicaid Forms 377 & 378. This information includes: adding the name, address, and relationship of the caregiver, etc. and continues to include the falsification statement/paragraph.

After a thorough evaluation, the Agency found it unnecessary to add this information to the CMS-485 form. However, providers are still required to keep this essential information on file to be in compliance with Medicare and Medicaid regulations.

Please address questions or concerns to Monica Abron, at (334)-242-5642.

August 31, 2010

ALERT

To: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes Providers

RE: PDL Update

Effective October 1, 2010, the Alabama Medicaid Agency will:

1. Require prior authorization (PA) for payment of non-preferred brands in the Genitourinary Smooth Muscle Relaxants drug class.
2. Require prior authorization (PA) for payment of generic lansoprazole and omeprazole-sodium bicarbonate. Preferred brands as well as OTC versions of Proton Pump Inhibitors will continue to be available with no PA necessary. The preferred status of the Proton Pump Inhibitors are listed below:

Preferred Brands	Preferred Generic or OTC	Non-Preferred Brand or PA Generic
Aciphex		
	Prevacid OTC	
	Prilosec OTC	
	Zegerid OTC	
		Dexilant
		lansoprazole (generic)
		Nexium
		omeprazole-sodium bicarbonate (generic)
		pantoprazole (generic)
		Prevacid*
	omeprazole	Prilosec*
		Protonix*

3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*
Aricept ODT-Behavioral Health/Alzheimer's Agents	**Azor**-Cardiovascular Health/Calcium Channel Blockers/Combos
Oxytrol-Genitourinary Agents/ Genitourinary Smooth Muscle Relaxants	**Cozaar-**Cardiovascular Health/ Angiotensin-II Receptor Antagonists
Teveten-Cardiovascular Health/ Angiotensin-II Receptor Antagonists	**Diovan HCT**-Cardiovascular Health/ Angiotensin-II Receptor Antagonists/Combos
Teveten HCT-Cardiovascular Health/ Angiotensin-II Receptor Antagonists/Combos	**DynaCirc CR**-Cardiovascular Health/ Calcium Channel Blockers
	Exforge-Cardiovascular Health/Calcium Channel Blockers/Combos
	Hyzaar-Cardiovascular Health/Angiotensin-II Receptor Antagonists/Combos
	Lescol-Cardiovascular Health/HMG CoA Reductase Inhibitors

ALERT

PDL Additions	PDL Deletions*
	Lescol XL-Cardiovascular Health/HMG CoA Reductase Inhibitors
	Maxalt-Pain Management/Autonomic Agents/Selective Serotonin Agonists
	Niaspan-Cardiovascular Health/ Miscellaneous Antilipemic Agents
	Norpace-Cardiovascular Health/ Antiarrhythmics
	Norpace CR-Cardiovascular Health/ Antiarrhythmics
	Treximet-Pain Management/Autonomic Agents/Selective Serotonin Agonists
	Veramyst-EENT Preparations/Intranasal Corticosteroids

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

September 02, 2010

ALERT

To: All Providers

RE: National Correct Coding Initiative (CCI) Edits

The Patient Protection and Affordable Care Act (Public Law 111-148), Section 6507 requires that State Medicaid agencies implement National Correct Coding Initiatives (NCCI) edits into their claims processing systems. These edits are intended to reduce coding errors because of clerical mistakes and incorrect use of codes or their units of service. Therefore, in the coming months, the Alabama Medicaid Agency will implement the following edits:

(1) NCCI procedure to procedure edits for practitioner* and Ambulatory Surgical Center (ASC) claims

(2) NCCI procedure to procedure edits for outpatient hospital (including emergency department and observation) claims

(3) Medically Unlikely Edits (MUE) units of services for practitioner* and ASC claims

(4) MUE units of service for outpatient hospital (including emergency department and observation) claims

(5) MUE units of service for DME claims

**Practitioners are defined as: all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act of 1965, and the Code of Federal Regulations*

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The coding principles are explained in the National Correct Coding Initiative Policy Manual for Medicare Services available on the CMS NCCI website at http://www.cms.gov

Educational tools are available on the CMS NCCI website at http://www.cms.gov/nationalcorrectcodinited.

The Alabama Medicaid Agency will notify the providers when these NCCI edits are scheduled to be implemented.

September 08, 2010

ALERT

TO: All Pharmacy Providers, Pharmacy Associations, and Pharmacy Vendors

RE: Average Acquisition Cost (AAC) Reimbursement for Drug Ingredient Cost

The Alabama Medicaid Agency will move to an Average Acquisition Cost (AAC) reimbursement for drug ingredient cost, plus a modified dispensing fee, for outpatient pharmacy claims effective September 22, 2010. Pharmacy providers will not be required to take any new or additional action when submitting claims.

Additional information can be found on the Agency AAC website at the link http://www.medicaid.alabama.gov/programs/pharmacy_svcs/AAC.aspx

September 17, 2010

ALERT

TO: All Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Hospitals, Renal Dialysis Facilities and Nursing Homes

RE: Compound Drugs for Non-Pharmacy Providers

In order for Medicaid to reimburse non-pharmacy providers for drugs purchased from a compounding pharmacy, these guidelines must be followed:

- The compound drug **must not** be commercially available.
- The active ingredient of the compound drug must follow coverage policy of drugs (FDA approved, non-DESI, not obsolete, etc).
- The billed amount should represent the lesser of the actual acquisition cost for the drug or Medicaid rate on file (ASP CMS pricing) at the time of service.
- The Agency does not reimburse non-pharmacy providers for prescription compounding time or non-covered ingredients used in the compounding process. The Alabama Medicaid Agency only reimburses for the compounding time by the billing of NDC numbers through the Pharmacy Program.
- When billing the HCPCS code for a purchased compounded drug, only one NDC can be used per procedure code. Providers must use the HCPCS procedure code, billing units and corresponding covered NDC number on the claim form.

  For example, if billing HCPCS code J1094 (Injection, dexamethasone acetate, 1 mg), the NDC billed should be the one that represents the drug as described in the HCPCS code definition, in this case, dexamethasone acetate. See Appendix H of the Medicaid Provider Billing Manual entitled "Calculation of Billing Units and Wastage" for information on calculating billing units.

Questions should be directed to the Provider Assistance Center at 1-800-688-7989 for instate providers or (334) 215-0111 for out-of-state providers.

September 27, 2010

ALERT

TO: All Instate Hospitals

RE: Inpatient and Outpatient Changes for Instate Hospitals for PHP Closeout

Effective September 18, 2010, **inpatient** hospital claims will be processed and paid as fee-for-service by the Alabama Medicaid Agency's fiscal agent, HP Enterprise Services. All billing rules for inpatient claims still apply.

Effective September 18, 2010, **outpatient** hospital claims will be processed as encounters. All billing rules for outpatient claims will still apply. The remittance advice that each hospital will receive beginning with the October 8, 2010, check write will look the same except an encounter procedure code (T1015) will be added for the encounter payment.

Outpatient Hospital Adjustments

Instate hospitals should **HOLD** all Outpatient Hospital adjustments for fee-for-service claims paid from October 1, 2009 to September 17, 2010, until further notice. However, if the outpatient claim was paid as an encounter (T1015 detail added by Medicaid), an adjustment may be submitted. Please reference the *Claim Denial 3307* below for instructions.

Outpatient Hospital Payments

For the two-year period beginning October 1, 2009, and ending September 30, 2011, all outpatient claims will be paid as encounters. An audit payment or recoupment on the September 17, 2010 check write was initiated in order to adjust outpatient claims paid at the fee-for-service rate to the outpatient encounter rate that was established as a part of the hospital assessment legislation. The amount was based on claims processed by quarter for FY 2010. The quarters are as follows: October-December 2009, January-March 2010, April-June 2010 and June-August 2010.

Note: The last quarter (June-August 2010) will be adjusted to include July-September paid dates and the difference will appear either as an audit payment or recoupment on the October 22, 2010 remittance advice.

Outpatient Hospital Encounter

As outlined in Emergency Rule No. 560-X-7-.17-.02 ER, Outpatient Hospital Services, of the Medicaid Administrative Code, effective September 2, 2010, the following bullets describe an outpatient hospital encounter:

- Outpatient hospital encounters are generally face-to-face contacts between a patient and a health professional for medically necessary services.
- An encounter may also be classified as non-patient hospital services such as specimens and blood samples sent to the hospital for performance of tests. This may also include collection and processing of blood samples.
- Claims for ER and noncertified outpatient visits must be all inclusive. All inclusive means all charges associated with that visit such as lab and radiology services.

ALERT

- Each hospital shall continue to bill for outpatient services as it did prior to the implementation of the encounter payment methodology. This means that Medicaid should not see a huge increase or decrease in the amount of claims with the implementation of the encounter payment methodology. If a hospital provider span billed for services such as chemotherapy, radiation services, or physical therapy services prior to implementation of the encounter payment methodology, then continue to span bill these services. Periodic post-payment reviews will be conducted by Medicaid.
- One encounter rate will be paid per ICN (internal control number).

Outpatient Hospital NDC Requirement

Hospital providers received an Alert dated August 3, 2010 regarding the mandatory national drug codes (NDC) for all physician administered drugs. Medicaid will require that hospitals report the NDC for all physician-administered drugs on the UB-04 claim form beginning October 1, 2010 as described in the Alert. This requirement does not apply to 340-B providers enrolled on the HHS website.

Outpatient Hospital Claim Denial 3307

If you are using the web portal to resubmit a denied outpatient claim or adjust a paid outpatient claim that contains the detail T1015, you must first delete the T1015 detail line before submitting. Otherwise, your claim will receive denial code 3307.

If you have further questions contact Jerri Jackson via phone at 334-242-5630 or e-mail at jerri.jackson@medicaid.alabama.gov.

September 27, 2010

ALERT

Attention: All Medicaid Providers

RE: Medicaid Implementing National Correct Coding Initiatives (NCCI) Edits Effective November 9, 2010

The Patient Protection and Affordable Care Act (Public Law 111-148), Section 6507 requires that State Medicaid agencies implement National Correct Coding Initiatives (NCCI) edits into their claims processing systems. These edits are intended to reduce coding errors because of clerical mistakes and incorrect use of codes or their units of service

While the law specifies the effective date as October 1, 2010, Alabama Medicaid will implement these edits on November 9, 2010, due to the programming and system testing required. The Alabama Medicaid Agency will **not** reprocess any claim with dates of service October 1, 2010, and thereafter, that were processed before the implementation date of November 9, 2010.

The Alabama Medicaid Agency will implement the following edits on November 9, 2010:

(1) NCCI procedure to procedure edits for practitioner* and Ambulatory Surgical Center (ASC) claims
(2) NCCI procedure to procedure edits for outpatient hospital (including emergency department and observation) claims
(3) Medically Unlikely Edits (MUE) units of services for practitioner* and ASC claims
(4) MUE units of service for outpatient hospital (including emergency department and observation) claims
(5) MUE units of service for DME claims

*Practitioners are defined as: all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act of 1965, and the Code of Federal Regulations

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The coding principles are explained in the National Correct Coding Initiative Policy Manual for Medicare Services available on the CMS NCCI website at http://www.cms.gov.

Educational tools are available on the CMS NCCI website at http://www.cms.gov/nationalcorrectcodinited.

November 5, 2010

ALERT

TO: All Providers

RE: Medicaid Identification Number

After four years of transition, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID number for claims processing, effective January 17, 2011. **Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number.**

All new Medicaid ID numbers issued after the conversion also begin with a “5”. The old Medicaid ID number begins with “000”. Please verify the Medicaid ID number for Medicaid recipients at the time of service. If the Medicaid ID number begins with “000”, obtain the correct Medicaid ID number before submitting the claim to Medicaid for processing.

Providers with questions about the new recipient ID numbers should contact the Provider Help Desk at **1-800-688-7989.** Medicaid recipients with questions about the new ID numbers should call toll-free at **1-800-362-1504**. Other information is available at: http://www.medicaid.alabama.gov/news/medicaid_id_numbers.aspx?tab=2

November 08, 2010

ALERT

TO: All Medicaid Providers
All Provider Associations

RE: November 19, 2010 Checkwrite

The release of Medicaid funds for the 11/19/2010 checkwrite is expected to be Wednesday, December 1, 2010.

The release of direct deposits and checks depends on the availability of funds.

Please verify direct deposit status with your bank.

November 19, 2010

ALERT

TO: All Medicaid Physicians

RE: Radiology Management Program "Gold Card Changes"

Effective January 1, 2011, changes will be made to the "Gold Card" status based on Agency evaluation of prior authorization requests made between October 1, 2009 and September 30, 2010. The following changes will be made:

- Providers with "Gold Card" who maintained a 5% or less denial rate during the above timeframe will continue to have "Gold Card" status.
- Providers who currently have "Gold Card" status with low request volume will continue to have "Gold Card" status.
- Providers with high volume and high denial rate (>5%) will be removed from gold carding.
- Providers with high volume and low denial rates who will be added to the "Gold Card" program.

The status of all providers will be re-evaluated after one year. Redetermination will be based on the preceding 12 months' worth of data.

Providers with questions may contact Carolyn Thompson, Program Manager, Lab/X-ray services at carolyn.thompson@medicaid.alabama.gov or by phone at (334) 242-5048.

November 19, 2010

ALERT

TO: All Pharmacies

RE: Reimbursement for Administration of Pneumococcal and Tdap Vaccines

Effective December 1, 2010, Alabama Medicaid will begin reimbursing Medicaid-enrolled pharmacy providers for the administration, to eligible recipients age 19 and older, of pneumococcal vaccine and Tdap vaccine. Alabama Medicaid will also continue to, in addition to the administration reimbursement, reimburse pharmacies for the pneumococcal and Tdap vaccines (i.e. ingredient).

- Beginning December 1, pharmacy providers may bill the following NDC numbers on a pharmacy claim for reimbursement of vaccine administration:
  - NDC 99999-9992-11 for pneumococcal vaccine administration
  - NDC 99999-9993-11 for Tdap vaccine administration
- Reimbursement will be $5 per administration with no dispensing fee or co-pay applied.
- Claims should be submitted with a dispense quantity of 1 for vaccine administration. There is a maximum quantity for each administration of 1 injection per recipient within a timeframe in accordance with the CDC dosing regimen.
- A prescription from a recipient's Primary Medical Provider (PMP) is required for each Tdap and pneumococcal vaccine administration.
- To facilitate coordination of care, Pharmacy providers are required to inform (via phone, fax, e-mail, mail) each recipient's Primary Medical Provider (PMP) upon administration of the vaccine(s) for which an administration claim is submitted. Documentation must be kept on file at the pharmacy of the notification to the PMP. If the PMP is unknown, the pharmacy may call the Alabama Medicaid Automated Voice Response System (AVRS) system at 1-800-727-7848 to obtain the PMP information. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website at http://www.medicaid.alabama.gov/programs/pharmacy_svcs/pharmacy_services.aspx.
- Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.
- A separate claim for the vaccine (i.e. ingredient) should be submitted with the appropriate NDC of the vaccine (i.e. ingredient) and will be reimbursed according to the current drug/pharmacy reimbursement policy.

December 01, 2010

ALERT

TO: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes Providers

RE: PDL Update

Effective January 3, 2011, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*
None	**Aceon**-Cardiovascular Health/ACE Inhibitors
	Avandamet-Diabetic Agents/Thiazolidinediones
	Avandaryl-Diabetic Agents/Thiazolidinediones
	Avandia-Diabetic Agents/Thiazolidinediones
	Diovan-Cardiovascular Health/Angiotensin-II Receptor Antagonists
	Eurax-Skin and Mucous Membrane Agents/Scabicides and Pediculicides
	Micardis-Cardiovascular Health/Angiotensin-II Receptor Antagonists
	Micardis HCT-Cardiovascular Health/Angiotensin-II Receptor Antagonists
	Teveten-Cardiovascular Health/Angiotensin-II Receptor Antagonists
	Teveten HCT-Cardiovascular Health/Angiotensin-II Receptor Antagonists
	Vigamox-EENT Preparations/Antibacterials

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at http://aldrug.rxexplorer.com/.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

December 07, 2010

ALERT

TO: All Renal Dialysis Facility Providers

Re: Medicare Crossover Changes and Medicaid Changes

Medicare Crossover Changes:
Effective February 1, 2011, renal dialysis crossover claims will be received from Medicare and will be processed by Medicaid for all renal dialysis providers.

***Note:** Crossover claims with Dates of Service prior to January 1, 2011 that crossover from Medicare will not pay correctly. These crossover claims must be electronically submitted through the previous claim submission process to Medicaid.

Medicare claims billed by renal dialysis providers will cross over directly from Medicare and will be processed by Medicaid. Providers are limited to the following codes on Medicare crossover claims. Future Medicare revisions may require code updates to this table:

Revenue Codes	Condition Codes	Procedure Code	Description
821, 881	71, 72,73, 74, 76	90999	Hemodialysis, home hemodialysis, self care training, home hemo training and ultrafiltration.
831, 841, 851	74	90945	Dialysis procedure other than hemodialysis
831, 841, 851	73	90993	Dialysis training, patient, including helper.
634,<10,000 635, >or = 10,000		Q4081	Injection epogen
636		J0882	Darbopoetin alfa, injection
636		Appropriate Injectable Codes	Injectable Drugs
250		Appropriate NDC Codes (No HCPCS)	PO Drugs
31X, 921		Appropriate Lab Codes	Labs
270		A4697, A4913 (IV)	Supply/Admin
771		Appropriate vaccine HCPCS	Vaccine

January 24, 2011

Medicaid Changes:

All Medicaid services **beginning with dates of service January 1, 2011**, and thereafter, must be billed according to the following policy. Medicaid's new requirements mirror Medicare's as closely as possible.

Revenue Codes	Condition Codes	Procedure Code	Description
821	71	90999	Hemodialysis, limited to 156 units per year.
831, 841, 851		90945	Dialysis procedure other than hemodialysis.
831, 841, 851	73, 74	90993	Dialysis training, patient, including helper. Limited to 12 per lifetime.
634,<10,000 635, >or = 10,000		Q4081*	Injection epogen
636		J0882*	Darbopoetin alfa, injection
636		Injectable Codes	See Alabama Medicaid Injectable Drug Listing in appendix H for covered injectable drugs.

***EPO and Aranasp Monitoring Policy:**

Medicaid is requiring providers include the GS modifier, the ED modifier, or the EE modifiers in mirroring Medicare's policy, refer to Chapter 8 of the Medicare Claims Processing Manual for further definition. These modifiers will be considered 'informational only' when billed to Medicaid and no reductions in payment will be made for straight Medicaid claims. Medicaid expects the provider to adhere to the strict definitions defined below:

GS	Dosage of EPO or Darbopoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level.
ED	The hematocrit level has exceeded 39.0% (or hemoglobin 1evel has exceeded 13.0g/dL) 3 or more consecutive billing cycles immediately prior to and including the current billing cycle
EE	The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) less than 3 consecutive billing cycles immediately prior to and including the current billing cycle.

Providers may contact Jerri Jackson, RN, BSN, at 334-242-5630 or e-mail at jerri.jackson@medicaid.alabama.gov if you have any questions.

ALABAMA MEDICAID AGENCY

ALERT

March 7, 2011

Attention: Psychologists

RE: Upcoming Changes to Chapter 34 of the Provider Manual

During the past year, a workgroup consisting of Alabama Medicaid Agency staff and representatives from the Alabama Psychological Association has collaborated to identify changes that enable the agency to maintain a basic package of services while preserving the health care safety net for our most vulnerable citizens.

As a result of this ongoing effort, the following changes will be implemented **effective April 1, 2011**:

- **A 52 unit annual maximum limit (including any claims with a date of service beginning January 1, 2011) will be imposed for any combination of the following codes:**
  - Individual therapy codes 90804, 90806, 90810, 90812, 90816, 90818, 90823 and 90826.
  - Group therapy codes 90846, 90847, 90849 and 90853.
- **Individual and group codes listed above are subject to a limit of one (1) unit per week (effective date of service April 1, 2011 and thereafter).** However, providers may bill one individual and one group code within the same week **or** on the same date of service. Both units will count towards the the 52 unit annual maximum limit.
- To request an override to the **maximum weekly limit**, submit documentation of medical necessity **and** the exceptional circumstance (e.g. how the recipient is an imminent danger to self or others and/or is at risk for hospitalization or decompensation) along with the original CMS-1500 claim form (with the red drop out ink), related progress note(s) and cover letter to the following address:

  Mental Health Program Director
  Institutional Services
  Alabama Medicaid Agency
  P.O. Box 5624
  Montgomery, AL 36103-5624

  A sample cover letter titled "Psychologist Override Request Form" can be found at: http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.9_Mental_Health_Services/4.4.9.2_Clinical_Psychologists/4.4.9.2_Psychology_Override_Request_Template.pdf

  When billing for testing, please note the following:

  - The date of service billed must be the date the test was given.
  - Providers may bill for testing, scoring, interpretation and report writing in 30-minute increments. However, it is only necessary to document the time spent in face-to-face service delivery.
  - Billing should reflect the **total** time for face-to-face administration, scoring, interpretation and report writing.
  - The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes.

Providers with questions should contact Karen Smith via phone at 334-353-4945 or by e-mail at: karen.watkins-smith@medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

March 8, 2011

Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes

RE: Preferred Drug List Update

Effective April 1, 2011, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*
Dulera-Respiratory/Inhaled Corticosteroids	**Day trana**-Behavioral Health/Cerebral Stimulants for ADD/ADHD-Long Acting
Ritalin SR-Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Short and Intermediate Acting	**Dexedrine-**Behavioral Health/Cerebral Stimulants for ADD/ADHD-Short and Intermediate Acting
	Pataday-EENT Preparations/Antiallergic Agents
	Patanase- EENT Preparations/Antiallergic Agents
	Patanol- EENT Preparations/Antiallergic Agents

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at http://aldrug.rxexplorer.com/.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

March 25, 2011

Attention: All Providers

RE: National Correct Coding Initiatives (NCCI) Edits Appeals Process

Effective November 9, 2010, Medicaid introduced the NCCI edits into the Medicaid claims processing system. These edits were set as "informational" edits. On March 23, 2011, these edits were set to deny for any services that do not meet the NCCI edit criteria and were furnished on or after October 1, 2010.

The use of applicable modifiers will be critical in successful implementation of the NCCI procedure to procedure edits. Once a claim or line item on the claim has been denied for an NCCI procedure to procedure edit, then the claim cannot be adjusted by the provider. If a claim is denied for an NCCI Medically Unlikely Edit (MUE), the provider can resubmit the claim with the correct units as long as the units are equal to or lesser than the NCCI MUE edit allows. If the units are more than the NCCI MUE edit allows, then an appeal must be requested.

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The Medicaid NCCI Coding is available on the CMS NCCI website at *http://www.cms.gov/MedicaidNCCICoding/01_Overview.asp#TopOfPage*

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can **NEVER** overturn the denial. These claims are final and no appeal is applicable except for an administrative law judge who can determine that the denied column two code should be paid. These instances will be rare.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1" or is for an MUE, an appeal can be submitted.

All NCCI denials begin with an error code "59nn". To validate a claim denied for an NCCI error code, download the remittance advice from the web-portal which contains the Medicaid specific error codes.

Individual claim denials may be appealed at three levels. The levels, listed in order, are:

1. Redetermination Request
2. Administrative Review
3. Fair Hearing

If all appeals have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family. This denial is a provider liability.

First Level of Appeal: Redetermination Request

The Alabama Medicaid Agency contracts with a fiscal agent (HP Enterprise Services {HPES}) to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. HPES will also be responsible for the redeterminations, which is the first level of appeals and adjudication functions.

A *redetermination* is an examination of a claim and operative notes/medical justification by HPES personnel. The provider has 60 days from the date of receipt of the initial claim determination to request a redetermination. The provider must complete the attached HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:

- Completed NCCI Redetermination Review form
- Corrected Paper Claim for the procedure codes that denied
- Operative Notes/Medical Justification

Send the request for redetermination review along with all supporting documentation to:

HP Enterprise Services
Request for NCCI Redetermination
PO Box 244032
Montgomery, AL 36124-4034

HPES will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. The ICN region for the redetermination request will begin with '91'. For example: 911108212345 6.

Second Level of Appeal: Administrative Review

When the redetermination request results in a denial by HPES, the provider may request an *administrative review* of the claim. A written request for administrative review **must be received by the Alabama Medicaid Agency within 60 days of the date of the redetermination denial from HPES**.

To request an Administrative Review, the provider must complete the attached Alabama Medicaid Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review. The request should clearly explain why you disagree with the redetermination denial.

The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review
- Correct Paper Claim for the procedure codes that denied
- Copy of previous request for redetermination correspondence sent to HPES
- Copies of all relevant remittances advices or HPES' redetermination denial notification
- Copy of any other useful documentation

Send the request for administrative review along with all supporting documentation to:

NCCI Administrative Review
Alabama Medicaid Agency
Attn: System Support Unit
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

Documentation that is submitted after the Administrative Review request has been filed may result in an extension of the time required to complete the review. Further, any documentation noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the Administrative Review decision. Documentation not submitted at the Administrative Review level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the documentation late.

This information will be reviewed and a written reply will be sent to the provider within 60 days.

Third Level of Appeal: Fair Hearing

When the administrative review does not resolve the issue, the provider has the option to request a fair hearing. A written request must be received within 60 days of the date of the administrative review decision. The request must identify any new or supplemental documentation. Send the written request for a fair hearing to:

Alabama Medicaid Agency
Attn: Office of General Counsel
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

If you have further questions, contact the Provider Assistant Center at 1-800-688-7989 or (334) 215-0111.

Request for NCCI Redetermination Review
HP Enterprise Services
PO Box 244032
Montgomery AL 36124-4032

Complete ALL Fields Below - Print or Type

ICN #	**Date of Service**
Recipient Name	**Recipient Medicaid Number**
Provider Name	**Provider NPI Number**
NCCI Denial Code(s) **1.** ☐ **2.** ☐ **3.** ☐	
Date of Denial	

Required Attachments (check box to indicate which attachment is being submitted with request):
Corrected paper claim submitted with procedure code(s) that denied along with specific reports (see below):

- ☐ **Anesthesia report for denied procedure codes in the range: 00100 – 01999**
- ☐ **Operative report for denied procedure codes in the range: 10000 – 69999**
- ☐ **Radiology report for denied procedure codes in the range: 70000 – 79999**
- ☐ **Pathology or Laboratory report for denied procedure codes in the range: 80000 – 89999**
- ☐ **Medical report for denied procedure codes in the range: 90000 – 99605**

Comments:

_____

_____

_____

Signature of either the provider or his/her representative

Date
Address
City, State and Zip code
Telephone Number, including area code
Signature

Alabama Medicaid Agency

Request For National Correct Coding Initiative (NCCI) Administrative Review

This form is to be completed only when the Redetermination Request results in a denial by the Fiscal Agent.

Section A

Print or Type

Provider's Name	Provider Number
Recipient 's Name	Recipient's Medicaid Number
Date of Service	ICN

I do not agree with the Redetermination denial by the Fiscal Agent Dated: _____

Section B

My reasons are:

Section C

Signature of **either** the provider **or** his/her representative

Provider Signature	Representative Signature
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

This form may be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

May 5, 2011

Attention: Physicians, FQHCs, IRHCs, RHCs, Outpatient Hospitals, and Independent Radiology Providers

RE: Natural Disaster PA Requirements for PET, CT, MRI, and MRA

During times of natural disasters, health care providers and patients in affected areas often must overcome challenging circumstances to furnish or obtain health care services. To assist patients and providers in areas affected by recent tornadoes, the Alabama Medicaid Agency will grant an exemption to prior authorization requests for PET scans, CT scans, MRIs and MRAs for two weeks, effective May 2, 2011. The exemption is only for recipients and requesting providers from one of the counties designated by the federal government as a disaster area.

In order for the claim to be paid, providers will need to submit a prior authorization request to MedSolutions as usual. If a provider has received a denial for a request started after May 2, 2011, please contact MedSolutions at 888-693-3211. Any other questions should be directed to Toni Hopgood at 334-353-4724 or toni.hopgood@medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

May 18, 2011

Attention: All Outpatient Hospital Providers

Effective for dates of service October 1, 2010, and thereafter, outpatient observation CPT codes 99218 through 99220 have been replaced with HCPCS Level II procedure code G0378. The policy is revised as written below:

Outpatient Observation

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

- Patient must be admitted through the emergency room.
- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours, but no more than 23 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 G0378 should be used to bill the 4th through 23rd hour for the evaluation and management of a patient in outpatient observation.

Procedure Code G0378 must be billed with a facility fee (99281-99285). The facility fee is billed with units of one and covers the first three hours.

Ancillary charges (lab work, x-ray, etc.) may be billed with the facility fee and observation charge.

If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.
Outpatient observation charges cannot be billed in conjunction with outpatient surgery.

Medical records will be reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria.

If there are any questions contact Jerri Jackson by telephone at 334-242-5630 or by e-mail at jerri.jackson@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

May 25, 2011

Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes

RE: Preferred Drug List Update

Effective July 1, 2011, the Alabama Medicaid Agency will:

1. No longer reimburse for Prevacid OTC. Prilosec OTC and Zegerid OTC will continue to be covered.
2. Require prior authorization (PA) for payment of generic buprenorphine (example brand names: Butrans, Buprenex, Subutex) products.
3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*	
Daytrana Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting	**Aciphex**	Proton-pump Inhibitors
	Astelin	EENT Preparations /Antiallergic Agents
	Besivance	EENT Preparations/Antibacterials
	Elidel	Miscellaneous Skin and Mucous Membrane Agents
	Levemir	Insulins
	Luvox CR	Antidepressants
	Protopic	Miscellaneous Skin and Mucous Membrane Agents
	Symbicort	Respiratory/Orally Inhaled Corticosteroids

**Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at http://aldrug.rxexplorer.com/.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

May 27, 2011

Attention: All Providers

RE: Medical and Quality Review Services Contractor

The Agency's current contractor, the Alabama Quality Assurance Foundation (AQAF) will stop receiving and reviewing prior authorization requests, hospice and nursing home records effective June 1, 2011. Effective June 1, 2011, the following procedures apply:

For Hospice, Nursing Home, PEC and Swing bed records:

Effective June 1, 2011, these records should be mailed to the Alabama Medicaid Agency:

LTC Medical and Quality Review Unit, Room 3014
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

Hospice status change and LTC request for action forms should be faxed to (334) 353-4909.
For inquiries about records or forms received on or after June 1, 2011, please call:
Dodie Teel (334) 242-5149, Cheryl Cardwell (334) 242-5578, or Theresa Carlos (334) 353-3711.

