

Provider Insider

Alabama Medicaid Bulletin

January 2005

The checkwrite schedule is as follows:

1/07/05 1/21/05 2/04/05 2/18/05 3/04/05 3/18/05

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

In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed by the last day of February of the following year. The fiscal year begins October 1 and ends September 30. Listed below are examples of filing deadlines:

- Any inpatient claims with dates of service from October 1 through September 30 that are filed after February 28 of the next year (February 29 if a leap year) will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for retroactive coverage with dates of service from October 1 through September 30 that are filed after February 28 of the next year (February 29 if a leap year) will be denied by EDS. Hospitals must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason. However, a hospital that accepts a patient as private pay before rendering service is not obligated to bill Medicaid if the patient receives retroactive eligibility. In this case, the recipient may be billed.
- Any inpatient claims with dates of service from October 1 through September 30 that are filed after February 28 of the next year (February 29 if a leap year) with third party liability action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to October 1 of the previous fiscal year are considered outdated. Recipients may not be billed.



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Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

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

Patient 1st Case Management Fee

When enrolling as a Patient 1st Primary Care Provider (PMP) it is required that the provider (group or individual) initial the component(s) in which the PMP intends to participate. These components are listed on Attachment C of the Patient 1st Agreement. As a PMP (group or individual) who indicated participation in the component of Electronic Notices additional documentation is required to become a participant. To ensure this component indicator and fee is added to the PMP's file, please make certain to complete and submit the Electronic Delivery Form. The Electronic Delivery Form was made available in the September 2004 Provider Insider is available on the web at:

WWW.MEDICAID.STATE.AL.US; on the home page click PROVIDERS; in the blue box to the left click FORMS; scroll down to the PROVIDER ENROLLMENT heading and select Electronic Delivery Form listed as the tenth bullet.

NOTE: If enrolled as an individual PMP who is also a participant in a group, when completing the claim form, the provider name and number indicated should be that of the group with which the PMP is associated.

The Electronic Delivery Form may be submitted via facsimile to (334) 215-4298 or mailed to the attention of Provider Enrollment at:

P. O. Box 241685, Montgomery, AL 36124

NOTE: If submitting the Electronic Delivery Form via fax, it is not necessary to follow up with an original via mail.

Attention Provider Specialties

In order to ensure the proper billing of an EPSDT Referral, please refer to Chapter 5, Filing Claims, which outlines the appropriate values to place on the claim form. It is very important to complete the claim form with all the applicable fields in order to capture that the service is a result of an EPSDT Screening or Referral. The EPSDT Referral requires the referral to be written on Form 362 which can be found on the Website. If you have any questions about filing EPSDT Referred claims, please contact your Provider Representative at EDS at 1-800-688-7989.

Administrative Review Request Must Be Submitted on New Form 402

All requests for an administrative review of an outdated claim should now be submitted on the new Form 402, Request For Administrative Review Of Outdated Medicaid Claim, in lieu of submitting a letter. Form 402 became effective January 1, 2005. The form can be found on page 3.

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

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

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

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial. In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the final administrative remedy for the following reasons:

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

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

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

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

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

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



Alabama Medicaid Agency

REQUEST FOR ADMINISTRATIVE REVIEW OF OUTDATED MEDICAID CLAIM

This form is to be completed only if the claim is more than one year old as specified on the reverse side.

Section A

Print or Type

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

I do not agree with the determination you made on my claim as described on my Explanation of Payment dated:

Section B

My reasons are:

SAMPLE

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.state.al.us

Form # 402
Created 11/22/04

Alabama Medicaid Agency

New Policy for Ophthalmoscopy Extended and Subsequent

Ophthalmoscopy extended (92225) and subsequent (92226) are considered reasonable and necessary services. Examples of reasonable and necessary services are evaluation of tumors, retinal tears, detachments, hemorrhages, exudative detachments, retinal defects without detachment, and other ocular defects for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem when photography is not adequate or appropriate. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy which requires further detailed study. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. Accordingly, medical record documentation and diagnoses should reflect medical necessity.

Visit Alabama Medicaid
ONLINE



www.medicaid.state.al.us

Providers can :

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

Medicaid Policy for Other Insurance Copayments And Deductibles

When a provider accepts a patient who has both Medicaid and other health care coverage, the provider must file with the patient's other coverage prior to filing Medicaid. Once the primary payer pays or denies a claim, the provider can then submit the claim to Medicaid for coverage of the primary payer's co-payment, coinsurance and/or deductible. Providers should submit the full claim to Medicaid and indicate the amount paid by the primary payer. Medicaid will then deduct that amount from the Medicaid allowed amount and pay the provider the difference if the claim is payable by Medicaid.



Providers are prohibited from collecting the primary payer's co-payments, coinsurance and/or deductibles from the patient for Medicaid covered services. This applies to claims where Medicaid pays the full or partial recipient cost share. It also applies to claims where Medicaid makes no payment because the primary payer's payment exceeds the Medicaid allowed amount and results in no Medicaid payment to the provider.

Policy Clarification for Injections

Medicaid covers administration of injections provided during an office visit as a component of the office visit charge. For example, if a physician sees a patient and diagnoses an infection, the physician may bill an antibiotic in addition to the office visit but not the administration fee. An administration of a routine injection (i.e., codes 90471 and 90782) may not be billed in conjunction with an office visit or a nursing home visit on the same date of service. Effective February 1, 2005, codes 90783 through 90788 are included in the above policy.