NOTE: Due to the storms of April 27, 2011, the June retrospective audit for nursing home admissions, re-admissions and transfers will not be done. The Agency reserves the right to request these records at a later date, per Administrative Code Rule No. 560-X-1-.21. Provider Medicaid Records Inspection/Audit.

For Prior Authorizations:

- The process for submitting PA requests to HP remains the same. The Agency will review requests received on or after June 1, 2011.
- For inquiries about PAs received into the system on or after June 1, 2011, please call:
  - Transportation: Brenda Fincher (334) 242-5455
  - Eyecare: Kathy Hardwick (334) 353-5017
  - All other PAs: Dodie Teel (334) 242-5149, Sheila McDaniel (334) 242-2366 or Theresa Carlos (334) 353-3711.

Please allow at least 30 calendar days for all reviews above. During this transition phase, the Agency requests the cooperation of providers *to limit phone calls* to Agency staff, unless absolutely necessary, to allow staff to complete reviews timely.

The status of PA requests may be accessed using AVRS (1-800-727-7848), or the Provider Web Portal, using the link below:
https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/65/Default.aspx

Please use this link for instructions about using the web portal for PAs:
http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2011/6.7.1.2_April_2011/6.7.1.2_Webuser.pdf

ALABAMA MEDICAID AGENCY

ALERT

June 29, 2011

Attention: Independent and Provider-Based Rural Health Clinics

RE: Nurse Practitioners and Federal Electronic Health Record Incentive Program

In order to qualify for the federal Electronic Health Record Incentive program, nurse practitioners associated with Independent and Provider-based Rural Health Clinics are required to enroll as a Medicaid provider.

For more information about the federal Electronic Health Record Incentive Payment program, please go to *http://onehealthrecord.alabama.gov/providers.aspx*

For questions regarding the federal Electronic Health Record Incentive Program, please contact Kim Davis-Allen at *Kim.Davis-Allen@medicaid.alabama.gov* or (334) 242-5011.

Also, effective October 1, 2011, Independent and Provider-Based Rural Health Clinics must use the nurse practitioner's NPI number on all claims submitted for services provided by a nurse practitioner.

For questions regarding enrollment, contact HP Provider Enrollment at 1-888-223-3630.

ALABAMA MEDICAID AGENCY

ALERT

July 1, 2011

Attention: Nursing Homes, ICF-MR, Hospice, PEC, Swing Bed, DME and Physicians Providers

RE: Medical and Quality Review Services Contractor

The Alabama Medicaid Agency's new medical and quality review services contractor, Qualis Health, will begin reviews of prior authorization (PA) requests, and hospice, nursing home, ICF-MR, PEC and swing bed records on July 1, 2011. **Qualis will NOT review pharmacy, dental or radiology PAs.**

Qualis will review PA requests with Julian dates of 6/16/2011 and after. For inquiries regarding PAs submitted on June 16, 2011 or later, providers may contact Qualis at (888) 213-7576. The fax number is (888) 213-8548.

For Hospice, Nursing Home, ICF-MR, PEC and Swing Bed Records:

Effective July 1, 2011, these records **MUST** be mailed to HP, the Alabama Medicaid Agency's fiscal agent, along with a cover sheet, found on the website at:
http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Forms.aspx.
The HP address is found on each cover sheet.

These records will be scanned into the system by HP so that staff from the Agency and contractor can review them electronically. Please note that the cover sheet **MUST** be used to ensure that the record is added to the correct site electronically.

ICF-MR providers should use the "LTC records" cover sheet.
For hospice records, continue to include the Form 165A, along with the HP cover sheet.
Hospice recipient status change (Form 165B) and LTC request for action (Form 161B) forms should be faxed to Qualis at (888) 213-8548 effective July 1, 2011.

For Prior Authorizations:

The process for submitting PA requests to HP remains the same. The Agency will review requests received through June 15, 2011.

For inquiries about PAs received into the system through June 15, 2011, please call:
Transportation: Brenda Fincher (334) 242-5455
Eyecare: Kathy Hardwick (334) 353-5017
All other PAs: Dodie Teel (334) 242-5148, Sheila McDaniel (334) 242-2366 or Theresa Carlos (334) 353-3711.
For inquiries about PAs received on or after June 16, 2011, providers should call Qualis at (888) 213-7576.

Effective July 1, 2011, providers may enter the PA number to this webpage to notify Qualis staff when a denied PA is ready for reconsideration. http://www.qualishealth.org/healthcare-professionals/alabama-medicaid/provider-resources. Please submit the documents for reconsideration, along with the denial letter to HP, before submitting the PA number to Qualis.

The status of PA requests may also be accessed using:
AVRS (1-800-727-7848)
The Provider web portal, using the link
https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/65/Default.aspx
or the HP Provider Assistance Center at (800) 688-7989.

Please use this link for instructions about using the web portal for PAs:
http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2011/6.7.1.2_April_2011/6.7.1.2_Webuser.pdf

ALABAMA MEDICAID AGENCY

ALERT

July 29, 2011

TO: All Optometrists, Ophthalmologists, and Opticians

RE: New Award for Central Source Contractor for Eyeglasses

The Alabama Medicaid Agency awarded a new contract through an Invitation To Bid process to Steven Baker, Inc., D/B/A Korrect Optical as the Central Source Contractor for Eyeglasses. The effective date of the contract is July 1, 2011. Korrect Optical will begin accepting eyeglass orders on Tuesday, September 6, 2011. Further ordering instructions will be forwarded in the near future. Korrect Optical's Customer Service number is 1-800-624-4225.

The Alabama Medicaid Provider Manual, Chapter 15 will be updated in the October, 2011 edition to include prices and approved frames. The Manual will include changes made in the Eye Care Program regarding eyeglasses, such as previous stand-alone codes will now become add-on codes. Previously, stand-alone lens codes could not be billed with other lens. With add-on codes, the lens code and the applicable add-on code may both be billed on the same date of service. The changes will provide the Agency with improved utilization data. Eye Care providers may continue to order or fabricate eyeglasses as in the past and at the new contracted allowed amounts. Please refer to the Alabama Medicaid Provider Manual, Chapter 15 for the Eye Care Program policies.

The new contracted allowed amounts for eyeglasses will become effective August 1, 2011 and the changes are summarized in the following paragraphs. The new allowed amounts for lens, add-on codes, prior authorization codes, and frame codes are listed on the following page.

The Alabama Medicaid Agency is appreciative of your contributions and efforts as a Medicaid Eye Care Provider. If you have any questions, you may contact Mary Timmerman, RN, CPC at mary.timmerman@medicaid.alabama.gov or at (334) 242-5014.

Alabama Medicaid Contracted Allowed Amounts for Eyeglasses
Effective August 1, 2011

(Content is referenced from July 29, 2011 Alert entitled New Award for Central Source Contractor for Eyeglasses)

Single Vision

Lens Code Ranges	Price per lens
V2100-V2101	$11.00
V2102	$13.00
V2103-V2105	$11.00
V2106	$13.00
V2107-V2108	$11.00
V2109-V2114	$13.00
V2115	$14.00
V2118	$40.00
V2121	$13.00
V2199	$15.00

Trifocal Lens

V2300-V2314	$25.00
V2315-V2318	$35.00
V2319	$5.00
V2320	$10.00
V2321	$35.00
V2399	$25.00

Bifocal Lens

Lens Code Ranges		Price per lens
V2200		$12.00
V2201-V2202		$14.00
V2203-V2204		$12.00
V2205-V2206		$14.00
V2207		$12.00
V2208-V2209		$14.00
V2210		$25.00
V2211-V2214		$14.00
V2215-V2218		$30.00
V2219		$5.00
V2220		$10.00
V2221		$30.00
V2299		$14.00

Other Lens

V2410-V2700		$10.00
V2710		$30.00
V2715	Add-on cost	$0
V2718	Add-on cost	$30.00
V2745	Add-on cost	$0
V2784	Add-on cost	$0

Lenses Requiring Prior Authorization from Medicaid before Ordering (per lens)

V2744	Add-on cost	$25.00
V2755	Add-on cost	$0
V2781	Add-on cost	$10.00
V2782	Add-on cost	$10.00
V2783	Add-on cost	$20.00

Add-on cost: This item to be billed in addition to appropriate lens code.

Frames

V2020	Frames	$0

Frames Requiring Prior Authorization

*V2025	Special Order Frames	$100.00

*This is a frame utilized for those patients requiring a special/unusual size and/or shaped frame.

ALABAMA MEDICAID AGENCY

ALERT

August 12, 2011

Attention: All Providers

RE: Synagis® Criteria for 2011 – 2012 Season

The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2011-2012 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx

- The approval time frame for Synagis® will begin October 1, 2011 and will be effective through March 31, 2012.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2011 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

Criteria

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

August 15, 2011

Attention: Hospice Providers

RE: Federal Rules Governing the Hospice Program

The federal rules governing the Hospice Program provides that an additional amount is paid to the hospice on behalf of an individual residing in a nursing facility. This amount must equal at least 95% of the per diem rate that the Medicaid Agency would have paid to that nursing facility for the individual in that facility. For example, if you have three (3) individuals receiving hospice services through your Agency, each residing in a different nursing facility, you should bill the room and board for each individual based upon 95% of **that** facility's per diem rate. If the per diem rate for the facility is $135.00, you should bill the room and board at $128.25.

If you are not aware of what the nursing facility per diem rate is, you should first request this information directly from the nursing facility. If you are unable to obtain this information from the nursing facility, you may request this information in writing from the Alabama Medicaid Agency, LTC, Provider/Recipient Services Unit, 501 Dexter Avenue, Montgomery, AL 36103-5624, or fax to (334) 353-5696. Below is a sample letter for you to recreate in requesting this information.

LTC, Provider/Recipient Services Unit
501 Dexter Avenue
Montgomery, Alabama 36103-5624
FAX #: (334) 353-5696

Requesting Hospice Provider: _____

Hospice Provider #: _____

Hospice Provider Telephone #: _____

Hospice Provider Fax # _____

Contact Person's Name: _____

_____
Nursing Facility Address

Do you now provide Hospice services to individuals in this facility? Yes or No

Received AMA _____

Returned by Fax on: _____

Signature: _____

ALABAMA MEDICAID AGENCY

ALERT

August 25, 2011

Attention: All Providers

RE: Pharmacy Changes for October 2011

Effective October 3, 2011, the Alabama Medicaid Agency will require prior authorization (PA) of all antipsychotic medications utilizing the electronic PA process. The PA process will affect all recipients (children and adults) as well as all antipsychotics (brand and generic, first and second generation). The PA criteria for this drug class can be found on the Agency's website at www.medicaid.alabama.gov.
Claims not approved through the electronic PA process at the pharmacy point of sale will require a manual PA form to be submitted; prescribers will receive automatic fax notification if additional medical justification is required.

Effective October 1, 2011, the Alabama Medicaid Agency will:

1. Limit the number of brand name prescriptions to four per month per recipient. There will not be a limit on the number of covered generic or over-the-counter prescriptions a recipient may receive. This limitation does not apply to children under the age of 21 or to recipients living in nursing facilities. In certain drug classes, allowances are allowed in the event of an adverse or allergic reaction, or failure to respond. Medicaid will also continue to allow for prescriptions to exceed the four brand limit for anti-psychotic and anti-retroviral medications; however, there will be no instance where the limit may exceed ten brand name drugs per month per recipient. Providers with questions concerning the prescription limitation should contact:

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

2. No longer require prior authorization (PA) for payment of generic pantoprazole (Protonix). Brand name Protonix will continue to require prior authorization.

   For additional PDL and coverage information, visit our drug look-up site which can be accessed using the following link:
   http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5_Pharmacy_Services.aspx

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

ALABAMA MEDICAID AGENCY

ALERT

September 14, 2011

Attention: Prosthetic, Orthotic & Pedorthic (POP) Providers

RE: Newly Covered Code for the Prosthetic, Orthotic & Pedorthic Program

Effective immediately, Medicaid has approved Procedure Code L5972 (Flexible Keel Foot) as a newly covered code for the Prosthetic, Orthotic, & Pedorthic Program.

Procedure Code L5972 must be provided by a licensed prosthetic, orthotic and/or pedorthic practitioner in the State of Alabama practicing at an accredited facility. The provider must obtain a written prescription, must keep the prescription on file, and must have supporting documentation that the device is medically necessary.

Medicaid pays for basic level prosthetic, orthotic, and pedorthic devices for ages 21-65.

For questions or concerns regarding the POP Program, please contact Felicha Fisher at (334) 353-5153.

ALABAMA MEDICAID AGENCY

ALERT

November 1, 2011

Attention: Nursing Home Providers

RE: Institutional Review Record Request

Effective December 1, 2011, Qualis Health, Medicaid's medical and quality review services contractor, will begin faxing requests for medical records to conduct retrospective reviews. In the past, a certified letter requesting medical records for the review process was mailed to the facilities. The new process requires faxing the request to the facility's designated staff.

Example of faxes that might be received:

- **First Fax Notification** –Acknowledgment of Fax Receipt. Confirmation is complete after printing name and signing signature. Mail medical records to HP for record review
- **Second Fax Notification**-Acknowledgment of Fax Receipt. Confirmation is complete after printing name and signing signature. Mail medical records to HP for record review
- **Final Fax Notification**- Mail medical records to HP for record review
- **Letter of Imposition** - Mail medical records to HP for record review

The process for **mailing** medical records will remain the same.

Please mail records with the HP LTC Records coversheet to:

HP Enterprise Services

P.O. Box 244032

Montgomery, AL 36124-4032

Please contact Qualis Health at 1-888-213-7576 for questions regarding this process.

ALABAMA MEDICAID AGENCY

ALERT

November 17, 2011

Attention: IUDs and Implants: Changes to Contraceptive Coverage

RE: To: All Pharmacies, Physicians, Maternity Care Primary Contractors, FQHCs, RHCs, and Health Departments

The Alabama Medicaid Agency is making important changes regarding the coverage of intrauterine devices (IUDs) and implantable contraceptive devices. Effective January 1, 2012, these devices will be reimbursed only when billed on a medical claim. Pharmacies will no longer be able to bill for these devices for a specific patient and ship to the provider for insertion/implantation. Example devices include Mirena®, Paragard®, Implanon®, etc.

Questions regarding this change can be sent to Nancy.Headley@medicaid.alabama.gov or by calling 334-242-5684.

ALABAMA MEDICAID AGENCY

ALERT

December 13, 2011

Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

RE: Preferred Drug List (PDL) Update

Effective January 3, 2012, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*	
None	**Azasite**	EENT Preparations/Antibacterials
	Nasacort AQ	EENT Preparations/Intranasal Corticosteroids
	Neosporin	EENT Preparations/Antibacterials
	Poly-pred	EENT Preparations/Antibacterials

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

January 10, 2012

To: Outpatient Hospitals, Physicians, and Independent Laboratories

RE: Policy on Qualitative Drug Screening

Effective beginning dates of service January 1, 2012, and thereafter, Medicaid will adopt the following policy on qualitative drug screening:

The following drug screens will be limited to one specimen every seven days per recipient, per provider (providers within a group are considered a single provider), and may not be billed in any combination: 80100, 80101, 80102, and 80104.

Example: A test that is done on Wednesday cannot be done again until the following Wednesday.

A qualitative drug screen is used to detect the presence of a drug in the body. A blood or urine sample may be used; however urine is the best specimen for broad qualitative screening, as blood is relatively insensitive for many common drugs, including psychotropic agents, opioids, and stimulants. Detection of a drug or its metabolite(s) in urine is evidence of prior use. It does not, by itself, indicate that the drug remains in the blood.

Current methods of drug analysis include chromatography, immunoassay, chemical ("spot") tests, and spectrometry. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound (a laboratory must possess a valid reference agent for every substance that it identifies). Drugs or classes of drugs are commonly assayed by qualitative screen followed by confirmation with a second method.

Note: Medicaid will only reimburse one screen (whether the specimen is blood or urine) per recipient, per provider, per seven-day period.

Note: A recipient cannot be billed for panels within the specimen.

Drugs or classes of drugs that are commonly assayed by qualitative screen, followed by confirmation with a second method, include the following:

- Alcohols
- Amphetamines
- Barbiturates
- Benzodiazepines
- Cocaine and Metabolites
- Methadones
- Methaqualones
- Opiates
- Phencyclidines
- Phenothiazines
- Propoxyphenes
- Tetrahydrocannabinoids
- Tricyclic Antidepressants

Policy on Qualitative Drug Screening

CPT Codes

The following CPT codes are applicable for services under the qualitative drug screening policy (maximum unit limitation per recipient, per provider, per seven-day week):

- 80100-Drug screen, qualitative; multiple drug classes, each procedure-1 unit per specimen
- 80101-Single drug class, each drug class-1 unit per specimen
- 80102-Drug confirmation, each procedure-1 unit per specimen
- 80104-Drug screen, qualitative; multiple drug classes other than chromatographic method-1 unit per specimen

Note: Use the appropriate chemistry code (82000 – 84999) for quantitation of drugs screened, and the appropriate therapeutic drug assay code (80150 – 80299) for therapeutic drug levels.

Drug Screening Test Frequency

Medicaid allows payment of a screening test frequency of once per every seven-day period.

Coverage Criteria

Medicaid will cover medically necessary qualitative drug screens as follows:

1. Suspected drug overdose, **and** one or more of the following conditions:
   - Unexplained coma;
   - Unexplained altered mental status;
   - Severe or unexplained cardiovascular instability (cardiotoxicity);
   - Unexplained metabolic or respiratory acidosis;
   - Unexplained head trauma with neurological signs and symptoms; and/or,
   - Seizures with an undetermined history.
2. Beneficiary presents with clinical signs/symptoms of substance abuse.
3. High risk pregnancy **only** when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does **not** consider a qualitative drug screen as a **routine** component of assessment.
4. EPSDT services **only** when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does **not** consider a qualitative drug screen as a **routine** component of assessment.

Exclusions

Medicaid will **not** cover qualitative drug screens for the following:

- To screen for the same drug with both a blood and a urine specimen simultaneously.
- For medicolegal purposes, including those listed under ICD-9 code V70.4. (Blood-alcohol tests, paternity testing and blood-drug tests).
- For employment purposes (i.e., as a pre-requisite for employment or as a means for continuation of employment).
- For active treatment of substance abuse, including monitoring for compliance.
- As a component of routine physical/medical examination, including those for subpopulations listed under ICD-9 code V70.5. (Armed forces personnel, Inhabitants of institutions, Occupational health examinations, Pre-employment screening, preschool children, Prisoners, Prostitutes, Refugees, School children and Students).
- As a component of medical examination for administrative purposes, including those listed under ICD-9 code V70.3. (General medical examination for: admission to old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission and sports competition).

Prior Approval

Prior approval will not be required for qualitative drug screens.

Policy on Qualitative Drug Screening

Documentation Requirements

The **ordering/referring** provider must retain documentation supporting medical necessity in the medical record. Documentation must include the medical necessity for performing the screen. All tests must be ordered in writing, and all drugs/drug classes to be screened must be indicated in the order. A copy of the lab results must be retained in the medical record.

If the **provider rendering the service** is other than the ordering/referring provider, the provider rendering the service must maintain hard copy documentation of the ordering/referring provider's order for the test and the lab results. The order must include clinical indication/medical necessity in addition to all drugs/drug classes to be screened.

Documentation must be legible and available for review upon request.

ALABAMA MEDICAID AGENCY

ALERT

January 25, 2012

Attention: Medicaid Certified Nursing Facilities

RE: Revision to Nursing Facility Admission Criteria

The Alabama Medicaid Agency has updated Rule No. 560-X-10-.10 to consolidate all activities of daily living (ADLs) under one criterion for initial nursing facility admission. This means that multiple items under (k) on Form 161 will only count as one criterion.

Admission to a certified nursing facility still requires that the patient meet two or more criteria listed on Form 161 (a-k). As a result, an individual who meets one or more ADL deficits under (k) must also meet an additional criterion from the list (a-j). All applications for admission to a nursing facility must include supporting documentation.

Two exceptions are noted:

- Criterion (a) and criterion (k)-7 are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k)-7 may not be used as the second qualifying criterion.

- Criterion (g) and criterion (k)-9 are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), criterion (k)-9 may not be used as the second qualifying criterion.

Form 161 is available on the Alabama Medicaid Agency website, or you can click the link below:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC_Admission_&_Evaluation_Data_Form161_Revised_1-30-12.pdf.

Questions regarding this ALERT should be directed to the LTC Provider/Recipient Services Unit at (334) 353-4754.

ALABAMA MEDICAID AGENCY

ALERT

January 31, 2012

Attention: All Providers and Vendors

RE: Updated Alabama interChange System Vendor Interface Specifications Document

The Alabama interChange System Vendor Interface Specifications Document intended for Software Vendors to use when developing applications to interact with the Alabama Medicaid Interactive Website has been updated.

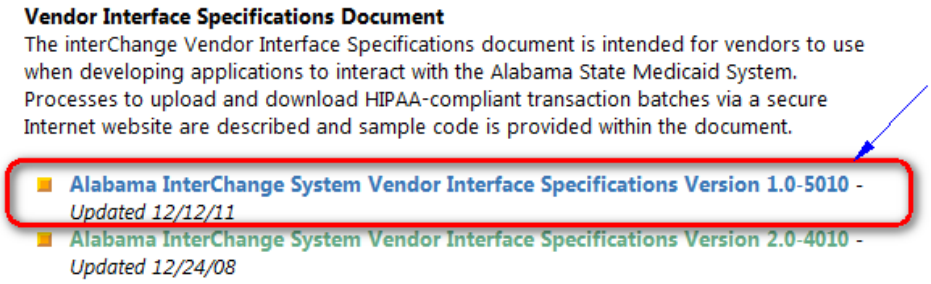
The major change made to this process is the addition of a required field that must be submitted within the XML request in support of the dual processing of 4010 and 5010 transactions:

- **cde_industry** – Identifies the HIPAA version. Please see Appendix A within the document for the value that must be submitted for both 4010 and 5010 transactions.

We are requesting Providers and Vendors send an email to alabamaictesting@hp.com by February 15th and provide the following information if you are a trading partner that utilizes this submission method.

1. Trading Partner Name and ID.
2. Software Used.
3. Time it will take to make this change and have it ready for testing.

The document has been posted to the Alabama Medicaid website at the following link:
http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx



Questions regarding this provider notice should be directed to the EMC helpdesk:

Monday – Friday
7:00 a.m. – 8:00 p.m. CST
Saturday
9:00 a.m. – 5:00 p.m. CST

(800) 456-1242

ALABAMA MEDICAID AGENCY

ALERT

February 3, 2012

Attention: All Providers Except Pharmacy

RE: 5010 Implementation Issues

Detail DOS (Date of Service) on Outpatient claims – deny for edit 264, From DTL DOS missing. The situation under which this information is to be billed changed for 5010. Any claim denied for error 264 should be resubmitted. Medicaid has set error 264 as informational meaning the edit will continue to post, but the claim will pay instead of deny.

Medicare paid amount - In 5010, the Medicare allowed amount will no longer be submitted on the 837I or 837P X12 crossover claims. Instead, this amount will be calculated as a sum of the Medicare paid amount and all applicable claim adjustment amounts (coinsurance, copayment, deductible, blood deductible, psychiatric, and late filing). We are addressing an issue related to how this amount is being calculated. Once it has been corrected, providers will be notified and you may resubmit your crossover claims.

2310C – Service Facility Location - 837P X12 files are currently rejecting for a HIPAA compliance error when the 2310C, Service Facility Location NM1 or REF information is not submitted. This compliance edit has been inactivated until a final determination can be made as to when this information is required for claim adjudication. If the service facility information is not submitted, but is needed to accurately adjudicate the claim, the claim will deny. Any files rejected for this error can now be resubmitted.

Medicare Crossover Claims (COBC – Medicare's clearing house) - Effective Monday, March 12, 2012, the Medicare clearing house will begin transmission of 5010-formated claims to Alabama Medicaid. There will be a "payment floor clearing" or transition period from March 12, 2012 to March 26, 2012. For details of this transition period see the *MNL Matters® Number SE1137 Revised* on the CMS website at *http://www.cms.gov/MLNMattersArticles/Downloads/SE1137.pdf*.
As a result, Medicaid providers should be aware of the following:

1) 4010 claims submitted before March 12, 2012, will come to Alabama Medicaid as 4010 claims with no conversion by COBC.
2) Due to the conversion performed by COBC, all situational data fields will be removed which may cause the claim to deny. If you get a denial for your claim during this time, which you feel is in error, resubmit the original claim directly to Medicaid via PES or Web Portal. **This applies to 4010 claims submitted *on or after* March 12, 2012**, and to **5010 claims submitted *before* March 12, 2012.**

   Examples of errors that may occur:
   - NDCs missing for procedure codes that require them for processing –deny for edit 4277, NDC requires procedure code
   - Taxonomy missing – deny for edits 1945/1946, Multiple SVC locations for billing provider.
3) **5010 claims submitted on or after March 12, 2012, will come to Alabama Medicaid as 5010 claims with no conversion by COBC.**

ALABAMA MEDICAID AGENCY

ALERT

February 6, 2012

ATTENTION: Hospice Providers

RE: Face-to-Face Communication Requirement for the Hospice Program

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th day recertification and every recertification thereafter, and to attest that the encounter occurred. This new face-to-face encounter requirement became effective for Medicare on January 1, 2011.

The Alabama Medicaid Agency will not require the ***Face-to-Face Communication*** for Medicaid hospice recipients. However, if a face-to-face visit has been performed for a Medicaid-only hospice recipient, Alabama Medicaid highly recommends that any documentation pertaining to the face-to-face visit be submitted to the Agency or its designee with the complete medical record. Submission of this information may provide important supporting documentation to validate the terminal status of the Medicaid hospice recipient and may also expedite review of the hospice record.

Therefore, although not a requirement, hospice providers are strongly encouraged to submit face-to-face documentation, if available.

For questions or concerns regarding the ***Face-to-Face Communication*** for the Hospice Program, please contact Felicha Fisher at (334) 353-5153.

ALABAMA MEDICAID AGENCY

ALERT

February 14, 2012

Attention: Family Planning Providers (Physicians, FQHC, IRHC, PBRHC)

RE: Implantable Contraceptive Capsules

Effective December 31, 2011, two CPT® codes (11975 and 11977) for reporting removal and insertion of implantable contraceptive capsules (e.g., Implanon, Nexplanon) were deleted.

As a result, Medicaid providers should use the following codes:

1 To bill insertion of a non-biodegradable drug delivery implant for contraception, use:

- 11981 – Insertion, non-biodegradable drug delivery implant
- This replaces deleted code 11975: Insertion, implantable contraceptive capsules

2 To bill removal of implantable contraceptive capsules with subsequent insertion of non-biodegradable drug delivery implant, use:

- 11976 – Removal, implantable contraceptive capsules
- 11981 – Insertion, non-biodegradable drug delivery implant
- These codes replace deleted code 11977: Removal with reinsertion, implantable contraceptive capsules

If a provider is enrolled with the Alabama Medicaid Plan First program, the – FP modifier must be appended to family planning service claims.

Refer to Medicaid Provider Manual Appendix C: Family Planning for additional details; the CPT code changes will be reflected in the April quarterly update.

For questions, contact Laura Hamilton, Associate Director, Maternity Care and Plan First at (334) 353-5539 or laura.hamilton@medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

February 22, 2012

Attention: Outpatient Hospitals, Physicians, and Independent Radiology Providers

RE: Retroactive Eligibility Prior Authorizations

Effective immediately, all claims with radiology procedure codes requiring prior authorization and with a date of service rendered during the recipient's retroactive eligibility period may now be filed electronically. These claims do not need manual override by Medicaid. If you have any questions or concerns, please contact Toni Hopgood, Program Manager, Lab/Radiology via phone at 334-353-4724 or via e-mail at toni.hopgood@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

March 1, 2012

Attention: Nursing Home Providers

RE: Estate Recovery Reviews

Health Management Systems (HMS) has been contracted by Alabama Medicaid to perform estate recovery services. These services are for the recovery of medical assistance payments from the estates of certain deceased Medicaid recipients and/or their spouses who previously received nursing home care paid for by Medicaid. Nursing home providers may soon be receiving letters or a questionnaire from HMS requesting information in order to recover the costs of Medicaid services, when it is appropriate. HMS is working as an authorized agent for the Alabama Medicaid Agency and security agreements are in place for a provider to be able to release recipient and sponsor information to HMS.

Providers are asked to complete requests from HMS within two weeks of receipt of the notice. Questionnaires must be completely filled out with all requested documentation and faxed to (855) 809-3983 or mailed to HMS, The Alabama Medicaid Estate Recovery Contractor, P. O. Box 166709, Irving, TX 75016-6709. Any questions about any letter or questionnaire should be referred to HMS at (855) 543-8395. Any questions that need to be directed to the Agency regarding the estate recovery services being performed by HMS can be directed to Keith Thompson at (334) 242-5248.

ALABAMA MEDICAID AGENCY

ALERT

March 1, 2012

Attention: All Medicaid Dental Providers

RE: Dental Service Code Changes

Effective: January 1, 2012, the following changes were made to the Dental Program:

1. Non-emergency oral examinations (D0150, D0120) are limited to two per calendar year whether it is a comprehensive oral examination and one periodic oral examination or two periodic oral examinations in a 12-month period.

2. For procedure D1351, teeth to be sealed must be free of caries and restorations. The surface sealed must be noted on the dental claim form. Reimbursement for restorations placed on a previously sealed surface by the same provider within a 12-month period will be reduced by the amount of the reimbursement for the sealant.

3. For procedure codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394, the reimbursement is based on the total number of unique surfaces restored, not to exceed the total number of surfaces characteristic of that tooth, and no surface shall be billed twice. Reimbursement is not based on the total number of restorations placed. For example, if a buccal, occlusal and lingual resin restoration was placed on a posterior tooth, the correct billing code would be BOL D2393 and not D2391 times three.

4. D2792, D2752, D2751 and D2750 pay only one code per tooth per lifetime.

This information is also available on the Agency's website at www.medicaid.alabama.gov under Programs/Medical Services/Dental

Questions about these changes should be directed to Leigh Ann Hixon, leighann.hixon@medicaid.alabama.gov, or by telephone at (334) 353-3031.

ALABAMA MEDICAID AGENCY

ALERT

March 6, 2012

Attention: DME Providers

RE: DME Paper Claims Changes

Effective February 1, 2012:

K0739 (Repair) procedure code's allowable units have been increased to 12. However, providers must continue to submit justification when billing more than four units. Please include all units over four on the PA request with justification for repairs. The request will be reviewed by Qualis Health. The PA letter will state the total units approved in the analyst's remarks section.

Effective March 1, 2012:

1. Disaster claims (fire and theft) should be submitted electronically to HP for processing. Provider must file these claims with the appropriate procedure code and **Modifier CR**. The provider must keep all documentation (fire report, theft report, etc) in the recipient's file. These claims will be monitored by Alabama Medicaid on a quarterly basis.

2. DME diabetic testing supplies claims billed for recipients with Gestational Diabetes must contain a diagnosis code in the range of 64880-64884. Units will be increased for procedure code A4259 to two (2) per calendar month and for A4253 to four (4) per calendar month. These claims will be processed electronically by HP. All documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.

ALABAMA MEDICAID AGENCY

ALERT

March 8, 2012

Attention: All Providers

RE: Program of All-Inclusive Care for the Elderly (PACE)

Alabama Medicaid Agency has initiated a new program called the Program of All-Inclusive Care for the Elderly (PACE). The PACE program operates as a capitated managed care benefit that features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with the needs of the participant.

Enrolled participants must receive all of their services through the PACE Organization. PACE services include but are not limited to the following: Primary Care (including doctor and nursing services); Hospital Care; Medical Specialty Services; Prescription Drugs; Dentistry; Nursing Home Care; Personal Care; Physical Therapy; Adult Day Care; Nutritional Counseling; Laboratory/X-ray Services; Social Services; and Transportation.

The program is currently limited to participants in Mobile and Baldwin counties although programs in other locations are expected later this year.

Providers serving Medicaid recipients in these counties need to be aware that PACE participants must receive all services from PACE program-contracted providers. **Claims submitted by non-contract providers will not be paid.**

PACE participants' Medicaid cards have a sticker identifying their affiliation with the program as well as a unique PACE program identification card. PACE participation is also reported through the Agency's AVRS eligibility verification system.

Individuals enrolling in the PACE program must meet each of the following criteria:

- meet the nursing home level of care
- are able to live safely in the community at the time of enrollment
- be 55 years of age and older
- live in a designated PACE service area, currently Mobile and Baldwin counties

PACE participants may be Medicaid-only, Medicare-only, Medicaid and Medicare (dually eligible), or private pay.

For questions or concerns regarding the PACE program, please contact Linda Lackey at (334) 242-5644, or Jan Sticka at (334) 353-4151 or go to the Agency's website at www.medicaid.alabama.gov under Programs/Long Term Care.

ALABAMA MEDICAID AGENCY

ALERT

March 8, 2012

Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes

RE: Preferred Drug List Update

Effective April 2, 2012, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	
PegIntron	Anti-infective Agents/Interferons
PDL Deletions*	
Avalide	Cardiovascular Health/Angiotensin II Receptor Antagonists
Avapro	Cardiovascular Health/Angiotensin II Receptor Antagonists
Benicar	Cardiovascular Health/Angiotensin II Receptor Antagonists
Benicar HCT	Cardiovascular Health/Angiotensin II Receptor Antagonists
Cleocin	Anti-infective Agents/Miscellaneous Antibacterials
Focalin	Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Short and Intermediate Acting
Pegasys	Anti-infective Agents/Interferons

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.
The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050.
Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

March 15, 2012

Attention: All Providers

RE: Information regarding Provider Electronic Solutions Software (PES) Version 3.0

PES version 3.0 must be in place before March 31st to submit 5010 and NCPDP 1.2 transactions.

Users have two options: 1) An upgrade from PES version 2.16 to PES version 3.0 (desired), or 2) A full install of PES version 3.0.

1) Upgrade information:

Prior to upgrading to PES version 3.0:

- Users must be using PES version 2.16
  - If not, you must upgrade to PES version 2.16 or do a full install
- Users must submit all "R" status transactions (these cannot be submitted once version 3.0 is in place).

Once PES version 3.0 upgrade has completed, list information will remain unchanged, but users will not be able to change, copy, resubmit, or restore archived transactions that were entered in PES version 2.16 of the Provider Electronic Solutions Software.

All transactions converted from PES version 2.16 to version 3.0 will be flagged with a new status based on the status the transaction was in at the time of the upgrade. No further action can be taken on X12 4010 or NCPDP 1.1 transactions. The following new status codes will be used:

Status	Description
U	All transactions previously in an 'I' status at the time the upgrade is performed will have the status changed to 'U'. U = 4010 Unfinished/Incomplete
B	All transactions previously in an 'A' status at the time the upgrade is performed will have the status changed to 'B'. B = 4010 Backup record/Archive
C	All transactions previously in an 'R' status at the time the upgrade is performed will have the status changed to 'C'. C = 4010 Completed not yet Submitted/Ready
S	All transactions previously in an 'F' status at the time the upgrade is performed will have the status changed to 'S'. S = 4010 Successfully Submitted/Finalized

2) Full Install information:

Prior to full installation to PES version 3.0:

- Users may be new to PES or using any previous version of PES
- Current PES users:
  - Lists will not be retained. It is recommended that users print their lists prior to installation so that their lists can be manually created in PES version 3.0.
  - Users must submit all "R" status transactions (these cannot be submitted once version 3.0 is in place).

ALABAMA MEDICAID AGENCY

ALERT

The Provider Electronic Solutions User Guide will be available Monday, March 19, 2012 on the Alabama Medicaid Website (http://www.medicaid.alabama.gov) by navigating to "Providers" and click on "Manuals" **OR** available now from the Alabama Medicaid Provider Portal (https://www.medicaid.alabamaservices.org/alportal) by navigating to "Information" and click on "AL Links".

Full Install and Upgrade files for the Provider Electronic Solutions Software will be available Monday, March 19, 2012 on the Alabama Medicaid Website (http://www.medicaid.alabama.gov) by navigating to "Providers" and click on "Provider Electronic Solutions Software" **OR** available now from the Alabama Medicaid Provider Portal (https://www.medicaid.alabamaservices.org/alportal) and navigate to "Information" and click on "AL Links".

For additional support or questions contact the EMC Helpdesk at 1-800-456-1242, or Provider Representative Linda Hanks at 1-855-523-9170, extension 2334580 or linda.hanks@hp.com.

ALABAMA MEDICAID AGENCY

A L E R T

March 20, 2012

Attention: All Providers

RE: Payment Delay – March 16, 2012 Checkwrite

The total amount of funds for the March 16, 2012 checkwrite will not be released on schedule.

Due to state cash flow issues (unrelated to state proration declared on Friday, March 16), the funds for Hospitals, Ambulatory Surgical Centers, Provider Based Rural Health Clinics, Independent Rural Health Clinics, Renal Dialysis Clinics and Maternity Care providers will be released on March 26, 2012.

A payment date for all other providers has not been established. As soon as funds are available, Medicaid will notify providers via the ALERT process and/or provider associations as well as on the Agency's website at: www.medicaid.alabama.gov

Please verify direct deposit status with your bank.

ALABAMA MEDICAID AGENCY

ALERT

March 26, 2012

Attention: SNF, ICF-MR and Waivers Providers

RE: New Long Term Care Admission Notification Software Version 2.4

New Version 2.04 will be available for download beginning on April 1, 2012. Version 2.04 *must* be installed on or before April 23, 2012 to submit Long Term Care transactions.

Version 2.03 will not be accepted after April 24, 2012.

Users have two options: 1) An upgrade from version 2.03 to version 2.04 (desired), or

2) A full install of version 2.04.

Option 1) Upgrade information:

- Prior to upgrading to version 2.4,
  - Users must be using version 2.03
  - If not, you must upgrade to version 2.03 or do a full install
  - Users must submit all "R" status transactions (these cannot be submitted once version 2.04 is in place).
- Important: Once the version 2.04 upgrade has completed, list information will remain unchanged, but users will not be able to change, copy, resubmit, or restore archived transactions that were entered in version 2.03 of the Long Term Care Admission Notification Software.

Option 2) Full Install information:

- These users may be new to the Long Term Care Admission Notification software or using any previous version of the software
- Prior to full installation to version 2.04:
  - Current software users are strongly encouraged to print their lists prior to installation so that their lists can be manually created in version 2.04. **Lists will not be retained**
  - Users must submit all "R" status transactions (these cannot be submitted once version 2.04 is in place).

The Long Term Care Admission Notification User Guide can be found on the Alabama Medicaid Website (http://www.medicaid.alabama.gov) by navigating to "Providers" and click on "Manuals" **OR** from the Alabama Medicaid Provider Portal (https://www.medicaid.alabamaservices.org/alportal) by navigating to "Information" and click on "AL Links".

ALABAMA MEDICAID AGENCY

ALERT

Full Install and Upgrade files for the Long Term Care Admission Notification Software are available from the Alabama Medicaid Provider Portal (https://www.medicaid.alabamaservices.org/alportal) and navigate to “Information” and click on “AL Links”.

Important notes about the new Version 2.04:

- The Long Term Care Admission Notification Software will now accept 6, 7, 8, 9 or 10 alpha numeric characters in the Provider and Performing Provider fields.
- When submission reason is "7" (death/discharge/termination/revoke), it will prompt a new drop-down box with the following options:
  - H - Recipient discharged home
  - D - Recipient died
  - T - Recipient was terminated from the program
- The Long Term Care Admission Notification software will no longer accept Medicaid numbers beginning with prefix ‘000’. If a user enters the old number, an error message will occur and the current Medicaid ID number will be required to save the file.
- For additional support or questions contact the EMC Helpdesk at-1-800-456-1242 or the following provider representatives:
  - Aleetra Adair 1-855-523-9170 extension 2334587
  - Remona Riley 1-855-523-9170 extension 2334532
  - Araceli Wright 1-855-523-9170 extension 2334560
  - Shamekia Pena 1-855-523-9170 extension 2334588

THIS ALERT SUPERSEDES ANY PREVIOUS ALERT REGARDING LONG TERM CARE ADMISSION NOTIFCIATION SOFTWARE VERSION 2.04.

ALABAMA MEDICAID AGENCY

ALERT

March 27, 2012

Attention: Physicians

RE: EPSDT Changes/Clarification

The Alabama Medicaid Agency has made changes to the sample referral form posted on the Alabama Medicaid website describing the "required fields." Please see the updated version attached.

Signatures accepted on referral forms: The following has been added to the April 2012 edition of Appendix A of the Alabama Medicaid Provider Manual:

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

Additionally, effective April 1, 2012, for services that require physicians' orders, all orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient's name. **The Patient 1st/EPSDT referral form may be considered the physician's order as long as these guidelines are met.** See the appropriate chapter of the April 2012 edition of the Alabama Medicaid Provider Manual for additional details regarding specific requirements for each program area.

ALABAMA MEDICAID AGENCY

ALERT

Alabama Medicaid Referral Form

REQUIRED FIELDS IN RED

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date REQUIRED

Date Referral Begins REQUIRED

Important NPI Information
See Instructions

MEDICAID RECIPIENT INFORMATION

Recipient Name REQUIRED	Recipient # REQUIRED	Recipient DOB REQUIRED
Address	Telephone # with Area Code Name of Parent/Guardian	

PRIMARY PHYSICIAN (PMP) INFORMATION	SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)
Name REQUIRED	Name REQUIRED (FOR EPSDT)
Address	Address
Telephone # with Area Code REQUIRED	Telephone # with Area Code REQUIRED (FOR EPSDT)
Fax # with Area Code	Fax # with Area Code
Email	Email
NPI # REQUIRED	NPI # REQUIRED (FOR EPSDT)
Medicaid Provider #	Medicaid Provider #
Signature REQUIRED (SEE APPENDIX A)	Signature REQUIRED (FOR EPSDT) (SEE APPENDIX A)

TYPE OF REFERRAL REQUIRED

☐ Patient 1st ☐ EPSDT Screening Date REQUIRED (FOR EPSDT) ☐ Case Management/Care Coordination	☐ Lock-in ☐ Patient 1st/EPSDT Screening Date REQUIRED (FOR EPSDT) ☐ Other

LENGTH OF REFERRAL

Referral Valid for REQUIRED month(s) or REQUIRED visit(s) from date referral begins. UP TO 12 MONTHS FROM SCREENING DATE

REFERRAL VALID FOR REQUIRED

☐ 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 PMP	Other conditions/diagnoses identified by PMP
REQUIRED	

CONSULTANT INFORMATION

Consultant Name REQUIRED	
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. 7-30-10

Alabama Medicaid Agency
www.medicaid.alabama.gov

2/23/12

Instructions for Completing The Alabama Medicaid Agency Referral Form (Form 362)

TODAY'S DATE: Date form completed

REFERRAL DATE: Date referral becomes effective

RECIPIENT INFORMATION:
Patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name

PRIMARY PHYSICIAN:* Provide all PMP information. For hard copy referrals, the printed, typed, or stamped name of the primary care physicians with an original signature of the physician or designee is required. Stamped or copied signatures will not be accepted. For electronic referrals provider certification is made via standardized electronic signature protocol.

SCREENING PROVIDER:* Screening provider (if different from primary physician) must complete and sign if the referral is the result of an EPSDT screening.

*NPI INFORMATION: Provide NPI number. For billing purposes indicate Medicaid Provider number, if available.

TYPE OF REFERRAL:

- Patient 1st - Referral to consultant for Patient 1st recipient only (See *Chapter 39 for Claim Filing Instructions).
- EPSDT - Referral resulting from an EPSDT screening of a child not in the Patient 1st program - indicate screening date (See *Appendix A for Claim Filing Instructions).
- Case Management/Care Coordination - Referral for case management services through Patient 1st Care Coordinators (See *Chapter 39 for Claim Filing Instructions).
- Lock-In - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy (See *Chapter 3 -3.3.2 for Claim Filing Instructions).
- Patient 1st/EPSDT - Referral is a result of an EPSDT screening of a child who is in the Patient 1st program - indicate screening date (See *Appendix A for Claim Filing Instructions).
- Other - For recipients who are not in Patient 1st program.

LENGTH OF REFERRAL: Indicate the number of visits/length of time for which the referral is valid.
Note: Must be completed for the referral to be valid.

REFERRAL VALID FOR:

- Evaluation Only - Consultant will evaluate and provide findings to Primary Physician (PMP).
- Evaluation and Treatment - Consultant can evaluate and treat for diagnosis listed on the referral.
- Referral by Consultant to Other Provider For Identified Condition (Cascading Referral) - After evaluation, consultant may, using Primary Physician's (PMP) provider number, refer recipient to another specialist as indicated for the condition identified on the referral form.
- Referral by Consultant To Other Provider For Additional Conditions Diagnosed By Consultant (Cascading Referral) - Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the Primary Physician (PMP).
- Treatment Only - Consultant will treat for diagnosis listed on referral.
- Hospital Care (Outpatient) - Consultant may provide care in an outpatient setting.
- Performance of Interperiodic Screening (if necessary) - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.

REASON FOR REFERRAL BY PRIMARY PHYSICIAN (PMP):
Indicate the reason/condition the recipient is being referred.

OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PRIMARY PHYSICIAN:
Indicate any condition present at the time of initial exam by PMP.

CONSULTANT INFORMATION: Consultant's name, address and telephone number.

PLEASE SUBMIT FINDINGS TO PRIMARY PHYSICIAN BY: The Primary Physician (PMP) should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

*The Alabama Medicaid Provider Manual is available on the Alabama Medicaid website| at
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx

ALABAMA MEDICAID AGENCY

ALERT

March 29, 2012

Attention: All Providers

RE: Total System Outage

WHEN: March 31, 2012

TIME: 12:00 AM to 5:00 AM

Alabama Medicaid will be installing system updates to **discontinue** accepting X12 4010 and NCPDP 5.1 transactions on March 31, 2012, from 12:00 AM to 5:00 AM.

Medicaid will reject any claims during this downtime. See ALERT dated March 12, 2012, for further details.

After system updates have been finalized, only X12 5010 and NCPDP D.0 transactions will be processed.

ALABAMA MEDICAID AGENCY

ALERT

April 03, 2012

TO: Physicians

RE: Guidelines For Billing Prolonged Services In The Office Or Other Outpatient Setting

Procedure Codes 99354 and 99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health professional on a given date providing prolonged service, even if the time spent on that date is not continuous.

Requirement for Physician Presence: Only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) beyond the typical/average time of the office visit code billed may be counted to determine whether prolonged services can be billed; and to determine the prolonged service codes that are allowable.

Documentation: Documentation is required to be in the medical record about the duration and content of the **medically necessary** evaluation and management service and prolonged services that are billed. The physician must appropriately and sufficiently document in the medical record that he/she personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. Time must be documented clearly in medical record to indicate the beginning of service time and the end of service time to justify these codes being billed in addition to the office visit.

Prolonged Services Associated With E & M Services Based On Counseling And/Or Coordination Of Care (Time-Based)

When an E & M service is dominated by counseling and/or coordination of care (the counseling and /or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician and the patient in the office, the E & M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E & M code) and should not be "rounded to the next higher level". For E & M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.

Effective July 1, 2011 Procedure Codes 99354 and 99355 (Note above paragraph before billing prolonged service codes):

- May be billed only in conjunction with procedure codes 99201-99215, 99241-99245, 99324-99337, 99341-99350, and only if the EP modifier is not billed. (Effective April 1, 2012, procedure code 99211 is excluded from this list and may not be billed with prolonged service codes).
- May not be billed alone.

***Refer to CPT guidelines for correct reporting** of prolonged physician services with direct patient contact in office/outpatient setting.*

Example of a BILLABLE Prolonged Service:

A physician performed a visit that met the definition of an office visit CPT code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills CPT code 99213 and *one* unit of code 99354

Example Of A Non Billable Prolonged Service:

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

For more examples, you may refer to https://www.cms.gov/MLNMattersArticles/downloads/MM5972.pdf

ALABAMA MEDICAID AGENCY

ALERT

May 7, 2012

Changes to Intrauterine Devices (IUD) and Implantable Contraceptive Coverage

ATTENTION: Family Planning Providers (Federally Qualified Health Centers and Rural Health Centers)

The Alabama Medicaid Agency is making changes to how FQHC's and RHC's are reimbursed for Intrauterine Devices and Implantable Contraceptives. Effective May 1, 2012, Mirena®, Paragard®, and Implanon® will be reimbursed in addition to the encounter rate. FQHCs and RHCs may submit a medical claim using the following procedure codes:

Mirena - J7302
Paragard - J7300
Implanon - J3707

For questions regarding this change, please contact Laura Hamilton, Associate Director of Maternity Care and Plan First Programs at (334) 353-5539 or Laura.Hamilton@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

To: All Providers

Subject: Payment Adjustment for Provider Preventable Conditions

CMS has recently approved an Alabama Medicaid State Plan change effective October 1, 2011. Federal regulations mandate that all providers must report Provider Preventable Conditions (PPCs) to Medicaid.

Provider Preventable Conditions are defined into two separate categories:

1. Healthcare Acquired Conditions, which include Hospital Acquired Conditions (HACs). Examples of HACs include but are not limited to foreign object retained after surgery, blood incompatibility, and development of pressure ulcer stages III and IV.

2. Other Provider Preventable Conditions (OPPCs). Examples of OPPCs include but are not limited to surgery on a wrong body part or site, wrong surgery on a patient, or surgery on the wrong patient.

Inpatient Psychiatric Hospitals (freestanding psychiatric hospitals and residential treatment facilities) must now use the UB-04 claim form to report HACs, as has already been required of inpatient hospitals.

It is the responsibility of the **provider** to identify and report any PPC and **not seek payment** from Medicaid for any additional expenses incurred as a result of the PPC. Provider payments may be disallowed or reduced based on a post-payment review of the medical record.

The PPC reporting policy is located on the Alabama Medicaid website at www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.6.6_Adverse_Events_Reporting.aspx

If you have any questions, please contact Patricia Williamson via e-mail at patricia.williamson@medicaid.alabama.gov or phone at 334-353-4142.

ALABAMA MEDICAID AGENCY

ALERT

May 18, 2012

To: All Providers

SUBJECT: General Fund Proration

As a result of General Fund proration declared on March 16, 2012, the Alabama Medicaid Agency has been directed to identify and implement cuts to its overall budget. After program impact analysis and multiple provider meetings and communications, the Agency will implement these cuts in three ways:

- Reduction of payments to certain provider groups by 10 percent
  - Physicians
  - Dentists
  - Physician Lab & X-ray
  - Durable Medical Equipment
  - Independent Lab & X-ray
  - Other licensed practitioners
  - Maternity primary contractors (Effective for dates of service on or after May 14, 2012)
- Reduction in services to adults (benefits to children remain unchanged)
  - Change coverage of routine eye exams and work-up for refractive error to once every three years (now one eye exam every two years)
  - End coverage of eyeglasses as a benefit (now one pair every two years)
  - Limit drugs to one brand-name drug per month; generics and covered OTCs remain unlimited. Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers. (In addition to children, LTC recipients are excluded from this reduction.)
- Reduction in cough/cold covered drugs for all recipients: Legend generic cough/cold drugs will no longer be covered (legend brand drugs are currently non-covered). Certain OTC drugs will remain covered.

Except as specified otherwise above, these reductions will be effective for dates of service on or after June 1, 2012.

ALABAMA MEDICAID AGENCY

ALERT

May 23, 2012

Attention: All Providers

RE: 05/18/12 Checkwrite Release

Due to the holiday on Monday, May 28, 2012, Medicaid will release the payments for the May 18, 2012 checkwrite on Friday, May 25, 2012.

Please verify direct deposit status with your bank.

ALABAMA MEDICAID AGENCY

ALERT

May 30, 2012

Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

Effective July 2, 2012, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	
Pegasys	Anti-infective Agents/Interferons
PDL Deletions*	
Concerta	Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting
Daytrana	Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting
Foradil	Respiratory/ Beta-Adrenergic Agonists
Ventolin HFA	Respiratory/ Beta-Adrenergic Agonists

** Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

May 31, 2012

TO: All Providers

RE: New Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable **only** if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

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

Faxed or emailed copies will not be accepted.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict).

Medicaid will allow a grace period until September 30, 2012 for OPR providers to become enrolled. On October 1, 2012, claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the October 1, 2012 deadline.

Providers should contact one of the following HPES Provider Representatives with any questions:

- Araceli Wright 1-855-523-9170 extension 2334560
- Remona Riley 1-855-523-9170 extension 2334532
- Shamekia Pena 1-855-523-9170 extension 2334588
- Aleetra Adair 1-855-523-9170 extension 2334587

ALABAMA MEDICAID AGENCY

ALERT

June 01, 2012

TO: All Providers

RE: Patient 1st Referral Change

Effective June 1, 2012 the Alabama Medicaid Agency will change Patient 1st Referral requirements to allow PMPs to see patients who are in the process of transferring to their panel without a referral. Once the PMP change becomes official, claims for the previous 60 days from the new PMP will be paid. When a recipient wishes to change their PMP, the change can be made directly by the recipient or made by the new PMP. In the past, the new PMP would have to obtain a referral from the old PMP in order to see the recipient prior to the official change date. PMP changes typically take 15 to 45 days. For example, if a PMP change is requested on June 18 it would become official on August 1. The new PMP will be able to treat the recipient, and claims for dates of service 60 days prior to August 1 will be paid on or after the effective date. These claims will deny prior to the change becoming official.

The new policy will allow the new PMP to both provide services and make referrals. Claims for referrals will also not pay until the PMP change is official. If the change does not become official the claims will not pay without a referral. This could happen if a subsequent change in PMP request is made before the original change is made active. This change does not alter the process or rules for the old PMP. Claims from the old PMP will be paid as normal. The old PMP should no longer be requested to provide referrals for a recipient transferring to other PMPs. Medicaid will monitor PMP changes to ensure that this policy change is not misapplied.

ALABAMA MEDICAID AGENCY

ALERT

June 21, 2012

TO: All Pharmacy Providers

RE: Dispense as Written (DAW) Code of 9 for brand Adderall XR

Effective July 2, 2012, Alabama Medicaid will begin allowing the use of a Dispense as Written (DAW) Code of 9 for brand Adderall XR. Generic versions of the drug will be non-preferred and will require prior authorization. Additional drugs may be added to the DAW 9 list at a future time.

A DAW Code of 9 indicates the following:

Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed.

This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but Alabama Medicaid requests the brand product be dispensed. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. A DAW of 9 will result in a claim paying the brand Average Acquisition Cost (AAC).

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

June 26, 2012

TO: All Provider Associations

RE: Alabama MMIS Maintenance Window

This is notification of an extended maintenance window for the Alabama Medicaid system. The impact of this outage will be as follows until the conclusion of the maintenance:

1. Remittance Advices will be unavailable for download via the Alabama Medicaid Web Portal
2. Managed Care reports will be unavailable for download via the Alabama Medicaid Web Portal

WHEN:

Friday, June 29, 2012, beginning at 8:00 AM Central Daylight Saving Time to

Monday, July 2, 2012, ending at 7:00 AM Central Daylight Saving Time.

All other web portal functionality will continue to be available during this extended maintenance window.

ALABAMA MEDICAID AGENCY

ALERT

July 19, 2012

Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

Re: Four (4) Brand-Name Limit

Effective for drugs dispensed on or after **August 1, 2012**, the Alabama Medicaid Agency will reinstate the four (4) brand-name drug limit per month.

The one brand-name drug limit will remain in effect for June 1, 2012 through July 31, 2012.

Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers.

Children (recipients under 21) and nursing facility recipients are excluded from the four brand-name limit.

Generics and covered over the counters remain unlimited.

Policy questions concerning this ALERT should be directed to the Pharmacy Program at (334) 242-5050.

ALABAMA MEDICAID AGENCY

ALERT

August 13, 2012

Attention: Family Planning Providers
(Physicians, FQHCs, IRHCs, PBRHCs)
SUBJECT: Smoking Cessation Products Covered for Plan First
Smoking Cessation Products and Preconception Care: Satellite Conference on September 11, 2012

Effective for dates of service October 1, 2012, and thereafter, selected smoking cessation products will be covered for Medicaid recipients on the Plan First program. Products to be covered include nicotine patches, nicotine gum, nicotine lozenges, bupropion tablets, and varenicline tablets.

1. Prior authorization through the Pharmacy Administrative Services contractor, Health Information Designs, will be required. Providers with questions regarding prior authorization for smoking cessation products may contact Health Information Designs at 1-800-748-0130.
2. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline (1-800-784-8669).
3. Approval will be granted for up to three months at a time.
4. Only one course of therapy will be approved per year.
5. For additional details, refer to the Alabama Medicaid Provider Manual Appendix C: Family Planning.

The Alabama Public Health Training Network is providing a two-hour satellite conference and live webcast called *Preconception Care: Tobacco Cessation* on September 11, 2012, from 2:00-4:00 PM. The speakers are Clemice Hurst, R.Ph., Clinical Pharmacist, Alabama Medicaid Agency and Annie Vosel, BSN, RN, Bureau of Family Health Services, Alabama Department of Public Health. Continuing education for nurses and social workers is pending. To access and register for the live training, go to http://adph.org/ALPHTN. For those unable to view the program during the scheduled air time, it may be accessed at http://adph.org/ALPHTN by clicking "On Demand".

For questions, contact Nancy Headley, Director, Managed Care at (334) 242-5684 or nancy.headley@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

August 22, 2012

Attention: **Medicaid Certified Nursing Facilities**

RE: **Coverage for Ventilator-Dependent and Qualified Tracheostomy Care Residents**

Effective January 16, 2012, the Alabama Medicaid Agency will pay nursing facilities a supplemental fee-for-service payment in addition to the daily nursing facility rate for care provided to ventilator-dependent residents and/or qualified tracheostomy residents who are eligible for Medicaid benefits. The nursing facility must meet specific provider requirements and the ventilator-dependent/tracheostomy care resident must meet specific medical criteria established by the Alabama Medical Agency.

Information regarding the required documentation for the nursing facility and the resident is included in Alabama Medicaid Administrative Code Chapter 63. Nursing facilities must mail all documentation for the facility and resident to HP with a correctly completed Long Term Care Records coversheet. The coversheet is located on the Medicaid website at:
http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC%20Records%20Coversheet_6-11.pdf

The records should be mailed to the following address:

HP ENTERPRISES SERVICES
P. O. BOX 224032
MONTGOMERY, AL 36124-4032

An incorrectly completed coversheet will result in the record being returned to the provider. Please write, “VENT/TRACH” on the coversheet. To facilitate review of the record, please send an e-mail to theresa.carlos@medicaid.alabama.gov with ONLY the Medicaid ID, stating, “The record is ready for review.” Do not send any PHI in the e-mail.

Questions regarding this ALERT should be directed to the Long Term Care Provider/Recipient Services Unit at (334) 353-4754.

ALABAMA MEDICAID AGENCY

ALERT

TO: All Providers
RE: Synagis® Criteria for 2012 – 2013 Season

- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2012-2013 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

  http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx

- The approval time frame for Synagis® will begin October 1, 2012 and will be effective through March 31, 2013.

- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.

- There are no circumstances that will result in approval of a sixth dose.

- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.

- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.

- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2012 (for an October 1 effective date).

- Stamped or copied physician signatures will not be accepted and will be returned to the provider.

- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.

- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.

- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

Criteria
Alabama Medicaid follows the 2012 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

Effective October 1, 2012, the Alabama Medicaid Agency will:

1. Require prior authorization (PA) for payment of generic escitalopram and zafirlukast. Preferred brands will continue to be available with no PA necessary.
2. Allow the use of a Dispense as Written (DAW) Code of 9 for brand Lexapro and Accolate. Generic versions of the drug will be non-preferred and will require prior authorization. DAW Code of 9 indicates the following: Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed. This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but Alabama Medicaid requests the brand product be dispensed.
3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	
Intuniv	Behavioral Health/Cerebral Stimulants Agents for ADD ADHD-Long Acting
Pristiq	Behavioral Health/Antidepressants
Pulmicort Flexhaler	Respiratory/Orally Inhaled Corticosteroids
PDL Deletions*	
Diastat[‡]	Behavioral Health/Anxiolytics, Sedatives, Hypnotics: Benzodiazepines
Maxalt MLT	Pain Management/Selective Serotonin Agonists
Singulair[‡]	Respiratory/Leukotriene Modifiers

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

[‡]*Covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

ALABAMA MEDICAID AGENCY

ALERT

To: Outpatient Hospitals

Subject: 340-B and OP Hospital Clinic Billing

Hospitals designated as 340-B entities

Effective for claims submitted on October 1, 2012, and after, hospitals designated as 340-B entities may bill 'total charges' on the UB-04 claim form when billing for outpatient pharmacy charges.

Hospital-Based Clinics

Effective for dates of service on or after October 1, 2012, Medicaid will allow revenue code 51X, clinic, to be billed with evaluation and management procedure codes 99201-99215. Only one visit per day will be allowed.

If you have any questions, please contact Jerri Jackson via e-mail at jerri.jackson@medicaid.alabama.gov or phone at 334-242-5630.