REMINDER



Notice for EPSDT Providers

This is a reminder for EPSDT screening providers to use modifier "EP" when filing claims for EPSDT services. Due to HIPAA requirements, use of modifier "EP" became effective 1-1-04. Procedure codes that require use of modifier "EP" are: 99381-99385-EP, 99391-99395-EP, 92551-EP, and 99173-EP. Post payment reviews are performed to determine appropriate utilization of services and are subject to reimbursement adjustments. Please ensure your staff is made aware of this policy

ALABAMA MEDICAID

In The Know

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

Changes Coming for Dental Providers Who Perform Hospital Dentistry

The Dental Program is requiring that providers who perform services in a hospital setting must document the following information in the patient record. Starting in January, the Dental Program will be auditing a percentage of provider records for any child receiving dental services in a hospital setting. This will include recipients under the age of 6 who do not require a prior authorization. If the audit determines that the documentation is not sufficient to prove the necessity of the procedures being performed in the hospital setting, the services can be recouped or claims can be reviewed prior to payment. The information below will be printed in the January Provider Manual and an ALERT is forthcoming. There also continues to be errors in billing incorrect place of service for these cases as well. These instances when found will be referred to the Provider Review Unit and further action will be taken. If you have questions, you can call the Dental Program at 334-242-5472 or 334-353-5959. The policy is as follows:

Effective January 1, 2005, for prior authorization for patients six years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. On children ages 3 through 5, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting. Criteria number 4 (without a physical or mental disability) further requires a report of at least one active failed attempt to treat in the office. This report must include:

- a. recipient's behavior preoperatively
- b. type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
- c. recipient's behavior during the procedure
- d. the use, amount, and type of local anesthetic agent
- e. use and dosage of premedication attempted
- f. use and dosage (% , flow rate and duration) of nitrous oxide analgesia used
- g. procedure(s) attempted
- h. reason for failed attempt
- i. start and end times of the procedure(s) attempted
- j. name(s) of dental assistant(s) present in the treatment room
- k. presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

Attention Vaccine For Children (VFC) Providers

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

Information Concerning Emergency Room Services

Emergency room visits (99281-99285) must be billed with revenue code 450. Any surgical procedures performed in the ER during the emergency room visit must be billed under the appropriate CPT code for the ER facility fee noted above. Surgical procedures performed in an operating room must be billed under the appropriate CPT code with revenue code 360. Surgical procedure codes billed with revenue code 450 will be denied or recouped on retrospective review.

Billing Information for EPSDT Referred Therapy and Independent Radiology Providers

Effectively immediately, as outlined in the March 2004 Issue of the Provider Insider, EPSDT Referred Therapy Providers (those providing services outside the outpatient hospital setting) and Independent Radiology Providers should discontinue billing place of service 99 and use POS 11 (office).



www.medicaid.state.al.us

Urgent Information for Residents and Supervising Physicians

Physicians, when writing medication prescriptions please be sure:

- Handwriting is legible.
- A typed or printed name of the prescriber is on the prescription.
- The pseudo license number for a resident is clearly indicated.

When a prescription is written legibly and thoroughly, it is a win-win situation. For example, there is a faster turn around for reimbursement to pharmacies as well as a substantial decrease in the number of inappropriate letters generated to providers. Outlined below are the Agency's specific guidelines for your information and convenience.

A physician enrolled in and providing services through a residency training program shall not bill Medicaid for services performed. For tracking purposes only, these physicians will be assigned pseudo Medicaid license numbers. Pseudo license numbers must be used on prescriptions written for Medicaid recipients. Pharmacists must have the physician's license number prior to billing for prescriptions. Pharmacies shall use the correct physician license number when submitting a pharmacy claim to Medicaid.



Attention Renal Dialysis Providers

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuing Cycling Peritoneal Dialysis (CCPD) are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis. Providers are to report the number of days in the units field on the claim.

The daily IPD or CAPD/CCPD payment does not depend upon the number of exchanges of dialysate fluid per day (typically 3-5) or the actual number of days per week that the patient undergoes dialysis. The daily rate is based on the equivalency of one week of IPD or CAPD/CCPD to one week of hemodialysis, regardless of the actual number of dialysis days or exchanges in that week.

Important Mailing Addresses

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

EDS Provider Representatives

G R O U P 1

North: Jenny Homler, Karen Hutto, and Lisa Hodge

Bibb, Blount, Calhoun, Cherokee, Chilton, Clay, Cleburne, Colbert, Coosa, Cullman, DeKalb, Etowah, Fayette, Franklin, Greene, Hale, Jackson, Jefferson, Lamar, Lawrence, Lauderdale, Limestone, Madison, Marion, Marshall, Morgan, Pickens, Randolph, Shelby, St. Clair, Talladega, Tuscaloosa, Walker, Winston



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South: Melanie Waybright and Denise Shepherd

Autauga, Baldwin, Barbour, Bullock, Butler, Chambers, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Tallapoosa, Washington, Wilcox

Nurse Practitioners
Podiatrists
Chiropractors
Independent Labs
Free Standing Radiology



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CRNA
EPSDT (Physicians)
Dental
Physicians
Optometric
(Optometrists and Opticians)

G R O U P 2

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



stephanie.westhoff
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334-215-4199



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334-215-4158

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

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home



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

State Fiscal Year 2004-2005 Checkwrite Schedule

01/07/05	04/01/05	07/08/05
01/21/05	04/15/05	07/22/05
02/04/05	05/06/05	08/05/05
02/18/05	05/20/05	08/19/05
03/04/05	06/03/05	09/09/05
03/18/05	06/17/05	09/16/05

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