ALABAMA MEDICAID AGENCY

ALERT

UPDATED September 25, 2012

Effective October 1, 2012, the Alabama Medicaid Agency will:

1. Require prior authorization (PA) for payment of zafirlukast. Preferred brands will continue to be available with no PA necessary.

2. Allow the use of a Dispense as Written (DAW) Code of 9 for brand Accolate. Generic versions of the drug will be non-preferred and will require prior authorization. DAW Code of 9 indicates the following: Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed. This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but Alabama Medicaid requests the brand product be dispensed.

3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	
Intuniv	Behavioral Health/Cerebral Stimulants Agents for ADD ADHD-Long Acting
Pulmicort Flexhaler	Respiratory/Orally Inhaled Corticosteroids
PDL Deletions*	
Diastat‡	Behavioral Health/Anxiolytics, Sedatives, Hypnotics: Benzodiazepines
Maxalt MLT	Pain Management/Selective Serotonin Agonists
Singulair‡	Respiratory/Leukotriene Modifiers

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

‡*Covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

ALABAMA MEDICAID AGENCY

ALERT

October 2, 2012

To: All Providers

Subject: Reversal of Proration Cuts

The Alabama Medicaid Agency today announced that payment reductions implemented earlier this year due to proration of the General Fund budget will be reversed no later than November 1, 2012. The reversals were made possible following the passage of a state Constitutional Amendment on September 18 which enabled Medicaid's 2013 Fiscal Year Budget to receive additional monies through the state's General Fund.

Effective for dates of service October 1, 2012 and thereafter, the change will reverse the 10 percent payment reduction for physicians, dentists, Physician Lab and X-ray providers, Independent Lab and X-ray providers, and other licensed practitioners (e.g. psychologists, podiatrists, chiropractors, therapists, audiologists/hearing aid, nurse practitioners, CRNAs).

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Effective for dates of service November 1, 2012 and thereafter, the change will reverse the 10 percent payment reduction for durable medical equipment and supply providers. In addition to the payment changes, the Agency will also reinstate the coverage of eyeglasses for adults (one pair every two years) and will reinstate the coverage of routine eye exams and work up for refractive error from once every three years to once every two years. The delay for durable medical equipment, supplies and eyeglasses is due to federal requirements for public notice of the change.

ALABAMA MEDICAID AGENCY

ALERT

October 16, 2012

To: Providers Submitting Claims with Third Party (TPL) Primary

SUBJECT: Changes to the Third Party Liability (TPL) Billing for Alabama Medicaid

Effective October 23, 2012, HP will begin capturing Third Party Liability patient responsibility amounts at both header and detail levels. **Changes will be made to all claim types except Pharmacy**.

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payor).

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for professional claims only. All other claim types will continue to price as usual at this time. System changes will be implemented at a later date for the payment methodology of other claim types.

A new TPL attachment form has been created for TPL denials. This form will be required with the CMS 1500 form when third party denies a claim. The forms are available free of charge and may be ordered by calling the Provider Assistance Center at 1-800-688-7989.

Updates are being made to Provider Electronic Solutions (PES) software; however, currently we do not have a date for the next upgrade to accommodate the changes. Providers may use Medicaid's Interactive Web Portal until the upgrade is released.

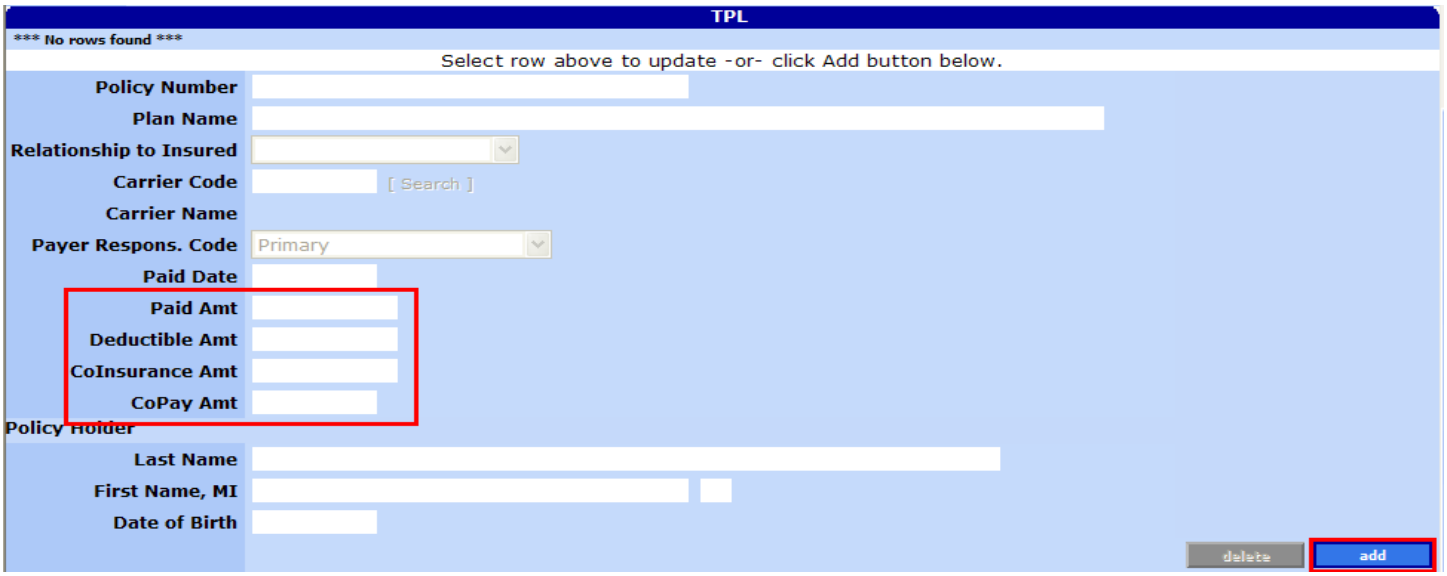
Vendors should reference the Vendor Specifications for requirements on segments/loops to accommodate the changes.

The next section outlines changes that have been made to the Interactive Medicaid Web Portal to accommodate the changes. See screen shots and descriptions for each claim type affected by this change.

Dental Claims:

Providers no longer have an option to enter the Total TPL Paid Amount in the Billing Information panel. The TPL Paid Amount should now be entered in the TPL panel. New fields have also been added to the TPL panel to allow providers to submit amounts applied to deductible, coinsurance, and copay per other insurance.

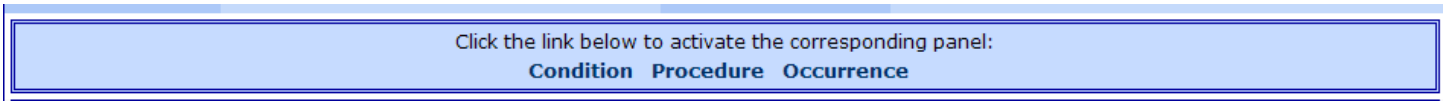
By selecting the add button in the TPL panel, providers can add up to 10 TPL carriers per claim.

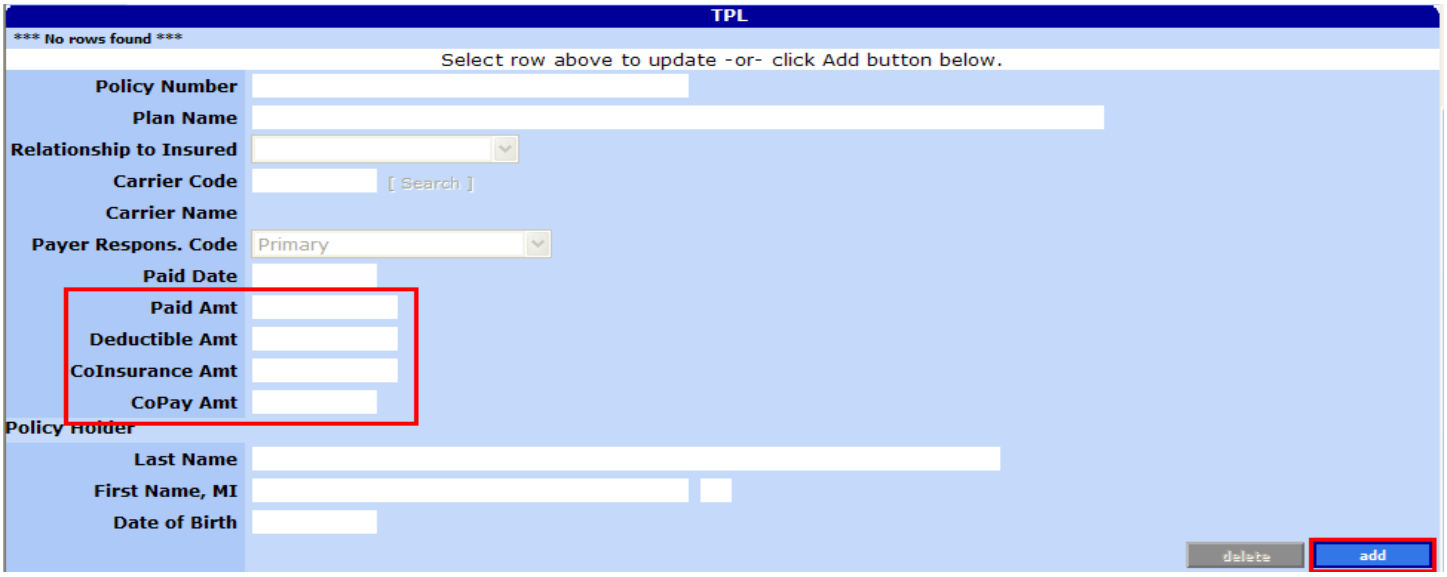


Institutional Claims:

The Payer panel has been removed from the web portal. The TPL Paid Amount should be entered in the TPL panel. New fields have also been added to the TPL panel to allow providers to submit amounts applied to deductible, coinsurance, and copay per other insurance.

By selecting the add button in the TPL panel, providers can add up to 10 TPL carriers per claim.



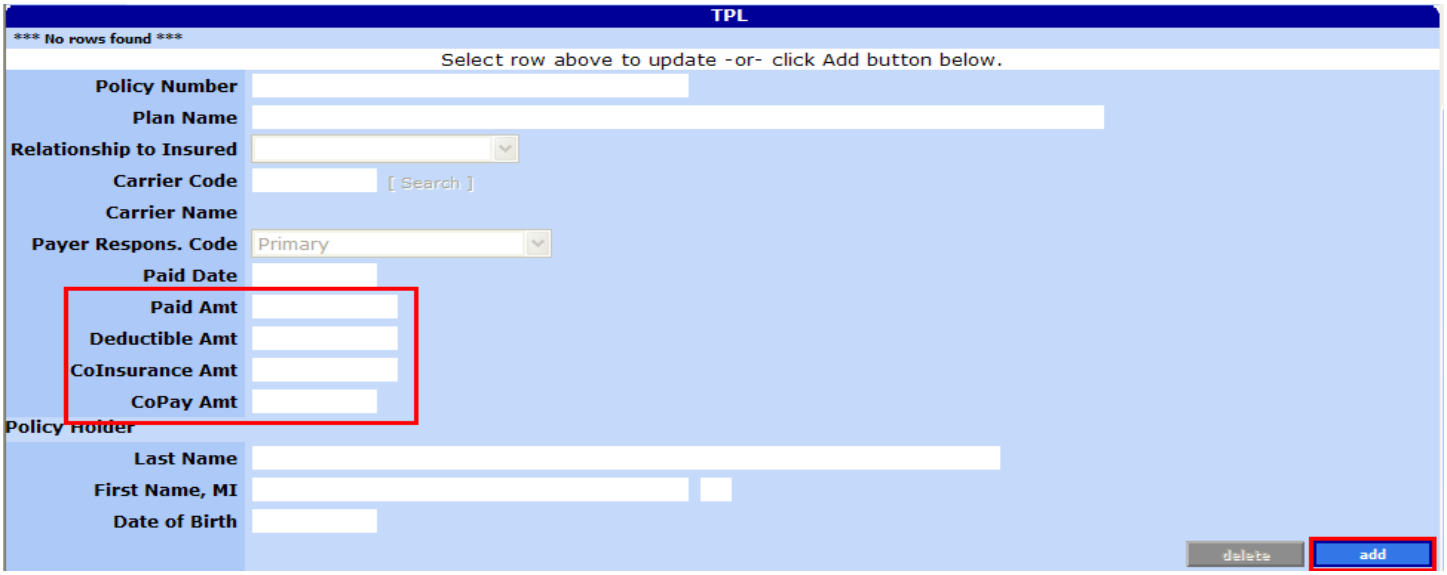


Professional Claims:

TPL will be captured at the header and the detail.

Providers no longer have an option to enter the Total TPL Paid Amount in the Billing Information panel. The TPL Paid Amount should now be entered in the TPL panel. New fields have also been added to the TPL panel to allow providers to submit amounts applied to deductible, coinsurance, and copay per other insurance.

By clicking the add button in the TPL panel, providers can add up to 10 TPL carriers per claim.



The Third Party Payments panel has been created. Providers need to enter TPL paid, TPL Co-Pay, TPL Coinsurance, and TPL deductible amounts on each detail respectively per carrier.

By clicking the add button in the Third Party Payments panel, providers can submit multiple payments per detail line item, to specify each carrier's payment.

The Totals submitted at the header for each carrier, should balance the Totals submitted at the detail per carrier.

ALABAMA MEDICAID AGENCY

ALERT

November 26, 2012

To: DME Providers, Prosthetics & Orthotics (P&O) Providers, Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, and Nursing Homes.

SUBJECT: Durable Medical Equipment (DME) Program Changes

The Alabama Medicaid Agency's Durable Medical Equipment Program will make changes to:

- Reimbursement for CPAP
- Humidifier Reimbursement
- External Breast Prostheses Prior Authorization
- Home Medical Equipment (HME) License
- Wheelchair~~s~~ Coverage Limit Change

Detailed information about each change is below. Also below is a reminder regarding the procedure for manually priced DME items' Prior Authorization (PA) Requests.

CPAP Reimbursement

Effective January 1, 2013, the CPAP (E0601) will be a capped rental to purchase item. The equipment can be rented for up to three months. After three months, if the recipient continues to meet criteria and must continue on the CPAP, the CPAP machine will transition to a purchase, with the total rental payments during the first three months and a subsequent one month payment equaling the purchase rate. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient.

The monthly payment will include delivery, in-service for the caregiver, maintenance, repair and supplies. Alabama Medicaid will not reimburse separately for procedure codes A7030, A7034, A7037 and A7038 during the CPAP's four month capped rental period. Recertification is required after the initial three months. If the CPAP is determined not be medically necessary (i.e., the criteria are no longer met), the device will be returned to the supplier. NOTE: Do not use the RR modifier for initial PAs submitted on or after 1/1/13.

If a recipient already has CPAP and/or humidifier devices via continuous rental on January 1, 2013:

For recipients with nine or more months of continuous rental for the devices (CPAP and/or humidifier), provider should submit a claim for needed supplies only. The device(s) is considered to have been purchased and Alabama Medicaid will no longer pay for continuous rental of the device. The device is considered to be owned by the recipient. Existing prior authorizations (PAs) will no longer be valid. Requests for Medicaid's authorization of a replacement CPAP device will be accepted for review every eight years. A request for replacement of the device submitted within less than eight 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.

For recipients with four to eight months of continuous rental, the current PA will be capped and the provider will be paid the remaining amount equal to a cumulative total of $800.42. If the cumulative amount has been reached, no additional claims will be paid. For these PAs, the provider will continue to include the RR modifier.

For recipients with three months rental, and the device continues to meet criteria on or after 1/1/13, the 4th month will cap the rental. If criteria are not met, then the device will be returned to the supplier.

Humidifier Reimbursement

Effective January 1, 2013, Alabama Medicaid will no longer reimburse procedure codes E0561 or E0562 separately when E0601 is requested at the same time. Procedure codes E0561 and E0562 can only be billed separately if requested for BiPAP (E0470, E0471, or E0472) only.

Therefore, providers are to ensure that recipients, who have current prior authorizations (PAs) for both devices, have both the CPAP and humidifier prior to January 1, 2013. These items will be considered as purchased and owned by the recipient. Therefore, after January 1, 2013, Alabama Medicaid will only reimburse the provider for needed supplies for these recipients.

External Breast Prostheses Prior Authorization

Effective January 1, 2013, prior authorization (PA) will no longer be required for external breast prostheses covered by Alabama Medicaid's Durable Medical Equipment Program. This change applies to procedure codes L8000, L8015, L8020, L8030, L8035 and L8039 submitted with one of the following breast cancer diagnosis codes: 174.0 through 174.9, 198.81 and 233.0.

Home Medical Equipment (HME) License

Effective January 1, 2013, applicable DME providers will need to provide verification of Home Medical Equipment (HME) license during the annual on-site provider re-enrollment visits. (All other required licenses/certifications continue to apply; See Chapter 14 of the Provider Manual for provider enrollment requirements listing.) The chart below is provided to assist you with determining the required licenses/certification you must have. If you have any additional questions regarding HME licenses, please contact the Alabama Board of Home Medical Equipment Services Providers.

Type of Operation	License/Certification Required
Prosthetic, Orthotic & Pedorthic (POP) Services Only (custom fabricated devices only)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification
POP and Mastectomy in the same facility (custom fabricated devices only)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification
POP and HME (DME)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification **and** Alabama Board of Home Medical Equipment (HME) license
HME (DME) and Mastectomy	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification **and** Alabama Board of Home Medical Equipment (HME) license
Mastectomy Only (Boutique)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification

	and Alabama Board of Home Medical Equipment (HME) license
HME(DME) Only	Alabama Board of Home Medical Equipment (HME)

Wheelchair~~s~~ Coverage Limit Change

Effective January 1, 2013, all wheelchairs will be limited to one per recipient every seven years based on medical necessity. It was previously limited to one per recipient every five years.

PA Requests for manually priced DME items

When submitting PA requests for manually priced items, providers should only submit MSRPs (Manufacturer's Suggested Retail Price), procedure codes and item prices. All price calculations will be completed by Alabama Medicaid's PA contractor.

REMINDER: Beginning January 1, 2013, if a Medicaid service requires an ordering, prescribing, or referring provider and the ordering, prescribing, referring provider does not have a current enrollment record with Alabama Medicaid, the claim will be denied. See the July and October 2012 Provider Insider articles for more details.

ALABAMA MEDICAID AGENCY

ALERT

December 11, 2012

TO: All Providers

RE: Claims for Non-Enrolled OPR Providers to Deny Effective January 1, 2013

Federal law now requires any ordering, referring or prescribing providers to enroll with Medicaid, even if they do not accept Medicaid, to help prevent and detect fraud and abuse. **Alabama Medicaid will comply with this law effective January 1, 2013, by denying all claims that require a referral, order or prescription from a physician or other licensed health care professional unless that physician or provider has a current enrollment record on file.** To address this requirement, a new category of enrollment was created: ordering, prescribing, referring (OPR) provider; provider type 97.

Medicaid's claims processing system will monitor whether the ordering, prescribing, or referring provider is enrolled in Medicaid. Claims will deny if the ordering, prescribing, or referring provider is not enrolled.

Medicaid has been sending informational EOBs for medical claims since May 2012 informing the billing provider of the status of the ordering, referring, prescribing, physician or licensed health care provider. Medicaid has been sending informational EOBs on pharmacy claims since December 2012.

Action Required

Providers already enrolled as active Medicaid participating providers do not need to enroll again as an OPR provider.

Providers **not** enrolled as active participating Medicaid providers must enroll as OPR providers. NOTE: For providers who choose to enroll as OPR providers, it is important to remember that an OPR provider cannot submit claims to Medicaid for payment of services rendered. If the provider wishes to be able to submit claims for payment, enrollment as another participating provider type will be required.

Questions & Answers

Q: Why is Medicaid requiring these providers to become enrolled?
A: Medicaid is complying with Federal Medicaid Regulations 42 CFR 455.410(b) which provides that Medicaid must require all ordering or referring physicians or other professionals providing services be enrolled as providers, and 42 CFR 455.440 which provides that Medicaid must require all claims for the payment of items and services that were ordered, referred, prescribed to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribe such items or services.

Q: How does the ordering, referring, or prescribing provider enroll as a Medicaid provider?
A: The OPR Enrollment application can be found on the Medicaid Provider enrollment web page at: http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.

ALABAMA MEDICAID AGENCY

ALERT

December 11, 2012

RE: Claims for Non-Enrolled OPR Providers to Deny Effective January 1, 2013

Q: Our hospital is a teaching hospital so how do we report a "resident physician"?
A. Interns and non-licensed residents must use the NPI of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid and the NPI of the resident must be used on the claim for reimbursement.

Q: How does this affect hospital emergency room physicians?
A: Hospital emergency room physicians are required to enroll. They are not exempt from the requirement.

Q: How will these impact Alabama Medicaid recipients that cross state lines?
A: If services are furnished to an Alabama Medicaid recipient in another state, the out of state providers are required to enroll with Medicaid in order to receive reimbursement. Likewise, if the out of state provider writes a prescription, orders a service, or refers the patient, then the out of state provider must be enrolled with Medicaid.

Q: What if the provider is enrolled with another state's Medicaid? Will the provider need to enroll in all states in which he or she provides service?
A: Enrollment in another state's Medicaid program does not exempt a provider from enrolling with Alabama Medicaid. Providers are required to enroll in each state where they will provide services or where their order/referral/prescription will be provided.

Q: What if the ordering, prescribing, referring provider is with another State. For example, we receive prescriptions from out-of-state providers?
A: The out-of-state ordering, prescribing, referring provider must be enrolled with Alabama Medicaid.

Q: If Alabama Medicaid is secondary to a commercial insurance, would the claim be accepted without an enrolled ordering, prescribing, or referring provider requirement?
A: No, the enrollment requirement also applies if Medicaid is being billed as the secondary to a commercial insurance.

Q: Do Medicare crossover claims require the ordering, prescribing, or referring provider to be enrolled?
A: No, for claims that crossover directly from Medicare to Medicaid. These claims are identified with as region 30 - COBA crossover claims. When Medicare implements their edits, then Medicaid will require the region 30 claims to comply. All other Medicare/Medicaid related claims will require the provider be enrolled.

Q: How do we know the NPI of the physician or licensed health care provider who wrote the prescription or order?
A: Any prescribing physician or licensed health care provider must include his or her NPI on any prescription/order he or she writes, to allow the provider filling the prescription/order to submit their claim.

ALABAMA MEDICAID AGENCY

ALERT

December 11, 2012

RE: Claims for Non-Enrolled OPR Providers to Deny Effective January 1, 2013

Q: I have the provider's NPI, but how can I tell if he or she is enrolled with Alabama Medicaid?

A: For pharmacies filling a prescription for medication, simply bill the claim with the NPI of the prescriber. If the prescriber is not enrolled with Medicaid, you will receive a claim rejection that informs you of the prescriber's status.
For all other providers, the Medicaid Agency is enhancing the Provider web portal to add functionality to look this information up. This functionality should be available early 2013. Until it is available, you may call the Provider Assistance Center at 1-800-688-7989.

Providers of services that are ordered or prescribed (such as a laboratory or radiology facility, a pharmacy, or a medical supply company) will always need the NPI of an ordering or prescribing practitioner in order to submit their claims for payment to the Medicaid program.

NOTE: If you render services or provide medical supplies in response to a provider's order, prescription, or referral, this requirement may affect your reimbursement.
Medicaid cannot pay for any health care service requiring a referral, order, or prescription from a physician or other licensed health care professional unless the ordering, referring, or prescribing provider has a current enrollment record on file in Medicaid's system.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the December 31, 2012 deadline.

cc: Provider Associations

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ALABAMA MEDICAID AGENCY

ALERT

December 14, 2012

TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

Effective January 1, 2013, the Alabama Medicaid Agency will:

1. No longer cover benzodiazepines and barbiturates for Medicare Part D recipients. *However, these products will remain covered for non dual-eligible recipients*. Barbiturates (when used in the treatment of epilepsy, cancer, or a chronic mental disorder) and benzodiazepines will no longer be optional coverage classes for Medicare Part D.
2. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	
None	
PDL Deletions*	
DermaSmoothe FS[‡]	Skin and Mucous Membrane Agents/Anti-inflammatory Agents

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

[‡]*Covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

December 20, 2012

To: All Psychologists and Rehabilitation Option Providers

Due to recent CPT code changes by the American Psychiatric Association (APA), the Alabama Medicaid Agency will implement the following CPT coding changes effective for dates of service January 1, 2013, and thereafter. Incorrectly coded claims will deny on or after this date.

PSYCHIATRIC SERVICES 2012 TO 2013 CROSSWALK

For Psychology Providers

2012			2013		
Service	**CPT Code**	**2013 Status**	**Service**	**CPT Code**	**Report with interactive complexity (+90785)**
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	**90791**	When appropriate
			Diagnostic evaluation with medical	**90792**	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	**90791**	Yes
			Diagnostic evaluation with medical	**90792**	
Psychotherapy					
Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	**90832**	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	**90834**	
75-80 min	90808, 90821		60 (53+*) min	**90837**	
Interactive individual psychotherapy 20-30 min	90810, 90823	DELETED	30 (16-37*) min	**90832**	Yes
45-50 min	90812, 90826		45 (38-52*) min	**90834**	
75-80 min	90814, 90828		60 (53+*) min	**90837**	

******Code 90792 <u>will not</u> be a covered service for psychologists******

For Rehabilitation Option Providers

2012			2013		
Service	**CPT Code**	**2013 Status**	**Service**	**CPT Code**	**Report with interactive complexity (+90785)**
Diagnostic					
Diagnostic Interview	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate

Examination			Diagnostic evaluation with medical	90792	
Individual psychotherapy 20-30 min	90804	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
			45 (38-52*) min	90834	
			60 (53+*) min	90837	

******Code 90792 <u>will</u> be a covered service for the physician (psychiatrist) only******

*** = Per CPT Time Rule**

The Family and Group Therapy codes 90846, 90847, 90849, and 90853 remain unchanged.

For additional information in reference to the current behavioral health CPT code changes, click on the following link: http://www.psychiatry.org/practice/managing-a-practice/cpt-changes-2013 and go to the documents listed in the Additional Coding Resources section.

If you have further questions, you may contact the HP Provider Assistance Center at (800) 688-7989.

ALABAMA MEDICAID AGENCY

ALERT

February 11, 2013

TO: **Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, FQHCs, PBRHCs IRHCs, Health Departments, Hospitals, and Provider Associations**

RE: **Coding Changes for Injection, Medroxyprogesterone Acetate**

Effective December 31, 2012, CPT® procedure codes J1051 and J1055 for billing medroxyprogesterone acetate injections were deleted. Effective for dates of service January 1, 2013, CPT® procedure code **J1050**, Injection, medroxyprogesterone acetate, **1 mg,** must be used with a required modifier for all claims. **J1050** replaces the following codes:

J1051 – Injection, medroxyprogesterone acetate, 50 mg*
J1055 - Injection, medroxyprogesterone acetate for contraceptive use, 150 mg*
****NOTE: J1051 and J1055 will continue to be used for dates of service prior to January 1, 2013.***

Billing Instructions:
Procedure code **J1050** will require the use of a modifier in order for Medicaid to identify when the injection is for contraceptive use versus non-contraceptive use.

1. ***For contraceptive use:***
   J1050 with modifier FP and include a contraceptive management diagnosis code

2. ***For non-contraceptive use :***
   J1050 with modifier U1

Restrictions:

J1050-FP will be limited to female recipients 10 to 55 years of age
J1050-FP is limited to no less than 104 mg and no more than 150 mg per injection
J1050-FP injection will be allowed once every 70 days
J1050-FP must use a contraceptive management diagnosis code

J1050-U1 is covered for recipients of all ages
J1050-U1 is limited to 1000 mg per injection
J1050-U1 does not have a limitation other than the maximum units allowed per injection
J1050-U1 cannot use a contraceptive management diagnosis code

Reimbursement Amount:
The reimbursement rate for **J1050** is **$0.20 per unit (1mg).**

Since the code description is based on 1mg, providers should bill the applicable units based on the 1mg. Examples:

- A medroxyprogesterone acetate injection was given for 150 mg for contraceptive use. The provider would bill J1050-FP for 150 units and use a contraceptive management diagnosis code.
- A medroxyprogesterone acetate injection was given for 500 mg for non-contraceptive use. The provider would bill J1050-U1 for 500 units.

Claims for J1050 billed without a modifier will be denied for the modifier requirement.

For questions, contact Sylisa Lee-Jackson at (334) 353-4599 or sylisa.lee-jackson@medicaid.alabama.gov or call the Provider Assistance Center at 800-688-7989.

ALABAMA MEDICAID AGENCY

ALERT

February 13, 2013

TO: **All Medicaid Eye Care Providers**

RE: **Program Changes for Eye Exams and Eyeglasses**

Due to budget constraints, the Alabama Medicaid Agency will implement changes to the Eye Care Program benefit limits which will be effective **March 1, 2013**:

- Limit adults age 21 years and older to one routine eye exam every three years (now once every two years)
- Limit adults age 21 years and older to one pair of eyeglasses every three years (now one pair every two years)

The changes will only be for services provided to adults. There will be no changes for children.

This information is also available on the Agency's website at www.medicaid.alabama.gov under Programs/Medical Services/Ancillary Services/Eye Care Services.

Questions about these changes should be directed to Jacquelyn King, Jacquelyn.king@medicaid.alabama.gov, or by telephone at (334) 353-5407.

ALABAMA MEDICAID AGENCY

ALERT

March 5, 2013

TO: All Physician Providers (provider type 31)

RE: Primary Care Physician Rate Increase ("Bump")

A major provision of the Affordable Care Act (ACA) requires Alabama Medicaid reimburse certain ***primary care physicians*** at parity with Medicare for services provided between January 1, 2013 and December 31, 2014.

COVERED SERVICES:

Services eligible for an enhanced payment fall into two categories:

- Primary care services
- Vaccine administration service under the VFC program

Primary care services subject to the enhanced payment are Current Procedural Terminology (CPT) Evaluation and Management procedure codes 99201 to 99499.

Vaccine administration services under the VFC program are 90633, 90636, 90645, 90647, 90648, 90649, 90650, 90655, 90656, 90657, 90658, 90660, 90669, 90670, 90680, 90681, 90696, 90698, 90700, 90702, 90707, 90710, 90713, 90714, 90715, 90716, 90718*, 90721, 90723, 90732, 90733, 90734, 90744, and 90748. The Alabama Medicaid Agency requires the VFC administration codes to be billed using the specific product code (vaccine codes). *CPT deleted 90718 effective 12/31/2012; however, this code would still be used in calculating the 60% threshold for CY 2012.

ELIGIBLE PROVIDERS:

Under the federal regulations, the physicians qualify for the enhanced rate if:

- They have a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (A0A) and they actually practice in these areas.

- They are **not** board certified but are practicing in the fields of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, **and** 60% of their paid Medicaid procedures billed are for evaluation and management codes 99201 through 99499 and VFC administration services.
- **NOTE: To calculate your percentage, *divide* the total volume of E&M code and vaccine administration codes paid by Medicaid *by* the total volume of all codes paid by Medicaid. This calculation must be done for each eligible physician individually and not as a group practice. Although urinalyses, EKGs, and antibiotic administrations, are commonly provided by primary care physicians, CMS did not include them as primary care services in the numerator when calculating the 60% threshold for the enhanced primary care fee eligibility. Therefore, paid billed codes for ancillary services such as labs, x-rays, injections will cause the percentage threshold to be less.**

SELF-ATTESTATION:

Eligible providers must complete the Alabama Medicaid Certification and Attestation for Primary Care Rate Increase Form and submit to HP Enterprise Services (Medicaid's fiscal agent) for each service location. A copy of the board certification must be submitted with each completed attestation form. If a copy of the board certification is not available, a copy of the website verification is acceptable. The self-attestation form is available for download at:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment/Fillable_Forms/5.4.6_Ala_Med_Cert_Attest_Primary_Care_Rate_Increase_2-1-13.pdf

Qualifying physicians who submit their self-attestation to **HPES by March 29, 2013**, will be paid the enhanced reimbursement **retroactive to January 1, 2013.**

Qualifying physicians who submit their self-attestation to HPES **on or after April 1, 2013**, will be paid the enhanced reimbursement **for dates of service beginning with the date the attestation** is entered into the system by HPES.

Qualification for the payment increase will end the earliest of either December 31, 2014, or the expiration date of the board certification. Therefore, physicians whose board certifications expire during the CY 2013 or 2014 must reattest for the program. Services provided during any lapses in time between board-certification expiration and reattestation will not be eligible for the rate increase.
If the board certification is rescinded by the certifying board, the provider must notify HPES within 10 days. Qualification for the payment increase will end on the date the certification was rescinded by the certifying board.

At the end of each year, the Alabama Medicaid Agency must review a statistically valid sample of physicians who received the higher payments to verify that they met the requirements. Services retroactively found ineligible for the enhanced payment will be subject to recoupment.

NON-PHYSICIAN PRACTITIONERS:

Covered services provided by non-physician practitioners are eligible for enhanced payment when working under the personal supervision of a qualifying physician. In this case, the physician **must assume professional/financial responsibility** and is legally liable for the quality of services provided under his or her supervision.

Eligible non-physician practitioners include:

- Physician Assistants
- Nurse Practitioners

GROUP PROVIDERS:
Eligibility for enhanced reimbursement is based on **EACH** individual physician meeting the eligibility criteria.

EXCLUDED PROVIDERS:
Physicians are not eligible for enhanced rates when delivering services under one of the following:

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Health Departments (ADPH)

Physician specialist certified in areas other than the three specified in the ACA are **not** eligible for the increased payments even if they otherwise meet the 60% procedure code threshold. Physicians in these categories (for example: ER doctors and OB/GYN) should **NOT** attest.

CMS rules implementing the ACA specifically exclude independently practicing nurse practitioners from the enhanced payment.

RATE METHODOLOGY:
The Alabama Medicaid Agency will reimburse the lesser of the following:

- The provider's submitted charge
- The enhanced fee schedule rate

FEE SCHEDULES:
The enhanced rate is determined by comparing the 2013 Medicare Rate established by CMS to the 2009 Alabama Medicaid rate. The higher rate will establish the rate of payment for that code. A separate fee schedule of the enhanced rates will be made available in the near future under the Provider information heading on the Alabama Medicaid Agency website at www.medicaid.alabama.gov

The enhanced reimbursement rate for the VFC administration service (for each of the codes listed above under covered services) is **$19.79**.

WHEN WILL PROVIDERS SEE THE ENHANCED PAYMENTS:
Federal regulations were not issued to the states in time to implement the pay increase on January 1, 2013. For a limited period of time after January 1, 2013, claims will be paid at the regular Medicaid rates. CMS will not allow enhanced payments to be made until the State Plan Amendment (SPA) is approved and attestation forms are received and processed by HPES.

To ensure that payments can be made to qualifying physicians as soon as possible, the Alabama Medicaid Agency has taken the following steps:

1) Submitted the Tribal Letter Notification,
2) Published the Public Notice Letter,
3) Submitted the required SPA to CMS in January, the earliest states could submit a SPA,
4) Submitted the Change Order for system changes (Medicaid and HPES are working together to make the computer system changes needed to process the payments)

5) Developed a process for the self-attestation, and
6) Mailed a letter to all physicians who are currently enrolled with a primary care specialty or subspecialty designation.

Medicaid cannot make enhanced payments until all three of the following criteria are met:

- The Centers for Medicare and Medicaid Services (CMS) approves the State Plan Amendment (SPA).
- Medicaid implements the required system changes needed to process claims at the higher payment rate.
- Eligible physicians return the self-attestation form (along with a copy of the board certification/ website verification if applicable).
- They complete a self-attestation form to meeting the requirements above.

Once all these requirements are in place, eligible services with dates of services starting January 1, 2013, will be retroactively adjusted for enhanced payments.

The Alabama Medicaid Agency is working as quickly as possible to finalize a primary rate increase and will keep providers informed of the process and timeline.

ALABAMA MEDICAID AGENCY

ALERT

May 16, 2013

TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Nursing Homes, Hospitals, and Provider Associations

RE: **DEA Edits Effective Date Extended to July 8, 2013**

The effective date for implementing the DEA Edits has been extended from May 13, 2013, to **July 8, 2013**.

Effective July 8, 2013, Alabama Medicaid will DENY any claim for a controlled drug written by a prescriber who does not have their Drug Enforcement Administration (DEA) number registered with the Department of Justice (DOJ) **and** on file at Medicaid. These edits are designed to prevent controlled substances from being filled when the prescription is written by an unauthorized prescriber. The following edits have been in place since November 2012 and are currently displaying as informational on the provider's remittance advice:

Edit	Description
1038	DEA NOT ON FILE FOR PRESCRIBER
1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED
1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE

What action needs to be taken to prevent claims from denying on July 8, 2013?

Physicians – Make sure your DEA number is registered with DOJ and is on your enrollment file at Medicaid. **Medicaid deadline for submission: June 21, 2013**.

To confirm if your DEA number is appropriately registered with the DOJ, and to ensure your correct address/contact information is registered with the DOJ, you may go to the DEA website at:
https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp
Prescribers of controlled substances are mandated to re-register their DEA license every three years.

To ensure your DEA is on file at Medicaid, fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate. Medicaid will apply the DEA to all service locations based on the provider's NPI and license number. **The DEA information should be received by Provider Enrollment prior to June 21, 2013.** This deadline will allow Provider Enrollment time to enter the information in the provider's file before the July 8, 2013, implementation date.

Pharmacies – If you are receiving the informational edits, contact the provider who ordered the prescription and advise them to fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate.

Why is Medicaid implementing these changes?

In September 2009, the Government Accountability Office (GAO) issued the report "Medicaid Fraud and Abuse Related to Controlled Substances Identified in Selected States" which highlighted fraudulent, improper, or abusive actions in prescribing and dispensing of controlled substances. One of the report's primary recommendations was that states should use the Drug Enforcement Administration (DEA) Controlled Substance Registration file as part of their Medicaid claims processing efforts to prevent paying for controlled substances ordered by unauthorized prescribers.

Prescribers: Please take a moment to validate your DEA number information. Medicaid encourages all providers to be proactive and ensure the DEA number of the prescribing provider is registered with the Department of Justice (DOJ) and on file at Medicaid prior to June 21, 2013.

NOTE: The claims which are currently paying and posting one of the informational edits above, will deny effective July 8, 2013.

ALABAMA MEDICAID AGENCY

ALERT

Update: Dental Prior Authorization and Use of Dental Mailbox

May 17, 2013

TO: All Dental Providers

SUBJECT: Dental Prior Authorization (PA) Requests:

Effective: June 15, 2013

All Dental PA requests must be submitted on a Prior Review and Authorization Dental Request Form (Form 343). All sections of the form must be completed. If the form is not completed in its entirety or if the PA request is submitted on any other form, the request will be denied.

The form and the required documents should be forwarded to HPES, P.O. Box 244032, Montgomery, AL 36124-4032 or faxed to HPES at 1-334-215-4272.

For Emergency PA requests, contact HPES at 1-334-215-4144.

Documents Required with PA Requests:

- Radiographs are required with PA requests for procedure codes D7240 and D7241. A report by tooth number of actual unusual surgical complication(s) is also required for procedure code D7241.
- Radiographs and medical documentation (clinical notes) are required with PA requests for D3410 and D3430**.**
- Radiographs are required with PA requests for CDT codes D1515, D1510, and D4355.
- Complete periodontal charting, posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs are required with PA requests for D4341 and D4910.
- Medical documentation (clinical notes) is required with PA requests for CDT codes: D7970 D9420, D9610, and D9612.
- Radiographs, operative notes, and a completed ADA Dental claim form indicating procedures performed in the hospital setting are required with PA requests for hospital updates.

If required documents are not received with the PA request, the PA will be denied.

Use of Dental Mailbox:

In order to comply with HIPAA regulations, providers using the Dental Mailbox to submit x-rays or other documents must do so by encrypted e-mail. To obtain an encrypted e-mail password, please contact HPES at 334-215-4144 or Medicaid's Dental Program at 1-334-242-5472.

ALABAMA MEDICAID AGENCY

ALERT

May 23, 2013

TO: **All Providers**

RE: **Co-Payment Changes for Medicaid Services**

Effective for dates of service July 1, 2013, and thereafter, copayments for Medicaid covered services will be based on the federally approved maximum amounts shown below (including Medicare crossovers):

Services with Co-payments	**Co-payment Amounts**	**Based on Medicaid's Allowed Amount for the Services**
Office Visits *(including visits to physicians, optometrists, nurse practitioners)*	$1.30 to $3.90 per office visit code	$50.01 or more - $3.90 $25.01 - $50.00 - $2.60 $10.01 - $25.00 - $1.30
Federally Qualified Health Centers (FQHC)	$3.90 per encounter	
Rural Health Clinic (RHC)	$3.90 per encounter	
Inpatient Hospital	$50.00 per admission	
Outpatient Hospital	$3.90 per visit	
Ambulatory Surgical Centers	$3.90 per visit	
Durable Medical Equipment	$1.30 to $3.90 per item	$50.01 or more - $3.90 $25.01 - $50.00 - $2.60 $10.01 - $25.00 - $1.30
Medical Supplies and Appliances	$0.65 to $3.90 per item	$50.01 or more - $3.90 $25.01 - $50.00 - $2.60 $10.01 - $25.00 - $1.30 $10.00 or less - $0.65
Prescription Drugs	$0.65 to $3.90 per prescription	$50.01 or more - $3.90 $25.01 - $50.00 - $2.60 $10.01 - $25.00 - $1.30 $10.00 or less - $0.65

Co-payment does **not** apply to services provided to/for:

- Pregnant women
- Nursing facility residents
- Recipients less than 18 years of age
- Native American Indians with an active user letter from Indian Health Services (IHS)
- Emergencies
- Family Planning

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (co-payment) amount imposed.

ALABAMA MEDICAID AGENCY

ALERT

June 1, 2013

TO: **All Maternity Care Primary Contractors**

RE: **Reimbursement Changes**

Due to budget constraints, the Alabama Medicaid Agency will implement up to a 5 percent reduction in payment of global fee for deliveries to Medicaid Maternity Care Program Primary Contractors effective July 1, 2013. No Contractor reimbursement will be reduced beyond the current lowest bid for the Maternity Care Program. This reduction will be effective for dates of deliveries July 1, 2013 to September 30, 2014.

For questions regarding this change, please contact Sylisa Lee-Jackson, Associate Director of the Maternity Care and Family Planning/Plan First Programs at (334) 353-4599 or Sylisa.lee-jackson@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

June 7, 2013

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

RE: **Pharmacy/Preferred Drug Program Updates**

Effective July 1, 2013, the Alabama Medicaid Agency will:

1. **Make changes to its current policy regarding compound prescriptions and reimbursement for bulk products (i.e., powders) used in compounded prescriptions.** The changes are outlined below:
   - Bulk products will no longer be covered for adults age 21 and older (some exceptions may apply). Selected medically necessary bulk products will remain covered for children.
   - Claims for bulk powders must be submitted as a compound claim.
   - Compounding time will no longer be reimbursed by Alabama Medicaid.
   - The maximum payable amount for a compounded product will be $200 per claim. Overrides for medical necessity may be approved. Requests for overrides should be submitted to Health Information Designs, Inc. (HID).

   For information regarding compound claims and bulk powders, see section 27.2.5 of the Alabama Medicaid Provider Manual at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7_Provider_Manuals_2013.aspx

2. **No longer require prior authorization (PA) for payment of generic lansoprazole.** Brand name Prevacid will continue to require prior authorization (PA).

3. **Require prior authorization for payment of generic azelastine nasal spray.** Brand name Astelin will be preferred and available with no PA necessary.
   - Use Dispense as Written (DAW) Code of 9 for brand Astelin. Generic versions of the drug will be non-preferred and will require prior authorization. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.

4. **Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates.** The updates are listed below:

PDL Additions	
Astelin	EENT Preparations/Antiallergic Agents
PDL Deletions	
Astepro	EENT Preparations/Antiallergic Agents
Maxair Autohaler	Respiratory/Beta-Adrenergic Agents
Pegasys	Anti-infective Agents/Interferons

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

June 7, 2013

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

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   - Claims for bulk powders must be submitted as a compound claim.
   - Compounding time will no longer be reimbursed by Alabama Medicaid.
   - The maximum payable amount for a compounded product will be $200 per claim. Overrides for medical necessity may be approved. Requests for overrides should be submitted to Health Information Designs, Inc. (HID).

   For information regarding compound claims and bulk powders, see section 27.2.5 of the Alabama Medicaid Provider Manual at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7_Provider_Manuals_2013.aspx

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Pegasys	Anti-infective Agents/Interferons

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

June 13, 2013

TO: All Patient 1st Providers

RE: Change in Availability Date for Downloading the Monthly PMP Enrollment Roster for Patient 1st (MGD-0055-M)

Effective immediately, Medicaid is changing the date the Monthly PMP Enrollment Roster for Patient 1st will be available for downloading from the Alabama Medicaid Agency's Web-Portal. The availability date will change from the 21st of the prior month to the 1st day of the effective month.

Prior to this change, the July 2013 roster would be available for download on June 21, 2013; however, with this change, the July 2013 roster will not be available for download until July 1, 2013.

All future Monthly PMP Enrollment Roster for Patient 1st, will be available for downloading on the first day of the effective month.

This change does not affect the availability date for Medicare Advantage providers' rosters (MGD-0056-M).

Directions for downloading this document are available on the Alabama Medicaid website via either of the following links:

Downloading and Reviewing Patient 1st Roster Via Agency Web Portal

or

http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.10_Patient_1st.aspx

ALABAMA MEDICAID AGENCY

ALERT

June 19, 2013

TO: All Dental Providers

SUBJECT: Dental Prior Authorization (PA) Changes and Discontinuance of Dental Mailbox

Effective: July 15, 2013

Dental PA requests can be submitted either on paper via mail or electronically via Medicaid's web portal.

Emergency PA Requests:
When there is a need for an emergency PA, providers must contact HPES/Dental PA Unit by calling 334-215-4144. If there is no answer, a voice mail message will be accepted. The voice mail message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- NPI of dentist
- phone number of dentist including area code
- nature of emergency
- contact person if other than dentist for follow-up.

A paper or electronic PA request must be completed and received by HPES within ten business days of the telephone call/voice message request. If the paper or electronic request is not received within ten business days of the telephone call/voicemail message, the emergency PA request will be **denied**.

Paper PA Requests:
When submitting a paper PA request, the request must be submitted on a Prior Review and Authorization Dental Request Form (Form 343, revised 05/28/2013). All sections of the form must be completed. If the form is not completed in its entirety or if the PA request is submitted on any other form, the request will be **denied**.

The completed form must be submitted with required documentation as referenced in the *"Legible Documents Required for PA Requests"* section of this Alert and must be mailed to HPES (address listed below in the *"Mailing Address"* section). If required documents are not received with the paper PA request, the PA will be **denied**.

Electronic PA Requests:
When submitting an electronic request, select "Dental" if the service is being performed in the dentist office. Select "Surgical" if the service is being performed in an outpatient hospital setting.

Following submission of an Electronic PA Request, the required documentation as referenced in the *"Legible Documents Required for PA Requests"* section of this Alert must be mailed to HPES (address listed below in the *"Mailing Address"* section).

The documentation must have the PA number written ***legibly*** in the upper right hand corner of **each** page of documentation so the documentation can be matched to the electronic PA request. Documentation received without a PA number in the upper right hand corner will be shredded.

Electronic PA requests will be held for up to ten business days in order to allow sufficient time to receive the mailed documentation. **If the mailed documentation is not received in this time period, the PA request will be denied.** A new PA request must be submitted on paper with all the required documentation for the PA to be reconsidered.

Discontinuance of Dental Mailbox:

The Dental Mailbox is being discontinued effective July 12, 2013 at 5 p.m., CST, all documents including radiographs must be mailed to the address below.

In the case of radiographs, the original may be mailed in lieu of a paper copy. If original radiographs are to be returned to the provider, please include a self-addressed, postage-paid envelope.

Legible Documents Required for PA Requests:

- Radiographs are required with PA requests for CDT codes D7240 and D7241. A post-surgical report by tooth number of actual unusual surgical complication(s) is also required for CDT code D7241.
- Radiographs and medical documentation (clinical notes) are required with PA requests for CDT codes D3410 and D3430**.**
- Radiographs are required with PA requests for CDT codes D1515, D1510, and D4355.
- Complete periodontal charting, posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs are required with PA requests for CDT codes D4341 and D4910.
- Medical documentation (clinical notes) is required with PA requests for CDT codes: D7970 D9420, D9610, and D9612.
- Radiographs, operative notes, and a completed ADA Dental claim form indicating procedures performed in the hospital setting are required with PA requests for hospital updates.
- Radiographs and clinical notes are required with PA requests for medical (CPT) codes

Mailing Address:

The paper PA request form and all required documentation must be mailed to:

HPES
Dental PA Unit
P.O. Box 244032
Montgomery, AL 36124-4032

or

HPES
Dental PA Unit
301 Technacenter Drive
Montgomery, AL 36117

<u>Faxed copies will no longer be accepted.</u>

If required documents are not received, the PA will be denied.

The Current Dental Terminology (CDT) codes are copyright © American Dental Association.

ALABAMA MEDICAID AGENCY

ALERT

July 10, 2013

TO: Patient 1st Providers

SUBJECT: Depression Screenings and BMI

Effective September 1, 2013, Patient 1st Providers are required to document two clinical outcomes on claim forms in order to provide data in support of the quality measures established for the Health Home State Plan Amendment (SPA) and the Adult Quality Measures Grant. The screenings include:

1) The outcome of depression screenings administered to recipients age 18 and older utilizing the PHQ-2 and PHQ-9 screening tools. The PHQ-9 is used when the score on the PHQ-2 is a four or higher. The PHQ-2 Screening tool may be accessed at: http://www.cqaimh.org/pdf/tool_phq2.pdf and the PHQ-9 screening tool at http://www.agencymeddirectors.wa.gov/Files/depressoverview.pdf

2) ICD-9 diagnosis codes for BMI on all Patient 1st recipients

Depression Screenings:

One of two CPT® Codes should be entered on the claim form:

- **G8431:** Positive Screening for Clinical Depression with Documented Follow-Up Plan; or
- **G8510:** Negative Screen for Clinical Depression, Follow-Up not Required

Note that these codes are for tracking purposes and have a zero reimbursement rate.

BMI:

One of diagnosis codes in the range V850-V8554 for BMI should be entered on the claim form.

Questions should be directed to:

Latonda Cunningham, Associate Director for Patient First
Phone: 334-353-4122
E-mail: Latonda.Cunningham@Medicaid.Alabama.gov

or

Carolyn Miller, Associate Director for Special Projects and Quality Improvement
Phone: 334-353-5539
E-mail: Carolyn.Miller@Medicaid.Alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

July 15, 2013

TO: All Optometrists and Ophthalmologists

SUBJECT: Coverage of Visual Evoked Potential (VEP)

Currently, the Alabama Medicaid Agency covers VEP only for neurologists. Effective for **dates of service on or after August 1, 2013**, Medicaid will also cover VEP for optometrists and ophthalmologists.

To bill for VEP, the provider must use the following CPT® procedure code:

- 95930 – Visual Evoked Potential (VEP) Testing Central Nervous System

If the provider owns the equipment and performs the reading, then procedure code 95930 would be billed **without** a modifier. This is called a global service.

If the provider does not own the equipment, but performs the reading, then procedure code 95930 must be billed **with modifier 26**. This is called a professional interpretation service.

The current reimbursement rate for 95930 is:

- $65.00 for the global
- $17.00 for the professional interpretation

ALABAMA MEDICAID AGENCY

ALERT

July 18, 2013

To: Hospice Providers

Subject: Changes to the Medicaid Hospice Election and Physician's Certification Form 165

Hospice providers are required to include within the medical record a Medicaid Hospice Election and Physician's Certification form (Form 165) that has been signed and dated by the physician. The exception to this is when an individual is eligible for Medicare as well as Medicaid. In that case, the Medicare election form will continue to serve as election for both hospice programs.

Form 165 was recently revised to include blanks to enter the ***Date of Benefit Period*** and the ***Date Physician Signed***. Effective September 1, 2013, all Hospice Providers should discard all copies of the previous Form 165 and utilize the revised form.

The revised Form 165 and the *Instructions for Completion of Hospice Election Form 165* will be located on the Agency's website, effective September 1, 2013 and can be accessed at the following: Resources/Forms Library/Long Term Care/Form 165

For questions or concerns regarding the ***Medicaid Hospice Program***, please contact Felicha Fisher at (334) 353-5153.

ALABAMA MEDICAID AGENCY

ALERT

August 15, 2013

To: All Providers

Subject: **Total System Outage**

The Alabama Medicaid system will be unavailable due to scheduled maintenance.

WHEN:
Saturday, August 24, 2013 at 5PM* Central Time

UNTIL:
Sunday, August 25, 2013 at 10:30PM Central Time

*Interactive pharmacy claim processing will be unavailable beginning at **6PM** on Saturday, August 24, 2013.

There will be no claims and eligibility processing or system access by any method during the system maintenance period.

ALABAMA MEDICAID AGENCY

ALERT

August 23, 2013

TO: Providers, Vendors and Clearinghouses

RE: Alabama Medicaid Provider and Vendor Testing for ICD-10

Providers may begin ICD-10 testing on August 26, 2013. Providers and vendors are encouraged to test to ensure file layout information is in the correct format prior to the federal mandate date for ICD-10, which is currently, October 1, 2014. It is critical that providers and trading partners test with Alabama Medicaid prior to implementation. We encourage early testing from August 26, 2013 through October 11, 2013. However, testing will continue until the ICD-10 federal mandate date. Testing will ensure our readiness and your readiness and will reduce the impact of this implementation for all parties.

What transactions are affected by ICD-10 changes?

- 837I (Institutional claims)
- 837P (Professional claims)
- 278 (Prior Authorization)
- 835 Remittance Advice and 835 Electronic remittance advice
    - No specific changes were made but new Explanation of Benefit (EOB) codes and corresponding Claim Adjustment Reason Code (CARC)/Remittance Advice Remark Codes (RARC) will be returned related to ICD-10

What do I need to do prior to testing if I use a vendor or clearinghouse, or if I am a vendor or clearinghouse?

ICD-10 changes must be made to your system first. If you work with a software vendor or clearinghouse, work with that vendor or clearinghouse to understand when the ICD-10 software upgrade will be available.

Review and understand the changes being made by Alabama Medicaid and how they affect you and the transactions you submit.

Understand the use of the ICD-9 end dates and ICD-10 effective dates.

Contact HP Enterprise Services (HP), who is the fiscal agent for Alabama Medicaid, in advance to ensure you are set up to test with us.

Obtain a copy of the spreadsheet required to record and submit testing activities and outcomes so we can better support you.

How do I begin testing if I use a vendor or clearinghouse?

If you have tested with HP in the past, attempt to logon to the secure web site by selecting the **Secure Site** link at https://www.alabama-uat.com/ALPortal/ and answer the security questions to reset the password. If this is unsuccessful, contact the EMC Helpdesk to ensure you are set up to test with us.

If you have **never** tested with HP, contact the EMC Helpdesk to obtain a Trading Partner ID for testing. The telephone number is 1-800-456-1242 and the e-mail address is AlabamaSystemsEMC@hp.com.

How will I test after I am assigned a Trading Partner ID?

Once a Trading Partner ID has been issued to you from the EMC helpdesk:

- Logon to the secure web site by selecting the **Secure Site** link at https://www.alabama-uat.com/ALPortal/ and select the **setup account** button.
- Enter the **Login ID** (Trading Partner ID) and **Personal Identification Number** (PIN) that has been issued and select **setup account** button.
- Enter data in all required fields to set up the web account and select **submit**.

The Medicaid Home Page will be displayed and you are now set up to begin submitting batch files for testing.

For those with an existing testing ID, if you are unable to logon, please attempt to answer the security questions and reset the password. If this is unsuccessful, please contact the EMC help desk for further assistance.

I use Provider Electronic Solutions, how do I test?

Ensure you have Version 3.02 of the Provider Electronic Solutions software which is ICD-10 compliant. Follow the instructions above to obtain a Trading Partner ID. Once a Trading Partner ID is obtained go through the steps to set up the web account establishing a user ID and password.

- Open Provider Electronic Solutions, select tools/options and under the Batch tab enter your Trading Partner ID, Web Logon ID (this is the user id you created on the web portal) and your Web Password.
- Lastly, select the Web tab, and change the Environment Indicator (Environment Ind) from a '**P**' to a '**T**' and select OK.
- You are ready to submit **test** files.

NOTE: Be sure to change the User ID and Web Password back to your production logon details and Environment Indicator back to 'P' if you need to submit **production** claims.

I use Medicaid's Interactive Web Portal to submit claims, how do I test?

Contact the EMC Help Desk and request a Provider Web Portal ID for User Acceptance Testing, you will need to provide the NPI and service location information for testing.

Once you receive the web logon ID and PIN, follow the steps listed above for setting up a Trading Partner ID to establish a provider web account for testing.

The link to the portal for testing is https://alabama-uat.com/ALPortal.

What other information do I need to know for ICD-10 testing?

- ✓ Submit "real" data, if possible. Use production data and submit it on the **testing** site with ICD-10 codes and compare results.
- ✓ Dates of service on the claims should be changed prior to submission based on ICD-9 end dates and ICD-10 effective dates listed below.
- ✓ Try conditions that you feel will be accepted and validate they are paid.
- ✓ Try conditions that you feel will fail and validate that they do deny.
- ✓ Keep track of the ICN's returned to help us research identified issues.
- ✓ For issues concerning submission errors (TA1 or 999) note the tracking number to assist with research.

The ICD-9 and ICD-10 Testing Effective Dates are as follows:

August 26, 2013 – March 31, 2014

- ICD-9 end date = August 25, 2013 & ICD-10 start date = August 26, 2013

April 1, 2014 – September 30, 2014

- ICD-9 end date = March 31, 2014 & ICD-10 start date = April 1, 2014

October 1, 2014 and thereafter

- ICD-9 end date = September 30, 2014 & ICD-10 start date = October 1, 2014

The ICD-9 end date indicates the last date where ICD-9 codes may be submitted without error.
The ICD-10 start date indicates the first date where ICD-10 codes may be submitted without error.

The schedule is also available on the ICD-10 testing page of the Alabama Medicaid website at:
http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.3_ICD-10_Testing.aspx

How will testing be monitored?

Monitoring will occur to ensure testing activity has begun. If we are not seeing transactions submitted, we will be contacting you to ensure there are no issues and offer assistance if needed.

Contact the EMC help desk for setup and account access issues.

Document any other issues on the Test Results Feedback spreadsheet located at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.3.4_ICD-10_Secure_Testing_Web_Site.aspx

Please submit your testing spreadsheet on a regular basis to the EMC Helpdesk by e-mailing the information to alabamasystemsemc@hp.com

How can I obtain additional information about ICD-10 testing?

Please be sure to visit this site for more information that you will need for testing.

The ICD-10 testing link on the Alabama Medicaid website may be accessed from the general page at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.3_ICD-10_Testing.aspx

A webinar will soon be available on the Alabama Medicaid website on the ICD-10 webpage.

ALABAMA MEDICAID AGENCY

ALERT

August 23, 2013

TO: All Providers

RE: Synagis® Criteria for 2013 – 2014 Season

- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2013-2014 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

  http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx

- The approval time frame for Synagis® will begin October 1, 2013 and will be effective through March 31, 2014.

- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.

- There are no circumstances that will result in approval of a sixth dose.

- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.

- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.

- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 3, 2013 (for an October 1 effective date).

- Stamped or copied physician signatures will **not** be accepted and will be returned to the provider.

- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.

- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.

- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

Criteria

Alabama Medicaid follows the 2012 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

August 30, 2013

TO: **Independent Laboratories, Independent Radiologists, Durable Medical Equipment, Home Health, Physicians, Physician Assistants, Certified Nurse Midwives, Certified Nurse Practitioners, Psychologists, Optometrists, Dentists, Podiatrists,**

RE: Ordering/Referring Provider's NPI Must Be Present on Claims

Effective October 1, 2013

Code of Federal Regulations (42 CFR 455.440) requires all claims for the payment of items and services that are ordered, referred, or prescribed to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribed such items or services.

Effective for claims received on or after October 1, 2013, all Medicaid claims from laboratories, imaging centers, home health agencies, and durable medical equipment providers MUST have the NPI of the ordering/referring provider.

There are three basic requirements:

1. The physician or non-physician practitioner must be enrolled in Medicaid as either a regular Medicaid provider or as an OPR provider.
2. The NPI used must be for an individual physician or non-physician practitioner and cannot be an organizational NPI.
3. Interns and non-licensed residents must use the NPI of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid and the NPI of the resident must be used on the claim for reimbursement.

Attention Physicians and Non-physician Practitioners:
You must furnish your NPI on all orders/referrals for laboratory, imaging services, home health services, and durable medical equipment. The laboratory facility, the radiology/imaging center, the pharmacy, the home health agency, and the medical supply company will always need the NPI of an ordering/prescribing/referring physician or non-physician practitioner in order to submit their claims for payment to the Medicaid program.

An enrollment application is available for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.

Providers can check to see if an ordering or referring provider is enrolled with Medicaid through the Medicaid Secure Website. Providers may search using an NPI or license number of a provider. This is available on the Providers/Provider Search tab using the following link.
https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx

ALABAMA MEDICAID AGENCY

ALERT

September 5, 2013

To: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Hospitals, and Nursing Homes

RE: Pharmacy Changes

Effective October 1, 2013, the Alabama Medicaid Agency will:

- Discontinue coverage of over-the-counter medications (OTCs) for adults and children; *OTC insulin and nutritional products will remain covered.*

- Decrease Wholesale Acquisition Cost (WAC) ingredient reimbursement to WAC + 0% from WAC + 9.2% for drugs without an Average Acquisition Cost (AAC).

Effective October 1, 2013, the Alabama Medicaid Agency will begin phasing in the following changes for an effective date of January 1, 2014. Informational edits and/or overrides will be available during the phase in period; providers are encouraged to use the phase in period to coordinate/find the best schedule for each individual recipient. Changes include:

- Implementation of a mandatory three month maintenance supply program for selected medication classes. A maintenance supply prescription will only be counted towards the prescription limit in the month in which it is filled. The selected classes include:

Medication Class	Medications Included
ACE Inhibitors	Preferred generics and brands
Antidepressants	Preferred generics and brands
Asthma	Generic montelukast only
Beta Blockers	Preferred generics and brands
Calcium Channel Blockers	Preferred generics and brands
Contraceptives	Oral, vaginal rings, patches only
Diabetic Agents/Supplies	Generic metformin, OTC insulins, and syringes
Diuretics	Preferred generics and brands
Lithium	All covered Products
Statins	Preferred generics and brands
Thyroid Replacement	All covered Products

- Limit the number of outpatient pharmacy prescriptions to five total drugs (including up to four brands) per month for adults. Children under 21 and nursing home recipients are excluded. In no case can total prescriptions exceed ten per month per recipient. Allowances will be made for up to five additional (10 total) prescriptions for brand and generic antipsychotics, antiretrovirals, and anti-epileptic drugs.

Additional pharmacy-specific billing information and override information can be found on the Pharmacy Services page of the Alabama Medicaid Agency website at
http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.5_Pharmacy_Services.aspx

ALABAMA MEDICAID AGENCY

ALERT

September 12, 2013

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

RE: **Pharmacy/Preferred Drug List Update**

Effective October 1, 2013, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	
Ciprodex	EENT Preparations/Antibacterials
Combivent Respimat	Respiratory/Respiratory Beta-Adrenergic Agonists
Pataday	EENT Preparations/Antiallergic Agents
Patanase	EENT Preparations/Antiallergic Agents
Vigamox	EENT Preparations/Antibacterials
PDL Deletions	
Tyzine	EENT Preparations/Vasoconstrictors

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

Additionally, on July 1, 2013, an accumulation edit was implemented to limit dispensing of early refills to no more than seven extra days' worth of medication per 120 rolling days. Claims that exceed, or result in the accumulation of more than seven extra days' worth of medication in a 120 - day time period will deny.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

September 12, 2013

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

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PDL Deletions	
Tyzine	EENT Preparations/Vasoconstrictors

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

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Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

September 19, 2013

TO: All Physicians and Independent Certified Registered Nurse Practitioners (CRNP)

RE: Reimbursement Change 7.5 Percent Reduction

Due to budget constraints, the Alabama Medicaid Agency will implement a 7.5 percent reduction in payments to all physicians, physician-employed nurse practitioners, physician-employed physician assistants, and to CRNPs.

Primary care provider rates for the evaluation and management (E&M) and Vaccine for Children (VFC) procedure codes under the Affordable Care Act will not be affected, but all other procedure codes will be reduced. Primary Care providers who qualify for the Primary Care Rate increase (also called BUMP increase) and have an attestation form on file with HPES will continue to be reimbursed at 100 percent for the E&M and VFC codes.

These reductions will be effective for dates of service on or after October 1, 2013.

ALABAMA MEDICAID AGENCY

ALERT

October 1, 2013

TO: All Ophthalmologists and Optometrists

RE: No Reimbursement Change for Routine Eye Exams

The recently announced reimbursement reductions to physicians will not apply to routine eye exams performed by ophthalmologists and optometrists. There will be no cut in rates for the following general ophthalmological codes:

92002 92004 92012 92014 92015

Please contact the HP Provider Assistance Center at 1-800-688-7989 for any questions related to this policy decision.

ALABAMA MEDICAID AGENCY

ALERT

September 5, 2013
Updated October 1, 2013

To: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Hospitals, and Nursing Homes

RE: Pharmacy Changes

Effective October 1, 2013, the Alabama Medicaid Agency will:

- Discontinue coverage of over-the-counter medications (OTCs) for adults and children; *OTC insulin, 2nd generation antihistamines, and nutritional products will remain covered.*

- Decrease Wholesale Acquisition Cost (WAC) ingredient reimbursement to WAC + 0% from WAC + 9.2% for drugs without an Average Acquisition Cost (AAC).

Effective October 1, 2013, the Alabama Medicaid Agency will begin phasing in the following changes for an effective date of January 1, 2014. Informational edits and/or overrides will be available during the phase in period; providers are encouraged to use the phase in period to coordinate/find the best schedule for each individual recipient. Changes include:

- Implementation of a mandatory three month maintenance supply program for selected medication classes. A maintenance supply prescription will only be counted towards the prescription limit in the month in which it is filled. The selected classes include:

Medication Class	Medications Included
ACE Inhibitors	Preferred generics and brands
Antidepressants	Preferred generics and brands
Angiotensin II Receptor Blockers	Preferred generics and brands
Asthma	Generic montelukast only
Beta Blockers	Preferred generics and brands
Calcium Channel Blockers	Preferred generics and brands
Contraceptives	Oral, vaginal rings, patches only
Diabetic Agents/Supplies	Generic metformin, OTC insulins, and syringes
Diuretics	Preferred generics and brands
Lithium	All covered Products
Statins	Preferred generics and brands
Thyroid Replacement	All covered Products

- Limit the number of outpatient pharmacy prescriptions to five total drugs (including up to four brands) per month for adults. Children under 21 and nursing home recipients are excluded. In no case can total prescriptions exceed ten per month per recipient. Allowances will be made for up to five additional (10 total) prescriptions for brand and generic antipsychotics, antiretrovirals, and anti-epileptic drugs.

Additional pharmacy-specific billing information and override information can be found on the Pharmacy Services page of the Alabama Medicaid Agency website at
http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.5_Pharmacy_Services.aspx

ALABAMA MEDICAID AGENCY

ALERT

October 22, 2013

TO: All Providers

RE: Procedure/Modifier Combination Requirements

Effective October 21, 2013, the Alabama Medicaid Agency will begin use of two new Explanation of Benefit (EOB) codes.

The new EOB codes will be:

- **EOB 3323** Procedure restriction – Required modifier not present
  - A procedure code was submitted without the required modifier.
- **EOB 3324** Procedure restriction – modifier not allowed
  - A procedure code was submitted with a modifier that is not allowed.

Between October 21, 2013, and November 21, 2013, these codes will be returned as informational messages only. Effective November 22, 2013, claims will be denied when submitted without the correct procedure and modifier combinations.

For **prior authorization** requests entered on the provider web portal, an error message will be returned to the user on the line item panel if the modifier entered for the procedure code is not allowed. In that case, the following online error message will be displayed: "Procedure code and modifier combination entered is invalid for the requested effective dates."

A user must correct the prior authorization record by removing or changing the modifier that is not allowed while on the line item panel prior to selecting NEXT to move to the next page.

The provider manual has additional information concerning billing modifiers for certain services.
http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx
Questions concerning this change may be directed to the Provider Assistance Center at 1-800-688-7989 or your Provider Representative at 1-855-523-9170.

ALABAMA MEDICAID AGENCY

ALERT

October 22, 2013

To: All Providers

Subject: Total System Outage

The Alabama Medicaid system will be unavailable due to scheduled maintenance.

WHEN:

Saturday, October 26, 2013 at 6PM Central Time

UNTIL:

Saturday, October 26, 2013 at 11:30PM Central Time

There will be no claims and eligibility processing or system access by any method during the system maintenance period.

ALABAMA MEDICAID AGENCY

ALERT

October 25, 2013

TO: Providers, Vendors and Clearinghouses

RE: Alabama Medicaid Implementation of

CORE Rules Phase I & II

CORE Rules Implementation

Alabama Medicaid is implementing changes for the ACA CORE Rules Phase I & II on 10/26/2013. The changes impact 270/271 Eligibility Request and Response.

The changes being implemented consist of 3 CORE Rules.

- **Rules 154/260**

Eligibility request and response will include generic or explicit service type information in addition to financial information.

- **Rule 258**

Normalization of the Subscriber's Last Name.

- **Rule 259**

General Error Reporting

Additional information concerning the changes is available on the Alabama Medicaid website. The Companion Guide for HIPAA 5010 has been updated.

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx

ALABAMA MEDICAID AGENCY

ALERT

Provider Web Portal

Alabama Medicaid will implement changes to the Provider Web Portal on 10/26/2013 for the CORE Rules Phase I & II.

- **Eligibility Verification Request Panel - *Updated***

The format of this panel has changed and an additional search criterion has been added to allow Providers the ability to submit a request for specified services. If no service type codes are selected a generic request and response will be returned which includes all of the CORE defined Generic Service Type Codes.

Generic Service Type Codes

	Description		**Description**
1	Medical Care	86	Emergency Services
30	Health Benefit Plan Coverage	88	Pharmacy
33	Chiropractic	98	Professional (Physician) Visit -office
35	Dental Care	AL	Vision (Optometry)
47	Hospital	MH	Mental Health
48	Hospital - Inpatient	UC	Urgent Care
50	Hospital - Outpatient		

- **Service Type Codes/Co-pay Panel - *NEW***

This new panel will be returned as part of the Eligibility response and will return the Service Type requested, Co-pay Min and Max, Co-Insurance, Deductible, Status of Covered/Non-Covered and a message if applicable.

ALABAMA MEDICAID AGENCY

ALERT

November 4, 2013

TO: All Border and In-state Hospital Providers

RE: Inpatient Quality Review Activities

Effective November 1, 2013, Qualis Health will be the Quality Improvement Organization (QIO) for inpatient hospital quality review activities. Please be prepared to furnish inpatient quality review staff contact(s) and any other information/documents that may be requested by the Qualis Health representatives.

Providers should note the following:

- Medical records requested by the previous contractor, AFMC, that were not provided to them by October 31, 2013 will not be required to be submitted to Qualis Health
- Hospitals are required to submit a Utilization Review Plan and a Medical Care Evaluation Study annually and these will be requested by Qualis for CY 2013
- Requests for medical records for quarterly retrospective review of inpatient admissions for dates of service April 1, 2013-September 30, 2013 will be sent out January 1, 2014
- All admissions must meet Alabama Medicaid Adult and Pediatric (SI/IS) Inpatient Care criteria

Providers with questions may contact Jan Sticka, Program Manager, Inpatient Hospital QI Program at jan.sticka@medicaid.alabama.gov or by phone 334-353-4151 or Karen Watkins-Smith, Associate Director, Clinics/Mental Health Programs at karen.watkins-smith@medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

November 8, 2013

TO: All OB/GYN Providers, FQHCs, Physicians, Radiologists, Anesthesiologists, and Plan First Providers providing services to recipients in Sumter, Choctaw and Marengo counties

RE: Changes to the Maternity Care Program for Sumter, Choctaw and Marengo Counties

Beginning November 16, 2013, the Greater Alabama Health Network is replacing Tombigbee Healthcare Authority (HealthStart) as the provider of maternity services to pregnant women covered by Medicaid and who live in Sumter, Choctaw and Marengo counties.

Providers should contact Becky Henderson, Director of Greater Alabama Health Network at 1-877-553-4485 or 205-345-1905 with any questions about serving as a subcontractor for the maternity care program in those counties.

If you have additional questions concerning this change, contact Sylisa Lee-Jackson, Associate Director of Maternity, Family Planning/Plan First and Nurse Midwife Programs, Alabama Medicaid Agency at 334-353-4599 or via e-mail at sylisa.lee-jackson@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

November 21, 2013

TO: Nursing Home Providers

RE: Handling Funds Following the Death of a Medicaid-Eligible Resident

The purpose of this alert is to clarify the procedures associated with handling funds following the death of a Medicaid-eligible nursing home resident. The Medicaid Administrative Codes 560-X-10-.14(3)(f) and 560-X-22-.25(5)(e) and the Social Security Administration Guide for Representative Payees require that nursing homes, upon the death of a resident, release any funds being held at the facility in the resident's name to the administrator of the deceased resident's estate. In the event that there is not a person who has been appointed to act as the administrator of the estate, the funds should be sent to the Alabama State Treasurer's Office, Unclaimed Property Division.

In an effort to ensure that all Alabama nursing home facilities are in compliance with the rules and regulations pertaining to the handling of the funds of deceased residents, the following instructions are provided:

A. Resident Trust Funds:

1. If the deceased resident has funds remaining at the nursing home, those funds must immediately be turned over to the legal representative of the resident's estate. The facility should obtain a copy of the letters of administration issued by the probate court identifying the legal representative.

2. <u>If there is no evidence of a person with legal authority to administer the estate of the deceased resident,</u> the facility must prepare and submit forms: UCP1 (Cover Sheet Required for All Reports) and UCP2 (For Reporting of Money and/or Securities Related Property), along with a check in the amount of the refund due the resident, to the Alabama State Treasury's Unclaimed Property Division. Forms may be obtained through the Alabama Treasury Website: www.moneyquest.alabama.gov.

   The UCP1 form requires information specific to your business and the UCP2 form will contain the reported owner information and assets reported and remitted for each owner account.
   To further illustrate what is required:

   a. Form UCP1, the unclaimed property report, must include the payment, which is the total amount of funds as reflected in your report (sum of all reported unclaimed property owner's assets). You will issue one check/wire with your unclaimed property report. This remittance of the report and assets enables your business to clear/close your ledger/accounting of those outstanding liabilities. Any future reference to these accounts after your reporting should be directed to the State Treasurer's Office, Unclaimed Property Division.

b. Form UCP2 is the report where you list the individuals for whom you are submitting funds to UCP.
Section 1 – Account #/Check# (does not need to be completed)
Section 2 – NAUPA Property Code (should state "Resident Trust Funds")
Section 3 – Amount being remitted for the deceased resident
Section 4 – Securities
Section 5 – Can be left blank
Section 6 – The resident's name
Section 7 – The name/address of your facility
Section 8 – The resident's Social Security number
Section 9 – Relation Code (should state "Payee")

The State of Alabama Treasurer's Office is available to help answer any additional questions you may have on this issue. If you wish to contact the Unclaimed Property Division on reporting unclaimed property contact the Reporting Section (toll free) at 888-844-8400 or visit the program's website at www.moneyquest.alabama.gov.

***Effective December 2013, nursing home facilities must notify the Alabama Medicaid Agency, within five (5) business days, of any submission to the Alabama State Treasury's Unclaimed Property Division. The resident's name, Social Security number, and the amount of funds submitted should be forwarded to the attention of the Estate Recovery Unit of the Third Party Division. To satisfy this requirement, nursing homes may choose to fax a copy of the UCP 2 form to the Alabama Medicaid Agency at 334/353-4820 at the time they submit to Unclaimed Property.**

B. Credit Balances (Other than resident trust funds):

Upon the death of a resident with a credit balance on the facility's financial records, the facility must convey promptly these funds, and provide a final accounting of said funds to the Alabama Medicaid Agency. When sending the credit balance information, the facility must provide the resident's name and social security number along with the funds to the attention of Estate Recovery.

If you have any questions regarding this matter, please contact Codie Rowland at 334-242-5652 or Teresa Dunbar at 334-242-5311.

ALABAMA MEDICAID AGENCY

ALERT

November 26, 2013

TO: All Providers Submitting Claims On The CMS-1500 Claim Form

RE: CMS-1500 Claim Form Updates: Alabama Medicaid to Accept Revised Form Beginning January 2014

The CMS-1500 Claim Form has been revised to more adequately support the use of the ICD-10 diagnosis code set, which is important as the October 1, 2014 transition approaches. The revised CMS-1500 form (version 02/12) will replace CMS-1500 (version 08/05). The revised form will give providers the ability to indicate whether they are using ICD-9 or ICD-10 diagnosis codes and also allows for additional diagnosis codes, expanding from 4 possible codes to 12 possible codes. Please note:

- **ICD-9 codes** must be used for services provided **before October 1, 2014**
- **ICD-10 codes** must be used for services provided **on or after October 1, 2014**

Alabama Medicaid will begin accepting the revised form on January 6, 2014.

- Claims submitted on the **revised CMS-1500 (version 02/12)** form **prior to January 6, 2014** will be returned without being processed.
- Claims submitted on the **retired CMS-1500 (version 08/05)** form **on or after April 1, 2014** will be returned without being processed.

HP Enterprise Services does not supply this form. Providers should obtain this form from a vendor supplying current CMS-1500 forms.

REMINDER: Alabama Medicaid requires all claims be submitted electronically. The only time a provider should submit a paper claim is for administrative review or other exceptions previously outlined. If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

ALABAMA MEDICAID AGENCY

ALERT

December 6, 2013

TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Hospitals and Nursing Homes

RE: Pharmacy Changes Effective January 1, 2014

Effective January 1, 2014, the Alabama Medicaid Agency will:

1. **Limit the number of outpatient pharmacy prescriptions to five total drugs (including up to four brands) per month for adults.** *Children under 21 and nursing home recipients are excluded.* Allowances will be made for up to five additional (10 total) prescriptions for brand and generic antipsychotics, antiretrovirals, and anti-epileptic drugs. In no case can total prescriptions exceed 10 per month/per recipient.
2. **Implement a mandatory three-month maintenance supply program for selected medication classes.** A maintenance supply prescription will only be counted towards the prescription limit in the month in which it is filled, and will be required after 60 days stable therapy. The selected classes include:

Medication Class	Medications Included
ACE Inhibitors	Preferred generics and brands
Antidepressants	Preferred generics and brands
Angiotensin II Receptor Blockers	Preferred generics and brands
Asthma	Generic montelukast
Beta Blockers	Preferred generics and brands
Calcium Channel Blockers	Preferred generics and brands
Cardiotonic Agents	Generic digoxin
Contraceptives	Oral, vaginal rings, patches only
Diabetic Agents/Supplies	Generic metformin, generic sulfonylureas, OTC insulins, and syringes
Direct Vasodilators	Generic hydralazine
Diuretics	Preferred generics and brands (now includes spironolactone containing products)
Estrogens	Generic estradiol tablets
Lithium	All covered products
Men's Health	Generic tamsulosin
Potassium Chloride	Generic potassium chloride
Statins	Preferred generics and brands
Platelet Aggregation Inhibitors	Generic clopidogrel
Thyroid Replacement	All covered products

3. **Reimburse for agents used to promote smoking cessation** in accordance with mandatory coverage required under the Affordable Care Act. These agents will require prior authorization and the recipient must enroll in the Alabama Department of Public Health Quitline. More information can be found at www.medicaid.alabama.gov under the Pharmacy/DME page.
4. **Cover benzodiazepines and barbiturates (under the PDL) for eligible recipients** in accordance with mandatory coverage required under the Affordable Care Act.
5. **Require prior authorization for payment of generic budesonide (Pulmicort). Brand Pulmicort Respules will be preferred with no PA.**
   - Use Dispense as Written (DAW) Code of 9 for brand Pulmicort Respules. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.
6. **Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates.** The updates are listed below:

PDL Additions	
Pulmicort	Respiratory/Orally Inhaled Corticosteroids
PDL Deletions	
Budesonide (generic Pulmicort)	Respiratory/Orally Inhaled Corticosteroids

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

December 19, 2013

TO: All Providers

RE: Children's Health Insurance Program (CHIP) will transition to Alabama Medicaid

The Affordable Care Act requires each state's Medicaid program to cover all children ages 6-18 whose family income is 133 percent of the Federal Poverty Level or less. As a result, approximately 25,000 children now enrolled in the Children's Health Insurance Program (CHIP) will transition to Alabama Medicaid on January 01, 2014. In Alabama, the CHIP program is known as ALLKids.

- The transition will require that all of these children participate in Medicaid's Patient 1st program and choose a Patient 1st Primary Medical Provider (PMP).

- Current CHIP enrollees who are patients of providers now enrolled in Medicaid Patient 1st and CHIP will automatically be assigned to their current physician.

- CHIP-enrolled children whose physicians participate in Alabama Medicaid, but are not Patient 1st PMPs will be enrolled as Medicaid fee-for-service recipients for a 30-day period. If the recipient does not choose an enrolled Patient 1st PMP within this period of time, the system will automatically assign one for them.

- Patient 1st PMPs may be changed at any time.

- To ensure the continuity of care for the children now within your practice, eligible providers are encouraged to enroll as Medicaid Patient 1st providers. Participation can be limited and physicians can specify the number they wish to accept in their panels.

- To enroll as a Patient 1st PMP, providers must complete and submit a **Patient 1st Application Package** (application and agreement) to the Hewlett Packard (HP) Provider Enrollment Unit. The application package is available on Medicaid's website at: www.medicaid.alabama.gov under **Providers>Provider Enrollment**. Providers not yet enrolled with Alabama Medicaid will need to complete an online **Provider Enrollment Application** as well. Any questions concerning the application process should be directed to the Provider Enrollment Unit at: 1-888-223-3630.

ALABAMA MEDICAID AGENCY

A L E R T

December 19, 2013

TO: Outpatient hospitals, physicians, nurse practitioners, nurse midwives, health departments, federally qualified health care centers (FQHCs), rural health clinics, opticians, optometrists, and pharmacies.

RE: Tobacco Cessation Counseling Services for Pregnant Women

Beginning January 1, 2014, the Alabama Medicaid Agency will cover a new smoking cessation benefit for Medicaid-eligible pregnant women. Medicaid will reimburse for up to four face- to-face counseling sessions in a 12-month period. The reimbursement period will begin in the prenatal period and continue through the postpartum period (60 days after delivery or pregnancy end). Documentation must support each counseling session.

Additional information regarding this mandate can be accessed at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf.

Alabama Medicaid Policy:

Face-to-face counseling services must be provided:

- By or under the supervision of a physician; or
- By another health care professional who is legally authorized to furnish such services under State law within their scope of practice and who is authorized to provide Medicaid covered services other than tobacco cessation services

The following CPT Codes are applicable:

- 99406—Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes
- 99407—Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

ALABAMA MEDICAID AGENCY

A L E R T

December 19, 2013

RE: Tobacco Cessation Counseling Services for Pregnant Women

The following diagnosis codes must be billed on the claim (UB-04 or CMS-1500 claim form) in order to be reimbursed by Medicaid:

V220-V222—Normal pregnancy

V230-V233—Supervision of high-risk pregnancy

V2341-V237—Pregnancy with other poor obstetric history, **or**

V242—Routine postpartum follow-up

AND

3051—Tobacco use disorder

Pharmacies must bill for these specific services through their DME NPI.

NOTE:
Although this policy will be effective on January 1, 2014, system changes have not been made to allow claim payment. As soon as system changes are implemented, another ALERT will be sent out to providers.

ALABAMA MEDICAID AGENCY

A L E R T

December 19, 2013

TO: DME Providers, Prosthetics & Orthotics (P&O) Providers, Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, and Nursing Homes.

RE: Durable Medical Equipment (DME) Program Changes

The Alabama Medicaid Agency's Durable Medical Equipment Program will make changes to:

- Reimbursement for BiPAP (E0470, E0471 & E0472)
- Humidifier Reimbursement (E0550,E0561, E0562 and E0565)

Detailed information about each change is provided below.

BiPAP/Humidifier Reimbursement:

DME Provider(s) that submit Prior Authorizations (PA) on BiPAP devices for dates of service on or after January 01, 2014:

- Will no longer be reimbursed for BiPAP and Humidifier devices billed separately on the same date of service;
- Will no longer be reimbursed for the humidifier as a continuous rental when billed with a BiPAP;
- Will receive the monthly reimbursement amount for procedure codes E0471 & E0472 of $475.37, totaling $4,753.76 at the end of the ten month capped rental period;
- Will receive a monthly reimbursement amount for procedure code E0470 for $219.68, totaling $2,196.80 at the end of the ten month capped rental period;

ALABAMA MEDICAID AGENCY

ALERT

December 19, 2013

RE: Durable Medical Equipment (DME) Program Changes

- Will use **(LL)** modifier when billing for initial PA approved for initial date of service 01/01/14 and after; *(Recertification continues to be required after the initial three month trial period.)*
- Will continue (*with approved recertification*) to bill the next six months for BiPAP with **(LL)** modifier.
- Will bill with **NO** modifier for the final month (totaling 10 months capped)
- Will no longer use the RR modifier for initial BiPAP PAs submitted on or after January 01, 2014

The monthly payment will include delivery, BiPAP and Humidifier devices, in-service for the caregiver, maintenance, repair and supplies. Alabama Medicaid will not reimburse separately for procedure codes A7030, A7034, A7037 and A7038 during the BiPAP's ten month capped rental period. Recertification continues to be required after the initial three months. If the BiPAP is determined not to be medically necessary (i.e., the criteria are no longer met), the device will be returned to the supplier.

If a recipient already has BiPAP and/or humidifier devices on January 01, 2014:

New PA number(s) will be assigned by HP and new PA letters will be mailed to the DME provider(s) to bill for the remaining capped rental months in 2014.

For these PAs, the provider will continue to include the LL modifier for the next up to six (6) claims and the final claim will be billed with no modifier to capture the 10th capped rental amount. If the cumulative amount has been reached, no additional claims will be paid.

Therefore, providers are to ensure that recipients, who have current prior authorizations (PAs) for both devices, have both the BiPAP and humidifier prior to January 01, 2014. These items will be considered as purchased and owned by the recipient. After January 01, 2014, Alabama Medicaid will only reimburse the provider for needed supplies for these recipients.

ALABAMA MEDICAID AGENCY

ALERT

December 19, 2013

RE: Durable Medical Equipment (DME) Program Changes

For initial PAs effective for dates of service on or after January 01, 2014:

Submit the initial PA for the three month trial period with procedure codes E0470, E0471, E0472, with modifier (LL) (RENTAL (APPLD TO PUR)) for three units. With approved recertification, submit the subsequent PA with two detail lines. The first detail will be for six units with modifier (LL) and the second detail will be for one unit with **NO** modifier.

Modifiers to be used:

PAs submitted on or after January 01, 2014:

- **LL** modifier should be included for the initial three month trial period and next six months
- **NO** modifier for the final month (totaling 10 months capped)
- **RA** will be used for replacement of machine only, within 8 year period. Replacement has to be prior approved by the Agency as directed by policy. (Max Fee price of $4,330.66 for procedure codes E0471 & E0472 and $1,773.70 for procedure code E0470)

REMINDER:

Requests for Medicaid's authorization of a replacement BiPAP device will be accepted for review every eight years. A request for replacement of the device submitted within less than eight 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 provider must obtain a prior authorization, submit the claim electronically to HP for processing with the appropriate procedure code and **Modifier CR** and keep all documentation in the recipient file.

ALABAMA MEDICAID AGENCY

ALERT

January 10, 2014

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Hospitals and Nursing Homes**

RE: **UPDATE TO MONTHLY PRESCRIPTION LIMIT Effective January 1, 2014**

Effective January 1, 2014, the Alabama Medicaid Agency will:

1. **Limit the number of outpatient pharmacy prescriptions to five total drugs (including up to four brands) per month for adults.** *Children under 21 and nursing home recipients are excluded.* Prescriptions will be tracked by the claims processing system, and up to five additional brand and generic antipsychotics, antiretrovirals, and anti-epileptic drugs will be automatically approved up to the 10 (total) prescription limit. ***Prescriptions for the three month maintenance supply will not count toward the monthly prescription limit. Due to this exclusion:***

   - ***Maintenance supply medications dispensed between 1/1/14 and 1/9/14 must be reversed and retroactively rebilled to be excluded from the prescription limit.***

   - ***Claims denied between 1/1/14 and 1/9/14 as a result of the prescription limit <u>may</u> now be eligible for coverage, and can be resubmitted.***

   - ***Maintenance medications dispensed on or after 1/10/14 will be excluded from the prescription limit. No further action will be needed for these claims.***

2. **Implement a mandatory three month maintenance supply program for selected medication classes.** A maintenance supply prescription will be required after 60 days stable therapy. The selected classes can be found on the Alabama Medicaid website.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

February 3, 2014

TO: **ALL PROVIDERS**

RE: **Clarification that the ALL Kids (Children's Health Insurance Program or CHIP) is not ending and which children are required to move from the ALL Kids (CHIP) program to Alabama Medicaid**

NOTE: This change did not occur for every child enrolled in the ALL Kids program, ONLY those that met the income and age criteria.

The Affordable Care Act required Alabama Medicaid to change its program to allow all children ages 6-19 whose family income is 100-146 percent of the Federal Poverty Level to be covered by Medicaid.

As a result, 23,000 children moved from ALL Kids to Medicaid on January 1, 2014.

The ALL Kids program is still in operation and continues to cover more than 60,000 children in Alabama.

Before providing services to children on Medicaid or ALL Kids, providers should verify patients' insurance coverage to ensure accurate, current information is in their billing system.

Refer to the following link for questions and answers and other documents for providers regarding this transition:

http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.10_Patient_1st.aspx

You may also contact Latonda Cunningham at 334-353-4122 or via e-mail at Latonda.cunningham@medicaid.alabama.gov or Gloria Wright at 334-353-5709 or via e-mail at Gloria.wright@medicaid.alabama.gov for any further questions.

ALABAMA MEDICAID AGENCY

ALERT

February 14, 2014

TO: **All Providers**

RE: **2/07/14 Check Write Release**

Due to the Federal and State holiday on Monday, February 17, 2014, Medicaid will release the payments for the 2/07/14 check write on Tuesday, February 18, 2014.

Please verify direct deposit status with your bank.

ALABAMA MEDICAID AGENCY

ALERT

February 27, 2014

TO: **All Hospitals**

RE: **Outpatient Hospital-Based Clinic Visits**

A new CMS policy requiring hospital to bill an outpatient hospital clinic visits using a single HCPCS code will be implemented in Alabama on April 1, 2014.

Effective **for dates of service April 1, 2014**, and thereafter, HCPCS code G0463 (Hospital Outpatient Clinic Visit for Assessment and Management of a Patient) will replace CPT E&M codes 99201-99205 and 99211-99215 for outpatient hospital-based clinic visits.

For claims **with dates of service through March 31, 2014**, the hospital will continue to bill the CPT E&M codes 99201 – 99205 and 99211 – 99215 for outpatient hospital-based clinic visits.

For claims **with dates of service April 1, 2014**, and thereafter the hospital will bill G0463 for outpatient hospital-based clinic visits.

The reimbursement amount for G0463 is $51.81.

For questions, please contact: Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via email at Solomon.williams@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

March 7, 2014

TO: **All Hospitals and All Physicians**

RE: **Long Acting Reversible Contraception (LARC)**

Effective for dates of service April 1, 2014, and thereafter, Alabama Medicaid will cover long acting birth control in the inpatient hospital setting **immediately** after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting **immediately** after discharge from the inpatient hospital. The cost of the device or drug implant will be captured in the hospital's cost. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement.

ICD-9 Diagnosis Codes for Hospitals and Physicians

- V255 Encounter for contraceptive management, insertion of implantable subdermal contraceptive
- V2511 Insertion of intrauterine contraceptive device
- V2502 Initiate Contraceptive NEC
- V251 Insertion of IUD

AND

ONE of the following delivery ICD-9 codes within the range:

- 630 -- 67914

ICD-9 Surgical Code (Inpatient Hospital Claims Only)

- 69.7 Insertion Contraceptive Device

Inpatient Hospital Reimbursement

The hospital must bill Medicaid for services provided after delivery on a UB-04 claim form and use one of the delivery diagnosis codes listed above. The ICD-9 surgical code 69.7 (insertion contraceptive device) must also be billed on the claim form along with one of the delivery ICD-9 codes.

NOTE: No additional payment will be made to the hospital. The hospital must capture the cost of the device or drug implant in the hospital's cost.

March 7, 2014 Re: Long Acting Reversible Contraception (LARC)--continued

Outpatient Hospital Reimbursement

When a postpartum woman is discharged from the hospital, she may receive a LARC in the outpatient hospital setting **immediately** after discharge from the inpatient hospital. The hospital should bill on a UB-04 claim form using one of the delivery diagnosis codes listed above. The following are applicable procedure codes for billing the insertion of the device/drug implant:

- 58300 –insertion of IUD
- 11981—insertion, non-biodegradable drug delivery implant
- 11983—Removal with reinsertion, non-biodegradable drug delivery implant

NOTE: The inpatient claim **must** be in Medicaid's system in order for outpatient services to be paid. The inpatient and outpatient hospital must capture the cost of the device through the cost report.

Physician Policy and Reimbursement

The physician should bill Medicaid utilizing a CMS 1500 claim form, one of the following applicable procedure codes below for insertion of the device/drug implant, and one of the delivery ICD-9 codes listed above. The physician should also bill a place of service code of '22' to indicate the service was provided in the outpatient hospital setting or a place of service code '21' to indicate the service was provided in the inpatient hospital setting.

- 58300 –insertion of IUD
- 11981—insertion, non-biodegradable drug delivery implant
- 11983—Removal with reinsertion, non-biodegradable drug delivery implant

NOTE: The Alabama Medicaid Agency covers permanent sterilization only if the recipient has signed a consent form at least 30 days before the procedure is performed.

For questions regarding hospital billing contact Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via e-mail at Solomon.williams@medicaid.alabama.gov.

For questions regarding physician billing contact Jessie Burris, Program Manager, Physicians Program, at 334-242-5014 or via e-mail at Jessie.burris@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

March 19, 2014 ---NOTE: THIS ALERT REPLACES THE ALERT DATED MARCH 7, 2014---

TO: **All Hospitals and All Physicians**

RE: **Long Acting Reversible Contraception (LARC) – Revised**

Effective for dates of service April 1, 2014, and thereafter, Alabama Medicaid will cover long acting birth control in the inpatient hospital setting **immediately** after a delivery or up to the time of the inpatient discharge for postpartum women, or in an outpatient setting **immediately** after discharge from the inpatient hospital. The cost of the device or drug implant will be captured in the hospital's cost. The insertion of the device/drug implant will be billable to Medicaid by both the physician and hospital for reimbursement.

Inpatient Hospital Setting:

The hospital will continue to bill Medicaid for inpatient delivery services. The hospital must use an ICD-9 delivery diagnosis code within the range 630 – 67914 ***and*** must use the ICD-9 surgical code 69.7 (insertion contraceptive device) to document LARC services provided after the delivery.

> **NOTE:** No additional payment will be made to the hospital for LARC inpatient services. The hospital must capture the cost of the device or drug implant in the hospital's cost.

Outpatient Hospital Setting:

When a postpartum woman is discharged from the hospital, she may receive a LARC in the outpatient hospital setting **immediately** after discharge from the inpatient hospital. The hospital should bill on a UB-04 claim form using **one** code from each of the following: *Modifier "FP" is required on 11981 and 11983.

Procedure codes:

- 58300 — Insertion of IUD
- 11981-FP*— Insertion, non-biodegradable drug delivery implant
- 11983-FP*— Removal with reinsertion, non-biodegradable drug delivery implant

ICD-9 diagnosis codes:

- V255 Encounter for contraceptive management, insertion of implantable subdermal contraceptive
- V2511 Insertion of intrauterine contraceptive device
- V2502 Initiate contraceptive NEC
- V251 Insertion of IUD

> **NOTE:** The inpatient claim **must** be in Medicaid's system in order for outpatient services to be paid. The inpatient and outpatient hospital must capture the cost of the device through the cost report.

ALABAMA MEDICAID AGENCY

ALERT

March 19, 2014 ---NOTE: THIS ALERT REPLACES THE ALERT DATED MARCH 7, 2014---

Re: Long Acting Reversible Contraception (LARC)--continued

Physician Billing for LARC Services Provided in the Inpatient/Outpatient Hospital Settings:

The physician should bill Medicaid utilizing a CMS 1500 claim form and one code from each of the following:

Procedure codes:

- 58300 — Insertion of IUD
- 11981-FP*— Insertion, non-biodegradable drug delivery implant
- 11983-FP*— Removal with reinsertion, non-biodegradable drug delivery implant

*Modifier "FP" is required on 11981 and 11983.

ICD-9 diagnosis codes:

- V255 Encounter for contraceptive management, insertion of implantable subdermal contraceptive
- V2511 Insertion of intrauterine contraceptive device
- V2502 Initiate contraceptive NEC
- V251 Insertion of IUD

Place of Service:

- 21 — Inpatient hospital setting
- 22 — Outpatient hospital setting

There are no changes to contraceptive management services currently furnished in the physician's office setting. These services will continue to be billed as you do today.

NOTE: The Alabama Medicaid Agency covers permanent sterilization only if the recipient has signed a consent form at least 30 days before the procedure is performed.

For questions regarding hospital billing contact Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via e-mail at solomon.williams@medicaid.alabama.gov.

For questions regarding physician billing contact Jessie Burris, Program Manager, Physicians Program, at 334-242-5014 or via e-mail at jessie.burris@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

March 20, 2014

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

RE: **Preferred Drug List Update**

Effective April 1, 2014, the Alabama Medicaid Agency will:

1. **Require prior authorization for payment of tobramycin inhalation solution (generic Tobi inhalation solution). Brand Tobi inhalation solution will be preferred with no PA.**

   - Use Dispense as Written (DAW) Code of 9 for brand Tobi inhalation solution. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.

2. **Include preferred Proton Pump Inhibitors in the mandatory three-month maintenance supply program.** Prescriptions for three month maintenance supply medications will not count toward the monthly prescription limit. A maintenance supply prescription will be required after 60 days stable therapy.

3. **Update the Preferred Drug List (PDL) to reflect the quarterly updates.** The updates are listed below:

PDL Additions	
Tobi Inhalation Solution	Anti-infective Agents/Aminoglycosides
PDL Deletions	
Levemir	Diabetic Agents/Insulins
Levemir Flexpen	Diabetic Agents/ Insulins
Tobramycin Inhalation Solution (Generic Tobi Inhalation Solution)	Anti-infective Agents/Aminoglycosides
Xopenex HFA	Respiratory/Beta-Adrenergic Agonists

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

April 15, 2014

TO: **Primary Care Providers**

RE: **Primary Care Physician Rate Increase Audit**

A provision of the Affordable Care Act (ACA) **42 CFR 447.400 Primary care services furnished by physicians with a specified specialty or subspecialty** requires that at the end of calendar years 2013 and 2014, the Alabama Medicaid Agency must review a statistically valid sample of physicians who received higher payment to verify that they met the following requirements:

1. They have a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA) and they actually practice in the areas. The American Board of Allergy and Immunology (ABAI) is an ABMS-recognized sub-discipline of the American Board of Pediatrics and the American Board of Internal Medicine.

2. They are **not** board certified but are practicing in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, **and** 60% of their **paid** Medicaid procedures billed are for evaluation and management (E&M) codes 99201 through 99499 and VFC administration services.

Note: To verify if the 60% threshold has been met, the following calculation will be used:

*Divide the total volume of E&M codes and vaccine administration codes **paid** by Medicaid by the total volume of all codes **paid** by Medicaid. This calculation will be done for each eligible physician individually and not as a group practice. Urinalysis, EKGs, and antibiotic administrations are commonly provided by primary care physicians, Centers for Medicare and Medicaid (CMS) did not include them as primary care services in the numerator when calculating the 60% threshold. Therefore, paid billed codes for ancillary services such as labs, x-rays, injections will cause the percentage threshold to be less.*

This letter is to notify you that beginning May 1, 2014, the Alabama Medicaid Agency will be conducting an audit of the calendar year 2013 claims to verify that the above requirements were met. If the audit reveals the above requirements were not met, the enhanced payment will be subject to recoupment and/or the enhanced payments will be stopped.

ALABAMA MEDICAID AGENCY

ALERT

April 21, 2014

TO: **All Physicians and Enrolled Patient 1st Providers**

RE: **Change to use of Group NPI and non-enrolled physicians in Patient 1st Program**

The Alabama Medicaid Agency is making changes to the Patient 1st program on June 1, 2014, to more precisely track referrals, and to improve patient care management and provider payment accuracy. These changes will also allow Medicaid to track performance measures of a Primary Medical Provider (PMP) in a more efficient manner.

The new changes are:

1. The group NPI number will no longer be recognized for referrals.
   This means the referring provider number on the claim must be the NPI of the referring physician, not the NPI of the group. A group NPI number will cause the claim to deny.

2. Physicians who are **not** enrolled as a Patient 1st provider will no longer be able to make referrals for or on behalf of an enrolled PMP and can only provide services if the patient was referred to them by a Patient 1st enrolled provider.

3. A self- referral will **no longer** be required for PMP's who see patients at different locations.

ACTION NEEDED:
*Enrollment in the PMP program will ensure payment. Physicians not enrolled with Patient 1st are encouraged to complete the online application as **soon** as possible.*

The application is available on Medicaid's website at: www.medicaid.alabama.gov under Providers>Provider Enrollment>Forms for Provider Enrollment>under Administrative Forms >Patient 1st Provider Enrollment. Questions concerning the application process should be directed to the Provider Enrollment Unit at: 1-888-223-3630.

For more information regarding these changes, please contact Latonda Cunningham via e-mail at Latonda.cunningham@medicaid.alabama.gov.

ALABAMA MEDICAID AGENCY

ALERT

April 29, 2014

TO: DME Providers, Prosthetics & Orthotics (P&O) Providers, Pharmacies, Physicians, Physician Assistants, Nurse Practitioners

RE: Durable Medical Equipment (DME) Program Changes and Reminders

In this five-page ALERT, the Alabama Medicaid Agency's Durable Medical Equipment Program is informing providers of the following information:

Changes:

- A4230 and A4232 Benefit Limit Changes
- A4351, A4352, and/or A4349 Benefit Limit Changes
- E0570 (Nebulizer) Continuous Rental Policy Change
- Form 384 (Wheelchair/Seating Evaluation Form, Revised)
- A4351, A4352, and/or A4349 (Catheter supplies) New Billing Process
- A4221 Contra Audits

Reminders

- Billable Modifiers for BiPAP
- Billable Modifiers for CPAP
- Exceeds Benefit Limit Requests
- NCCI Edits
- Criteria Compliance
- ICD-10 Implementation Delayed

Benefit Limit Changes Effective for dates of service on or after April 1, 2014:

Procedure Code	Procedure Code Description	Benefit Limit	Affected Recipients
Insulin Supplies			
A4230	Infusion set for external insulin pump, non-needle cannula type	30 units per two calendar months per recipient	Age 0-20; insulin dependent
A4230-U6		70* units per two calendar months per recipient	Age 0-20; insulin dependent Payment for this quantity will also require use of the appropriate diagnosis code in the range of 250.01 and 250.93 **and** U6 modifier
A4232	Syringe with needle for external insulin pump, sterile, 3cc	30 units per two calendar months per recipient	Age 0-20; insulin dependent
A4232-U6		70* units per two calendar months per recipient	Age 0-20; insulin dependent Payment for this quantity will also require use of the appropriate diagnosis code in the range of 250.01 and 250.93 **and** U6 modifier
The maximum number of units using A4230 (with or without a modifier) is 70. Example: If 30 units are billed without U6 modifier, then 40 is maximum number of units billable with the U6 modifier during any two calendar months.* ***Providers may bill the maximum allowed units in a one month period.* ***All appropriate documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.***			
Catheter Supplies			
A4349	Male external catheter, with or without adhesive, disposable, each	31 units per month per recipient	Age 0-999: no PA or EPSDT-referral required
A4351	Intermittent urinary catheter; straight tip, with or without coating	150 units per month per recipient	Age 0-20; EPSDT-referral required
A4352	Intermittent urinary catheter; Coude (curved) tip, with or without coating		

E0570 (Nebulizer) Continuous Rental Policy Change

Effective for dates of **service** on or after **April 1, 2014**, Alabama Medicaid will reimburse E0570 (Nebulizer) **as purchase only**, excluding cross-over claims. Cross over claims will continue to be reimbursed as a continuous rental when submitted as a rental. There is no change in the current criteria.

Form 384 (Wheelchair/Seating Evaluation Form, Revised)

Effective for dates of **submission** on or after **April 1, 2014**, the revised Wheelchair/Seating Evaluation Form, Form 384, must be submitted to the Agency's Fiscal Agent (HP Enterprise Services) for wheelchair/seating PAs.

The revised Form 384 has been added to the Agency's website and can be viewed by clicking the following link:
http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_Form_384_Wheelchair_Revised_2-18-14.pdf

Form 384 must be completed by an Alabama licensed Physical Therapist (PT)/Occupational Therapist (OT). Alabama Medicaid will only reimburse for the physical therapy evaluation for wheelchairs (manual with accessories and all power wheelchairs) for adults if the PT/OT is employed by a hospital enrolled with Alabama Medicaid. The evaluation must be performed in the hospital outpatient setting.

A4351, A4352, and/or A4349 (Catheter supplies) New Billing Process

Effective for dates of **service** on or after **May 1, 2014,** providers must submit a PA request and supporting documentation for procedure codes A4351, A4352 and/or A4349 to the Agency's Fiscal Agent (HP) for the Prior Authorization Vendor's (Qualis Health) approval for

(1) recipient age 0-20 needing more than 150 units per calendar month with an EPSDT screening, and
(2) recipient age 21-999 needing more than 31 units per calendar month.

The provider will receive the PA decision letter with the approval or denial. If approved, the provider will submit the claim(s) electronically with the appropriate procedure code(s): A4351, A4352 and/or A4349 **and** the **U8 modifier**.

This change means that providers will no longer submit override requests for these items and quantities to the Agency for review. **Hard copy claims of this type (for dates of service on or after May 1, 2014), submitted by providers to the DME Unit, will not be processed**. All appropriate documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.

A4221: Contra Audits

For dates of **service** on or after **January 1, 2014**, Alabama Medicaid will no longer reimburse for the below listed procedure codes when billed in combination with procedure code A4221- Supplies for Maintenance of Drug Infusion Catheter, Per Week:

A4244	A4245	A4246	A4247	A4450	A4452	A4455
A4927	A4930	A6216	A6230	A6250	A6257	A6258
A6259	A6266	A6403	A6404	J1642		

NOTE: *A4221 will only be reimbursed by Alabama Medicaid once per week and up to three units per week. The reimbursement amount for code A4221 includes all necessary supplies for one week in whatever quantity is needed by the recipient for that week. Providers that submit claims including A4221 are required to furnish the items and services described in the quantities needed by the recipient for the entire week.*

These changes are in compliance with the 2010 federal regulation regarding A4221.

REMINDERS:

Billable Modifiers for BiPAP

PAs submitted for dates of service on or after January 1, 2014 must comply with the following instructions:

LL modifier - Submitted for BiPAP's
- initial three month trial period and
- next six months

No modifier - Submitted for the final month (totaling 10 months capped)

RA modifier - Submitted for replacement of machine only, within the 8-year period. (Replacement has to be prior approved by Agency as directed by policy.)

Billable Modifiers for CPAP

PAs submitted for dates of service on or after January 1, 2013 must comply with the following instructions:

LL modifier - Submitted for CPAP initial three (3) months approval

No modifier - Submitted for final payment (starts benefit limit count)

RA modifier - Submitted for replacement of machine only, within the 8-year period (Replacement has to be prior approved by Agency as directed by policy.)

RR modifier was terminated for Medicaid claims effective December 31, 2012 (Accepted for cross-over claims only, after December 31, 2012)

Exceeds Benefit Limit Requests

If the prescription to be paid by Alabama Medicaid exceeds the maximum benefit limit established by Alabama Medicaid, the DME provider must request an override or prior authorization for the prescribed item(s). If the override/prior authorization request is denied, then the item(s) above the maximum benefit limit is non-covered and the recipient can be charged as a cash recipient for the item(s) in excess of the maximum benefit limit.

NCCI Edits

It is the provider's responsibility to ensure that requested items and/or quantities are in compliance with NCCI edits prior to submitting claims and/or prior authorization requests.

Prior authorization approval will not override NCCI edits.

The Medicaid NCCI Coding is available on the CMS NCCI website at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

Criteria Compliance

Please ensure compliance with the requirements listed in the Agency's Provider Manual and Administrative Code documents. Frequently, documentation is required to be maintained in the recipient's file on the DME site although the item(s) may not require prior authorization. An appropriate signature is also required for ALL items provided/delivered to recipients.

ICD-10 Implementation Delayed

On April 1, 2014, President Obama signed into law legislation (HR 4302) that delayed the ICD-10 compliance date until at least October 2015. As we learn more, we will keep you informed. The Alabama Medicaid Agency's claims processing system was updated in October 2013 to accommodate ICD-10.

ALABAMA MEDICAID AGENCY

ALERT

June12, 2014

TO: All Hospitals

RE: Change of Ownership (CHOW) and Closures

Effective July 1, 2014, and thereafter, hospitals are to notify Medicaid of any Change of Ownership (CHOW) or closure as soon as it is known to ensure proper payment and prevent recoupments.

Procedures Following a Change in Ownership:

- When Medicaid or HP Enterprise Services (HPES) verifies an ownership change or closure of an acute care hospital (Public or Private), the hospital's contract will be end dated effective with the date of the sale or closure.

- The facility's new owner should submit an enrollment application to Medicaid as soon as the purchase has been finalized. When HPES approves the new enrollment application, the hospital will be assigned a Medicaid provider number and a temporary six-month contract based on the effective date of the CHOW.

- This temporary enrollment will allow the new owners to bill for services provided on or after the CHOW effective date. It will also allow Medicaid time to receive the Certification and Transmittal (C&T) form from the Alabama Department of Public Health (ADPH). Once the C&T is received from ADPH, then Medicaid will update the hospital's contract**. If Medicaid is not notified of the CHOW within six months, the contract will automatically expire.**

Claims Processing:

- Claims for dates of service on or after the ownership change must be filed using the NPI/Medicaid ID for the new owner.

- Claims for dates of service prior to the date of the ownership change will continue to be billed under the previous owner's NPI.

Procedure Following a Closure

In the event that a hospital is closed, HPES will end date the hospital's contract effective the date of the closure. Any claims paid for dates of service after the closure will be recouped.

For Additional Information

Providers with questions should contact Solomon Williams, Associate Director, Institutional Services, at 334-353-3206 or via e-mail at solomon.williams@medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

June 12, 2014

TO: **All Providers**

RE: **Provider Application Fees**

Federal regulations now require States to collect an application fee from all reenrolling or newly enrolling institutional providers. States must collect this fee from institutional providers prior to enrollment or reenrollment if these providers have not paid a fee to Medicare or another State or are not enrolled with Medicare, another State's Medicaid program, or CHIP. Physicians and non-physician practitioners are not subject to the fee. The application fee amount is established by CMS and is updated annually. Currently the FY2014 fee amount is $542.

Institutional providers who are required to submit a fee include, but are not limited to the following: ambulance service suppliers, ambulatory surgical centers, hospitals, community mental health centers, DME suppliers, rural health clinics, outpatient therapy groups, hospices, home health agencies, rehabilitation facilities, extended care facilities, laboratories, federally qualified health centers, end stage renal disease centers, etc. (A complete list can be viewed on the Agency website at www.medicaid.alabama.gov.)

Institutional providers must submit the application fee in the form of a certified or cashier's check at the time of their initial enrollment or reenrollment. The application fee should be mailed to HPES Provider Enrollment Department at P. O. Box 241685, Montgomery, Alabama 36124-1685. Those institutional providers who have paid the application fee to Medicare or another State or are enrolled with Medicare, another State's Medicaid program, or CHIP will be exempt from paying the fee to Alabama Medicaid. Proof of this payment or enrollment must be submitted by the provider at the time of initial enrollment or reenrollment. Providers may also request a hardship exception from CMS as needed. If a hardship exception is granted by CMS, proof of the exception should be submitted to Alabama Medicaid at the time of initial enrollment or reenrollment. Providers can obtain more information on the hardship exception by visiting www.cms.gov.

Changes to Medicaid's provider enrollment system and the enrollment web portal are being developed and will be implemented by July 1, 2014. Any initial applications or revalidations from institutional providers already submitted or to be submitted will be subject to the application fee.

If you have any questions, please contact Provider Enrollment at 1-888-223-3630, option 1.

ALABAMA MEDICAID AGENCY

ALERT

June 17, 2014

TO: **Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

RE: **Preferred Drug List Update**

Effective July 1, 2014, the Alabama Medicaid Agency will:

1. **Require prior authorization for payment of the below listed generics. The equivalent brand will be preferred with no PA.**

- Use Dispense as Written (DAW) Code of 9 for these brand name products. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.

Generic	Brand Name
Lidoderm	Lidocaine Topical Patch
Dexmethylphenidate HCL	Focalin
Trospium Chloride	Sanctura
Diazapam Rectal Kit	Diastat Diastat Acudial
Modafinil	Provigil
Levalbuterol Inhalation Solution	Xopenex Inhalation Solution

2. **Update the Preferred Drug List (PDL) to reflect the quarterly updates.** The updates are listed below:

PDL Additions	
Azelastine HCL (generic Astelin)	EENT Preparations/Antiallergic Agents
Diastat	Behavioral Health/Benzodiazepines
Diastat Acudial	Behavioral Health/Benzodiazepines
Elidel	Skin and Mucous Membrane/Miscellaneous
Focalin	Behavioral Health/Cerebral Stimulants-Agents used for ADHD
Lidoderm	Skin and Mucous Membrane/Antipruritics and Local Anesthetics

Mentax	Skin and Mucous Membrane/Antifungals
Provigil	Behavioral Health/Wakefulness Promoting Agents
Sanctura	Genitourinary Agents/Genitourinary Smooth Muscle Relaxants
Sklice	Skin and Mucous Membrane/Scabicides and Pediculicides
Strattera	Behavioral Health/Cerebral Stimulants-Agents used for ADHD
Ulesfia	Skin and Mucous Membrane/Scabicides and Pediculicides
Xopenex Inhalation Solution	Respiratory/Selective Beta-2 Adrenergic Agonists
Zovirax (cream only)	Skin and Mucous Membrane/Antivirals
PDL Deletions	
Advair	Respiratory/Orally Inhaled Corticosteroids
Advair HFA	Respiratory/Orally Inhaled Corticosteroids
Astelin	EENT Preparations/Antiallergic Agents
Dexmethylphenidate HCL (generic Focalin)	Behavioral Health/Cerebral Stimulants-Agents used for ADHD
Diazapam Rectal Kit (generic Diastat) (generic Diastat Acudial)	Behavioral Health/Benzodiazepines
Levalbuterol Inhalation Solution (generic Xopenex)	Respiratory/Selective Beta-2 Adrenergic Agonists
Lidocaine Topical Patch (generic Lidoderm)	Skin and Mucous Membrane/ Antipruritics and Local Anesthetics
Modafinil	Behavioral Health/ Wakefulness Promoting Agents
Trospium Chloride (generic Sanctura)	Genitourinary Agents/ Genitourinary Smooth Muscle Relaxants
Zovirax (ointment only)	Skin and Mucous Membrane/Antivirals

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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Medicaid Pharmacy Administrative Services
P. O. Box 3210 Auburn, AL 36832-3210
Fax: 1-800-748-0116
Phone: 1-800-748-0130

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

June 25, 2014

TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes

RE: Preferred Drug List Update

Effective July 1, 2014, the Alabama Medicaid Agency will:

1. **Require prior authorization for payment of the below listed generics. The equivalent brand will be preferred with no PA.**
   - Use Dispense as Written (DAW) Code of 9 for these brand name products. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.

Generic	Brand Name
Lidocaine Topical Patch	Lidoderm
Dexmethylphenidate HCL	Focalin
Trospium Chloride	Sanctura
Diazapam Rectal Kit	Diastat Diastat Acudial
Modafinil	Provigil
Levalbuterol Inhalation Solution	Xopenex Inhalation Solution

2. **Update the Preferred Drug List (PDL) to reflect the quarterly updates.** The updates are listed below:

PDL Additions	
Azelastine HCL (generic Astelin)	EENT Preparations/Antiallergic Agents
Diastat	Behavioral Health/Benzodiazepines
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Lidoderm	Skin and Mucous Membrane/Antipruritics and Local Anesthetics

Mentax	Skin and Mucous Membrane/Antifungals
Provigil	Behavioral Health/Wakefulness Promoting Agents
Sanctura	Genitourinary Agents/Genitourinary Smooth Muscle Relaxants
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Trospium Chloride (generic Sanctura)	Genitourinary Agents/ Genitourinary Smooth Muscle Relaxants
Zovirax (ointment only)	Skin and Mucous Membrane/Antivirals

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

August 14, 2014

TO: **Durable Medical Equipment (DME) Out-of-State Providers**

RE: **New HME Law Alert for Out of State DME Providers**

Attention: Durable Medical Equipment (DME) Out-of-State Providers
On March 11, 2014, Governor Robert Bentley signed HB 226 into law (Act 2014-172), which requires all Home Medical Equipment ("HME") Licensees to have a physical location within Alabama that meets the Alabama Board of Home Medical Equipment's (the "Board") licensure requirements. In compliance with the Act, the Board approved amendments to its Rules and Regulations on July 8, 2014.

"**A provider of home medical equipment services that has a principal place of business outside this state shall maintain at least one physical location within this state, each of which shall be licensed**." Ala. Code § 34-14C-4 (1975). Therefore, an out of state HME provider's License will expire on August 31, 2014, unless the provider complies with the law prior to the expiration date.

Alabama Medicaid Durable Medical Equipment ("DME") providers must either have a current Alabama HME License or meet one of the licensure exemptions found in Ala. Code § 34-14C-5 (1975). All DME providers that do not have a current HME License or meet a licensure exemption on September 1, 2014 will be terminated as a Alabama Medicaid provider effective August 31, 2014. More information can be found at the link http://www.homemed.state.al.us/.

For questions related to the implementation of these new licensure requirements, please contact Paula McCaleb, Executive Director of the Alabama Board of HME @ (334) 215-3474 or Paula@leadership-alliance.org or Vivian Bristow, Medicaid DME Program Manager @ (334) 353-4756 or vivian.bristow@medicaid.alabama.gov

ALABAMA MEDICAID AGENCY

ALERT

August 20, 2014

TO: Nursing Home Providers

RE: Handling Funds Following the Death of a Medicaid-Eligible Resident

NOTE: THIS ALERT REPLACES THE ALERT DATED NOVEMBER 21, 2013

The purpose of this alert is to clarify the procedures associated with handling funds following the death of a Medicaid-eligible nursing home resident. 42 CFR § 483.10(c)(6), the Medicaid Administrative Code 560-X-10.-14(3)(f) and 560-X-22-.25(5)(e) and the Social Security Administration Guide for Representative Payees require that nursing homes, upon the death of a resident, release any funds being held at the facility in the resident's name to the individual or probate jurisdiction designated to administer the deceased resident's estate. Attached to this alert is a newly developed **Administrator of Estate Designation Form** which will provide a resident the opportunity to designate who should receive the remaining personal funds. Upon the death of the resident, the completed form in the patient's record will allow a nursing home facility to turn over any remaining funds to the designated Administrator of the Estate. The designated administrator may utilize these funds for the payment of burial expenses or for some other use; however, the administrator should be made aware that any remaining funds left to the estate may be subject to Medicaid estate recovery, pursuant to 42 USC § 1396p.

In an effort to ensure that all Alabama nursing home facilities are in compliance with the existing rules and regulations and these new procedures pertaining to the handling of the funds of deceased residents, the following instructions are being provided:

A. Resident Trust Funds:

1. If the deceased resident has resident trust funds remaining at the nursing home, those funds may be turned over promptly to the individual handling the estate of the deceased resident. In the absence of a letter of administration issued by the probate court identifying the legal representative, a properly executed Administrator of Estate Designation Form signed by the Medicaid recipient or their Power of Attorney may be used. Medicaid will make the Administrator of Estate Designation Form available to all facilities for use during the nursing home admissions process. No licensee, owner, administrator, employee, or representative of a long term facility shall be named as a beneficiary to such funds, unless that individual/intended beneficiary is the resident's next of kin.

2. If there is no administrator as designated by the probate court or a completed Administrator of Estate Designation Form, the facility must adhere to Medicaid Administrative Code 560-X-22-.25(5)(e).

***Effective September 15, 2014, nursing home facilities shall maintain documentation regarding the disbursement of any deceased resident funds. This documentation should include the resident's name, Social Security number, the person or entity to which payment was made, and the amount of funds submitted should be forwarded to the attention of the Estate Recovery Unit of the Third Party Division. To satisfy this requirement, nursing homes may choose to fax the completed Administrator of Estate Designation Form to the Alabama Medicaid Agency at 334/353-4820 at the time the funds are disbursed.**

B. Credit Balances (Other than resident trust funds):

Upon the death of a resident, the facility must determine if a credit balance exists on the facility's financial records and promptly convey the funds to the proper source:

1. Credit balances owed to Alabama Medicaid occur when a provider's reimbursement for services exceeds the allowable amount or when the provider receives payments from multiple parties for the same service. Facilities should review invoice records for credit balances and should be reconciling any identified overpayment with Medicaid. Pursuant to 42 CFR § 433.139, the Alabama Medicaid Agency is the payer of last resort. Any credit balance on the nursing home account resulting from an excess payment, as a result of patient billing or claims processing error, must be refunded to Alabama Medicaid Agency. Accordingly, the Medicaid Provider Agreement section 1.3.6 states, "Provider must refund to MEDICAID any overpayments, duplicate payments, and erroneous payments which are paid to Provider by Medicaid as soon as the payment error is discovered." When sending the credit balance information, the facility must provide the resident's name and Social Security number along with the funds to the attention of Estate Recovery.

2. Other credit balances:

   a. When the resident passes away, payments received from Social Security, Veterans Administration, Pension Funds, etc. are considered an overpayment and must be returned to the Social Security, Veterans Administration, Pension Funds, etc. at once.
   Examples of overpayments and timing of Social Security and SSI payments are available at the following link: Social Security - Guide for Organizational Representative Payees - Table of Contents

   b. Any out-of-pocket payments by a family member for non-covered services may be refunded to the individual who made the payment on behalf of the resident. Refunds to the family member for non-covered services would be limited to the month of death and the amount prorated from the date of death.

If you have any questions regarding this matter, please contact Codie Rowland at 334-242-5652 or codie.rowland@medicaid.alabama.gov or Teresa Dunbar at 334-242-5311.

Administrator of Estate Designation Form

Be it known to all, that I, _____(*Print Name of Resident)*_____, a resident of _____(*Print Name of Facility*)_____, hereby declares and designates that (*Print Name of Beneficiary*)_____, an adult next of kin, who resides at _____*(Print Address of Beneficiary*)_____, shall receive all monies held in my personal trust account held at said facility, if any, at the time of my death. If the above named adult next of kin predeceases me in death, I declare and designate that (*Print Name of Beneficiary*)_____, an adult next of kin, who resides at _____*(Print Address of Beneficiary*)_____, receive all monies held in my personal trust account.

By my signature below, I further declare that I am competent to execute this document and have done so voluntarily, free of undue influence, coercion, or duress of any kind. I further state that I have the right at any time to modify this form and designate another adult next of kin to receive the monies held in my personal trust account. I understand that my estate may be subject to recovery of any funds expended by Medicaid pursuant to federal regulation 42 USC § 1396p.

___(*Signature of Resident*)_____ _____
Resident Date

___*S.S.N. of Resident*_____
Social Security Number

_____ _____
Witness Date

_____ _____
Witness Date

FOR FACILITY USE ONLY:
Total Funds Distributed: _____ Date of Distribution: _____

Sent to: _____

Address: _____

Fax completed form to the Alabama Medicaid Agency/Estate Recovery Unit at 334/353-4820 **and** provide a copy of this form to the beneficiary of the funds in order to inform them of potential estate recovery.

ALABAMA MEDICAID AGENCY

ALERT

August 26, 2014

TO: Physicians, Hospitals, Rural Health Clinics, FQHC's, and Health Departments

RE: Alabama Medicaid Cardiology Prior Authorization Program Effective October 1, 2014

Beginning October 1, 2014, CareCore National, LLC (CareCore) will implement the Alabama Medicaid Agency prior authorization (PA) program for Cardiology procedures listed below:

1. Nuclear Cardiology – 78451, 78452, 78453, 78454
2. Diagnostic Heart Catheterization – 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461
3. Stress Echocardiography – 93350, 93351
4. Transesophageal Echo – 93312, 93313, 93314
5. Transthoracic Echo – 93303, 93304, 93306, 93307, 93308

Any of the procedures specified above will require a PA from CareCore. Information will be accepted (i.e., online submissions, or via telephone) beginning September 15, 2014, for services scheduled to be rendered on or after October 1, 2014.

The PA requirements will apply to the following Medicaid recipients:

1. SOBRA Children
2. Parents and Other Caretaker Relatives (POCR) Program, formerly, Medicaid for Low Income Families Program
3. Refugees, or
4. Supplemental Security Income

Please note that no PA is required for the following:

1. Medicare patients
2. Cardiology services performed as an inpatient hospital service, or
3. Cardiology services performed as an emergency room service

This Program is applicable to services provided in the following settings:

1. Freestanding imaging facilities
2. Hospital outpatient facilities
3. Physician offices
4. Public Health Clinics
5. Rural Health Clinics
6. Federally Qualified Health Clinics

Physicians may request a PA by contacting CareCore using one of the following methods:

1. Telephone (Alabama Medicaid) 1-855-774-1318, or
2. Online: www.carecorenational.com

Training Available:
CareCore will provide a training webinar on September 9, 2014, 11 a.m. – 12 p.m. CDT, and September 11, 2014, 12 p.m. – 1 p.m. CDT, to help you learn more about our program. The webinars will address the scope of the cardiology PA process; provide guidance on obtaining a PA, and answer providers' questions. The webinar link will be transmitted to providers on September 5, 2014. To learn more, please visit the Tools and Criteria Page at: www.carecorenational.com. You may find additional information about CareCore, and their policies, procedures, and plan specific information you and your staff will need to participate in the program on their website at: www.carecorenational.com. Providers may register on-line to set up an account to use CareCore's web site to submit PA requests.

09/09/2014 Alabama Medicaid meeting information

Topic: State of Alabama prior authorization information session
Date: Tuesday, September 9, 2014
Time: 11:00 pm, Central Daylight Time (New York, GMT-04:00)
Meeting Number: 733 500 473
Meeting Password: webex123

To start or join the online meeting

Go to
https://carecorenational.webex.com/carecorenational/j.php?MTID=mf3ef0ca74b1a11040f88e9aeac583fe2

Audio conference information

To receive a call back, provide your phone number when you join the meeting, or call the number below and enter the access code.
Call-in toll-free number (US/Canada): 1-877-668-4493
Call-in toll number (US/Canada): 1-650-479-3208
Global call-in numbers:
https://carecorenational.webex.com/carecorenational/globalcallin.php?serviceType=MC&ED=314247662&tollFree=1

Toll-free dialing restrictions: http://www.webex.com/pdf/tollfree_restrictions.pdf

Access code: 733 500 473

For assistance
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1. Go to https://carecorenational.webex.com/carecorenational/mc
2. On the left navigation bar, click "Support".

To check whether you have the appropriate players installed for UCF (Universal Communications Format) rich media files, go to https://carecorenational.webex.com/carecorenational/systemdiagnosis.php.
http://www.webex.com CCM: +16504793208x733500473#

To check whether you have the appropriate players installed for UCF (Universal Communications Format) rich media files, go to https://carecorenational.webex.com/carecorenational/systemdiagnosis.php.

http://www.webex.com

CCM: +16504793208x733500473#

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Alabama Medicaid Webinar 9/11 meeting information

Topic: State of Alabama prior authorization information session
Date: Thursday, September 11, 2014
Time: 12:00 pm, Central Daylight Time
Meeting Number: 735 153 026
Meeting Password: webex123

To start or join the online meeting

Go to
https://carecorenational.webex.com/carecorenational/j.php?MTID=m453af19a342ead828455c3b411421d8e

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Audio conference information

To receive a call back, provide your phone number when you join the meeting, or call the number below and enter the access code.
Call-in toll-free number (US/Canada): 1-877-668-4493
Call-in toll number (US/Canada): 1-650-479-3208
Global call-in numbers:
https://carecorenational.webex.com/carecorenational/globalcallin.php?serviceType=MC&ED=314249117&tollFree=1

Toll-free dialing restrictions: http://www.webex.com/pdf/tollfree_restrictions.pdf

Access code: 735 153 026

For assistance

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1. Go to https://carecorenational.webex.com/carecorenational/mc
2. On the left navigation bar, click "Support".

Questions:
Frequently Asked Question (FAQ) are available on CareCore's website, along with a complete list of Cardiology procedures at: www.carecorenational.com. You may also telephone CareCore at 1-800-918-8924, and then choose option "2".

Providers with additional questions may contact Russell Green, Associate Director, Medical Services Division, at (334) 353-4783.

Thank you for your participation with the Alabama Medicaid Cardiology PA program.

ALABAMA MEDICAID AGENCY

ALERT

August 28, 2014

TO: Long Term Care, Hospice, PEC, Swing Bed and Inpatient Psychiatric Providers

RE: Electronic Upload and Submission of Medical Records

Changes have been made to allow Long Term Care, Hospice, PEC, Swing Bed and Inpatient Psychiatric Providers to attach and upload medical records via the Medicaid Interactive Web Portal, eliminating the cost of mailing documents in for processing. A secure logon or access to the Medicaid Interactive Web Portal must be established if one does not already exist to access this new attachment option. Documents may be uploaded two different ways:

- Medicaid Interactive Web portal (preferred) https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx
- Fax information in for processing (bar coded cover sheet required)

Documents must be in a Portable Document Format (PDF) for upload through the Medicaid web portal. If you do not currently have the ability to create PDF versions of medical records, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, HP is including a list of three PDF creation utilities that can be installed to create PDF documents at no charge:

- PrimoPDF - http://www.primopdf.com/
- Solid PDF Creator - http://www.freepdfcreator.org/
- PDF24 - http://en.pdf24.org/creator.html

Once a PDF utility has been successfully downloaded and the PDF document created, providers should follow these steps to upload documentation for review:

1. Log on to Medical Interactive Web portal: https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx
2. Select Trade Files/Forms.

Forms Name field - select a form from the drop down list and click on 'Search'. The following is a list of forms available for selection.

a. LTC-Hospice Records
b. LTC-Records
c. LTC-PEC/Swing Bed Records*
d. LTC-Psychiatric/Retrospective Review Records*

***NOTE**: The Swing Bed Records and PEC Records forms are being replaced by the PEC/Swing Bed form. The Psychiatric Records and Psychiatric-Retrospective Review forms are being replaced by the Psychiatric/Retrospective Review Records form.

3. Complete all fields (record ID field will auto populate). Required fields are indicated with an asterisk (*).
4. Click on 'Browse' and select the required medical records documentation from your network drive or PC and select 'Submit'.

5. A message will be generated that states 'your form was submitted successfully' at the top of the page.
6. A barcode coversheet is generated and will be displayed.
7. Select the 'Print Friendly View' button to print the barcode coversheet or to save as a PDF. A copy of this barcode coversheet should be saved in the event additional documentation is required.

If a PDF document of the medical records cannot be created, information may also be faxed in for review. A fax cover sheet will be *required* with each submission; providers should follow the instructions below to fax documentation:

1. Follow steps 1-7 documented above.
2. Fax the required medical records documentation with the barcode coversheet on top of the documentation to 334-215-7416. Include the bar coded cover sheet with each submission for the same recipient.
3. Do not fax double sided pages.
4. Do not fax multiple sets of records at the same time, each fax should be sent separately.

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the bar code on the cover sheet or alter it in any manner.

Providers with questions concerning the upload of medical records should contact one of their Provider Representatives. A link to the Provider Representative's contact information may be found at the following link: http://www.medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6.1_Provider_Reps_G1.aspx

ALABAMA MEDICAID AGENCY

ALERT

August 29, 2014

TO: Physicians, Hospitals, Rural Health Clinics, FQHC's, and Health Departments

RE: Alabama Medicaid Cardiology Prior Authorization Program Effective October 1, 2014

Beginning October 1, 2014, CareCore National, LLC (CareCore) will implement the Alabama Medicaid Agency prior authorization (PA) program for Cardiology procedures listed below:

1. Nuclear Cardiology – 78451, 78452, 78453, 78454
2. Diagnostic Heart Catheterization – 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461
3. Stress Echocardiography – 93350, 93351
4. Transesophageal Echo – 93312, 93313, 93314
5. Transthoracic Echo – 93303, 93304, 93306, 93307, 93308

Any of the procedures specified above will require a PA from CareCore. Information will be accepted (i.e., online submissions, or via telephone) beginning September 15, 2014, for services scheduled to be rendered on or after October 1, 2014.

The PA requirements will apply to the following Medicaid recipients:

1. SOBRA Children
2. Parents and Other Caretaker Relatives (POCR) Program, formerly, Medicaid for Low Income Families Program
3. Refugees, or
4. Supplemental Security Income

Please note that no PA is required for the following:

1. Medicare patients
2. Cardiology services performed as an inpatient hospital service, or
3. Cardiology services performed as an emergency room service

This Program is applicable to services provided in the following settings:

1. Freestanding imaging facilities
2. Hospital outpatient facilities
3. Physician offices
4. Public Health Clinics
5. Rural Health Clinics
6. Federally Qualified Health Clinics

Physicians may request a PA by contacting CareCore using one of the following methods:

1. Telephone (Alabama Medicaid) 1-855-774-1318, or
2. Online: www.carecorenational.com

Training Available:
CareCore will provide a training webinar on September 9, 2014, 11 a.m. – 12 p.m. CDT, and September 11, 2014, 12 p.m. – 1 p.m. CDT, to help you learn more about our program. The webinars will address the scope of the cardiology PA process; provide guidance on obtaining a PA, and answer providers' questions. The webinar link will be transmitted to providers on September 5, 2014. To learn more, please visit the Tools and Criteria Page at: www.carecorenational.com. You may find additional information about CareCore, and their policies, procedures, and plan specific information you and your staff will need to participate in the program on their website at: www.carecorenational.com. Providers may register on-line to set up an account to use CareCore's web site to submit PA requests.

09/09/2014 Alabama Medicaid Webinar meeting information

Topic: State of Alabama prior authorization information session
Date: Tuesday, September 9, 2014
Time: 11:00 pm, Central Daylight Time
Meeting Number: 733 500 473
Meeting Password: webex123

To start or join the online meeting go to:
https://carecorenational.webex.com/carecorenational/j.php?MTID=mf3ef0ca74b1a11040f88e9aeac583fe2

Audio conference information
To receive a call back, provide your phone number when you join the meeting, or call the number below and enter the access code.
Call-in toll-free number (US/Canada): 1-877-668-4493
Call-in toll number (US/Canada): 1-650-479-3208
Global call-in numbers:
https://carecorenational.webex.com/carecorenational/globalcallin.php?serviceType=MC&ED=314247662&tollFree=1
Toll-free dialing restrictions: http://www.webex.com/pdf/tollfree_restrictions.pdf

Access code: 733 500 473

For assistance:
1. Go to https://carecorenational.webex.com/carecorenational/mc
2. On the left navigation bar, click "Support".

To check whether you have the appropriate players installed for UCF (Universal Communications Format) rich media files, go to https://carecorenational.webex.com/carecorenational/systemdiagnosis.php.
http://www.webex.com CCM: +16504793208x733500473#

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09/11/2014 Alabama Medicaid Webinar meeting information

Topic: State of Alabama prior authorization information session
Date: Thursday, September 11, 2014
Time: 12:00 pm, Central Daylight Time
Meeting Number: 735 153 026
Meeting Password: webex123

To start or join the online meeting go to:
https://carecorenational.webex.com/carecorenational/j.php?MTID=m453af19a342ead828455c3b411421d8e

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Global call-in numbers:
https://carecorenational.webex.com/carecorenational/globalcallin.php?serviceType=MC&ED=314249117&tollFree=1
Toll-free dialing restrictions: http://www.webex.com/pdf/tollfree_restrictions.pdf

Access code: 735 153 026

For assistance
1. Go to https://carecorenational.webex.com/carecorenational/mc
2. On the left navigation bar, click "Support".

To check whether you have the appropriate players installed for UCF (Universal Communications Format) rich media files, go to https://carecorenational.webex.com/carecorenational/systemdiagnosis.php.
http://www.webex.com CCM: +16504793208x735153026#

IMPORTANT NOTICE: This WebEx service includes a feature that allows audio and any documents and other materials exchanged or viewed during the session to be recorded. You should inform all meeting attendees prior to recording if you intend to record the meeting. Please note that any such recordings may be subject to discovery in the event of litigation.

Questions:
Frequently Asked Question (FAQ) are available on CareCore's website, along with a complete list of Cardiology procedures at: www.carecorenational.com. You may also telephone CareCore at 1-800-918-8924, and then choose option "2".

Providers with additional questions may contact Russell Green, Associate Director, Medical Services Division, at (334) 353-4783.

ALABAMA MEDICAID AGENCY

ALERT

September 4, 2014

TO: All Physicians and enrolled Patient 1st Providers

RE: Patient 1st Referral Change

The Alabama Medicaid Agency made changes to the Patient 1st Referral process on June 1, 2014, that no longer allowed a specialist or Primary Medical Physician to bill/refer using a Group NPI number. The effective date of this change has been extended to allow more time to implement this change.

In the interim, the **Group's NPI** number on the referral /claim/prior authorization as the **Referring Provider** will be accepted. However, Medicaid requests that specialists and PMP's continue to write referrals and bill Medicaid utilizing the individual NPI number whenever possible.

The reasons Medicaid is requesting providers continue to bill/refer utilizing the individual NPI include:

- Reinforce Medical Home Concept
- Ensure referrals are managed by the PMP
- Ensure PMP is responsible for recipient's total care
- Properly track caseload assignment for PMP's
- Obtain accurate profiler reports for case management

Medicaid will notify providers through an ALERT, prior to implementing a new effective date, when the change will resume. Please contact Latonda Cunningham, Associate Director of the Patient 1st Program via e-mail at latonda.cunnigham@medicaid.alabama.gov or via phone at (334) 353-4122 for any questions.

ALABAMA MEDICAID AGENCY

ALERT

September 5, 2014

To: All Medicaid Providers

Re: PDL Quarterly Updates

Effective October 1, 2014, the Alabama Medicaid Agency will:

Update the Preferred Drug List (PDL) to reflect the quarterly updates. The updates are listed below:

PDL Additions	
Bethkis	Anti-infective Agents/Aminoglycosides
Cipro HC	EENT Preparations/Antibacterials
Symbicort	Respiratory/Orally Inhaled Corticosteroids
PDL Deletions	
Bleph-10	EENT Preparations/Antibacterials
Ciprodex	EENT Preparations/Antibacterials
Patanase	EENT Preparations/Antiallergic Agents
Vigamox	EENT Preparations/Antibacterials

For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

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

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

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

ALABAMA MEDICAID AGENCY

ALERT

September 5, 2014

TO: Hospice Providers

RE: Changes to Reimbursement for Levels of Care - *Claims Processing for the Hospice Program*

Effective October 1, 2014, the following billing changes will be implemented for Hospice levels of care:

1. Hospice Providers will be required to span bill claims (up to one month) – billing only one detail line per claim.

2. Hospice Providers should bill one procedure code for one unit/per day of service for all hospice procedure codes except *T2045 General Inpatient Care/per day,* which can be billed with *T2042 Routine Home Care/per day*. T2042 should be billed on a separate claim with overlapping dates of service.

NOTE: This does not include *T2042-SC Continuous Care*. The Continuous Care billed amount must be calculated based upon the number of hours of care provided. The units will continue to be based upon the number of days.

The Agency will conduct a retrospective review of Hospice claims going back one year. If a Hospice Provider has "double-billed" and received reimbursement from the Agency within the review period, the Agency will recoup monies that were reimbursed for the erroneous billing.

For questions regarding this Alert, please contact Felicha Fisher, Hospice Program Manager @ (334) 353-5153 or felicha.fisher@medicaid.alabama.gov .

ALABAMA MEDICAID AGENCY

ALERT

September 5, 2014

TO: Dental Providers

RE: Reimbursement Changes for Dental Claims with TPL

Effective October 01, 2014, Alabama Medicaid will be changing its reimbursement for dental claims that have TPL. HP will begin capturing Third Party Liability patient responsibility amounts at both header and detail levels for Dental claims.

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer).

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for dental claims.

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

ALABAMA MEDICAID AGENCY

ALERT

September 5, 2014

TO: Hospital Providers

RE: Reimbursement Changes for Inpatient Claims with TPL

Effective October 01, 2014, Alabama Medicaid will be changing its reimbursement for inpatient claims that have TPL. Inpatient claims will continue to capture Third Party Liability patient responsibility amounts at the header.

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer).

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for inpatient claims.

System changes will be implemented at a later date for the payment methodology for Outpatient claims.

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

ALABAMA MEDICAID

October 2014 Provider Manual

Payment Delay Alerts

Click on Bookmarks to the left to view Alerts

RETURN TO MAIN MENU

ALERT

Attention: All Provider Associations

March 5, 2004 - Checkwrite Release for Nursing Home and Maternity Care Providers

March 19, 2004 - Checkwrite for All Providers

Medicaid funds for the nursing home and maternity care providers for the March 5, 2004 checkwrite will be released on April 6, 2004. Please verify direct deposit status with your bank. As of April 6, 2004, all funds for the March 5, 2004 checkwrite will be released.

As funds for the March 19, 2004 checkwrite are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at *www.medicaid.state.al.us*.

April 2, 2004

ALERT

Attention: All Provider Associations

March 19, 2004 - Checkwrite for Nursing Homes and Maternity Care Providers

Funds for the nursing home and maternity care providers for the March 19, 2004 checkwrite will be released on April 8, 2004. Please verify direct deposit status with your bank.

As funds for other providers are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at *www.medicaid.state.al.us*.

April 7, 2004

ALERT

Attention: All Provider Associations

March 19, 2004 - Checkwrite Release
April 09, 2004 - Checkwrite Release for Pharmacy Providers

Medicaid funds for the remainder of the March 19, 2004 checkwrite will be released on April 15, 2004. All funds from the March 19, 2004 checkwrite will now be released. Please verify direct deposit status with your bank.

Medicaid funds for the Pharmacy providers for the April 09, 2004 checkwrite will be released on April 15, 2004. As funds for other providers are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at *www.medicaid.state.al.us*.

April 13, 2004

ALERT

Attention: All Provider Associations

April 9, 2004 - Checkwrite Release for Non-Institutional and Nursing Home Providers

Medicaid funds for the Non-institutional and nursing home providers for the April 9, 2004 checkwrite will be released on April 22, 2004. Please verify direct deposit status with your bank.

As funds for hospitals and maternity care providers are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at www.medicaid.state.al.us.

April 20, 2004

ALERT

Attention: All Provider Associations

May 7, 2004, Release of Funds

Medicaid funds for the May 7, 2004, checkwrite will be released on time (May 13, 2004).

Please verify direct deposit status with your bank.

May 11, 2004

ALERT

Attention: All Provider Associations

May 21, 2004, Release of Funds

Medicaid funds for the May 21, 2004, checkwrite will be released on time (May 27, 2004).

Please verify direct deposit status with your bank.

May 24, 2004

ALERT

Attention: All Provider Associations

ATTENTION: All Provider Associations

June 4, 2004, Release of Funds

Medicaid funds for the June 4, 2004, checkwrite will be released on time (midnight June 10, 2004).

Please verify direct deposit status with your bank.

June 8, 2004

ALERT

Attention: All Provider Associations

The total Medicaid funds for the June 18, 2004 checkwrite will not be released on schedule. The funds for the Pharmacy and Maternity Care providers will be released on June 24, 2004.

Funds for all other providers will not be released. Medicaid's website will be updated with the actual release date. The Alabama Medicaid website may be accessed at www.medicaid.state.al.us.

Please verify direct deposit status with your bank.

June 22, 2004

ALERT

Attention: All Provider Associations

June 18, 2004 - Release of Funds

Medicaid funds for the remainder of the June 18, 2004 checkwrite will be released on July 7, 2004. All funds from the June 18, 2004 checkwrite will now be released. Please verify direct deposit status with your bank.

July 6, 2004

ALERT

Attention: All Provider Associations

July 9, 2004 - Release of Funds

Medicaid funds for the July 9, 2004 checkwrite will be released on time (July 15, 2004). Please verify direct deposit status with your bank.

July 12, 2004

ALERT

Attention: All Provider Associations

July 23, 2004 - Release of Funds

Medicaid funds for the July 23, 2004 checkwrite will be released on time (July 29, 2004). Please verify direct deposit status with your bank.

July 26, 2004

ALERT

Attention: All Provider Associations

August 6, 2004 - Release of Funds

Medicaid funds for the August 6, 2004 checkwrite will be released on time, August 12, 2004. Please verify direct deposit status with your bank.

August 9, 2004

ALERT

Attention: All Provider Associations

August 20, 2004 - Release of Funds

Medicaid funds for the August 20, 2004 checkwrite will be released on time, August 26, 2004. Please verify direct deposit status with your bank.

August 24, 2004

ALERT

Attention: All Provider Associations

September 3, 2004, Release of Funds

The total Medicaid funds for the September 3, 2004 checkwrite will not be released on schedule. Funds for all providers, EXCEPT Hospitals and Nursing Homes, will be released on Friday, September 10, 2004.

Funds for the Hospital and Nursing Home Providers will not be released. Medicaid's website will be updated with the actual release date. The Alabama Medicaid website may be accessed at *www.medicaid.state.al.us*.

Please verify direct deposit status with your bank.

September 9, 2004

ALERT

Attention: All Provider Associations

September 3, 2004, Release of Funds--Hospitals and Nursing Home Providers

Medicaid funds for the September 3, 2004, checkwrite for Hospitals and Nursing Homes will be released on Monday, September 13, 2004.

Please verify direct deposit status with your bank.

September 10, 2004

ALERT

Attention: All Provider Associations

September 10, 2004, Release of Funds

The total Medicaid funds for the September 10, 2004 checkwrite will not be released on schedule. Funds for all providers, EXCEPT Pharmacies and Nursing Homes, will be released on Thursday, September 16, 2004.

Funds for the Pharmacies and Nursing Home Providers will not be released. Medicaid's website will be updated with the actual release date. The Alabama Medicaid website may be accessed at *www.medicaid.state.al.us*.

Please verify direct deposit status with your bank.

September 14, 2004

ALERT

Attention: All Provider Associations

January 28, 2005: EDS Medicaid System Downtime

EDS will be performing maintenance on its translator software from approximately 2 pm - 5 pm CT on Sunday January 30, 2005. The translator software is one of the first stages in the claims submission (837), eligibility verification (270) via X.25 line, batch web eligibility verification (270), batch web claim status (276) and web prior authorization (278) processes on the EDS system. What this means is that none of these transactions will be processed during the maintenance window. Please be advised that if any of these transactions are submitted via the web for batch processing during this timeframe they will not be processed until the translator maintenance is completed. Interactive eligibility (270) and interactive claim status (276) submitted via X.25 mode will be down during this time.

This will not impact eligibility verification via AVRS, web interactive eligibility (270), web claim status (276) or interactive pharmacy claim submission. If you have questions please call the ECS helpdesk at 1-800-456-1242.

January 28, 2005

ALERT

Attention: Alabama Hospital Association

03/18/05 - Checkwrite Release for Hospital Providers

Medicaid funds for the hospital providers for the 03/18/05 checkwrite will NOT be released on time. Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at www.medicaid.state.al.us.

March 23, 2005

ALERT

Attention: Alabama Hospital Association

03/18/05 - Checkwrite Release for Hospitals

Medicaid funds for the hospital providers for the 03/18/05 checkwrite will be released on 03/29/05.

March 28, 2005

ALERT

To: Provider Associations

Monthly Case Management Payments Delayed

Due to a systems problem, the Monthly Case Management payments were not processed on the May 11, 2007 financial cycle. The problem will be corrected and payments will be processed on the May 25, 2007 financial cycle.

May 15, 2007

ALERT

To: Nursing Home Providers

RE: Payment Delay

The payments scheduled for the September 5 and September 12, 2008 **checkwrites** have been delayed. The process to release the payments for the September checkwrites will begin October 1, and the payments should be accessible on October 3, 2008.

Additional questions concerning the delayed payments should be directed to the Medicaid office at 334-242-5600, or to the Nursing Home Association at 334-271-6214.

September 11, 2008

ALABAMA MEDICAID AGENCY

ALERT

April 5, 2011

Attention: All Providers

RE: Extended Maintenance Window for the Alabama Medicaid System

Time Frame: Beginning April 9, 2011 at 10:00 PM Central until April 10, 2011 at 10:00 AM Central.

Impact: All Alabama MMIS services will be unavailable.

ALABAMA MEDICAID AGENCY

ALERT

November 8, 2011

ATTENTION: ALL PROVIDERS, VENDORS, AND PROVIDER ASSOCIATIONS

RE: TOTAL SYSTEM OUTAGE EXPECTED

WHEN: FRIDAY, NOVEMBER 11, 2011 BEGINNING AT 9:00 P.M. CENTRAL TIME
TO
MONDAY, NOVEMBER 14, 2011 AT 6:00 A.M. CENTRAL TIME

Alabama Medicaid will install updates to support 5010 and NCPDP D.0 transactions over the Veterans Day weekend as part of overall system upgrades.

Due to this upgrade, the system will not be available between 9:00 p.m., Friday, November 11, 2011 and at least 6:00 a.m., Monday, November 14, 2011. During this time, there will be no claims and eligibility processing or system access by any method. Submissions will not be available via batch, interactive, PES or web portal, and AVRS will be down.

The electronic media claims (EMC) helpdesk telephone line will provide updates throughout the weekend at 1-800-456-1242. The message will be updated as soon as the system is available.

Once complete, the following will be available:

- Transactions can be submitted as x12 4010 or x12 5010 / NCPDP 5.1, or NCPDP D.0.
- PES will support one version depending on your PES release. PES 2.16 will support 4010 until PES 3.0 is released. PES 3.0 will support 5010 transactions. You will be notified when PES 3.0 is released.
- Web portal direct data entry will reflect changes for x12 5010 and NCPDP D.0.
- AVRS will be operational.
- Remittance advice (835) will be available in both x12 4010 and x12 5010.
- Other responses will be returned in the same version as received.

Medicaid will continue to accept both x12 4010 and x12 5010 and both NCPDP 5.1 and NCPDP D.0 through December 2011.

Beginning January 1, 2012, only x12 5010 and NCPDP D.0 will be processed.

For updated information, please continue to visit the Medicaid website:
(*http://www.medicaid.alabama.gov/content/6.0_providers/6.5_hipaa_5010.aspx*)

Thank you for your patience as we transition to 5010 and NCPDP D.0.

ALABAMA MEDICAID AGENCY

ALERT

November 22, 2011

Attention: All Providers

RE: 11/18/11 Checkwrite Release

The payments scheduled for the November 18, 2011 **checkwrite** will be released on Wednesday, November 30, 2011.

As always, the release of payments depends on the availability of funds.

ALABAMA MEDICAID AGENCY

ALERT

January 12, 2012

Attention: All Providers

RE: 01/06/12 Checkwrite Release

Due to the holiday on Monday, January 16, 2012, Medicaid will release the payments for the January 6, 2012 checkwrite on Friday, January 13, 2012.

Please verify direct deposit status with your bank.