

# Provider Insider

Alabama Medicaid Bulletin

March 2005

The checkwrite schedule is as follows:

3/04/05 3/18/05 4/01/05 4/15/05 5/06/05 5/20/05

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

## Alabama Department of Senior Services Conducting Statewide Survey

Alabama Department of Senior Services (ADSS) Executive Director Irene Collins announced that the Department is conducting a statewide needs assessment survey to direct Alabama's aging services and prioritize programs for the next decade.

"This is a wonderful opportunity for Alabamians to communicate their concerns about the future of aging services in America. I expect we will hear a lot about opportunities and challenges presented by the baby boom population, as well as federal programs like Medicare and Social Security," said Collins.

According to Collins, the purpose of this survey is to gain input from older adults, caregivers, baby boomers, service providers, organizations and others who are interested in playing a role in the future of aging policy in the state and the nation.

To participate in the survey, call the local area agency on aging at 1-800-AGELINE (243-5463) or the Department at 1-877-423-2243, both of which are toll free. The survey will also be available on the Internet at [www.AGELINE.net](http://www.AGELINE.net).

The results of the survey, beginning in February, will be submitted to the 2005 White House Conference on Aging and will also be used in forming the State Plan on Aging due to the Administration on Aging in 2006.

"Two thousand-six is an important year in aging services in America, as well as Alabama. We are trying to collect as much data as possible to represent the choices and opinions of all Alabamians," said Collins.

Through 13 Area Agencies on Aging and 340 senior centers across the state, ADSS directs programs for more than 800,000 senior citizens and their caregivers by providing services such as congregate and home-delivered meals, legal assistance, insurance counseling, employment assistance, home health services, support for caregivers and many others. For more information call 1-800-AGE-LINE (243-5463) or visit [www.AGELINE.net](http://www.AGELINE.net).



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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 \_\_\_\_\_

## **Bevacizumab (Avastin) Update**

There are two new procedure codes (PC) available to use for billing Bevacizumab. Both codes became available January 1, 2005. The description for code J9035 is "injection, bevacizumab, 10 mg". The description for code S0116 is "bevacizumab, 100 mg". As a reminder, Avastin will be covered only if it is given as a combination treatment along with standard chemotherapy drugs for colon cancer, e.g., Fluorouracil, Leucovorin, Oxaliplatin, and Irinotecan. Providers must bill the other standard chemotherapy drug(s) being used with Avastin on the same claim form. Please be sure to use the description of the code to assist you in determining the code and max units to bill.

## **EDS Provider Reps Need Your Help**

The Provider Representatives are researching potential barriers that may be preventing claims from crossing over to Medicare from Medicaid. If you are experiencing problems with your claims crossing over, please contact your Provider Representative with the following information:

- The Medicare Carrier
- The Recipient's HIC Number
- Date of Service
- Date Medicare Paid
- Your provider number

We would like recent, specific examples you may be experiencing. You may contact your provider representative by calling 1-800-688-7989.



[www.medicaid.state.al.us](http://www.medicaid.state.al.us)

## **Anti-infective Agents added to the Preferred Drug List**

Effective March 1, 2005, the Alabama Medicaid Agency will require prior authorization (PA) for payment of non-preferred brands of Anti-infective agents. A list all of Alabama Medicaid's preferred agents to include the Anti-infective agents is available at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

Also, effective March 1, 2005, the Alabama Medicaid Agency will require prior authorization (PA) for payment of generic Oxycontin.

The PA request form can be found on the Agency website at [www.medicaid.state.al.us](http://www.medicaid.state.al.us), and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. According to regulations, requests may be called in, faxed or mailed to:

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



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

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

## **New Operating Microscope Policy**

Effective January 1, 2005, the use of an operating microscope (code 69990) may be paid separately **only** when submitted with the following CPT codes: 61304-61546, 61550-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64871, 64885-64891, 64905-64907. Changes will be included in the next Provider Manual update in Chapter 28, Physician's.



## **REMINDER**



### **Notice for Vaccine for Children Providers**

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

## ***Age Change for Dental Cases in the Hospital***

For claims processed on or after April 9, 2005, the Dental Program is dropping the age to five years old for prior authorization with hospital cases. This change was coordinated with the Dental Task Force with input from professional dental associations and the UAB School of Dentistry. Medicaid currently requires that providers who perform services in a hospital setting to document the information below in the patient's record. The Dental Program will be auditing a percentage of provider records for any child receiving dental services in a hospital setting. This will include all recipients and not just those who do 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 subsequent claims can be reviewed prior to payment. The information below has been printed in the January Provider Insider and the January Provider Manual. There continues to be errors in billing incorrect place of service for these cases. 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:

For prior authorization for patients FIVE years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization
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.

## **Policy for Vision and Hearing Screenings for Children**

Children should receive an objective (measurable) vision screening at 3 years of age. An objective (measurable) hearing screening should be performed at 5 years of age. If a child is uncooperative, document the reason in the medical record and reschedule an appointment to complete the tests. For billing purposes, proceed to bill the test(s) using the same date of service (DOS) as the comprehensive well child check-up. Documentation of well child check-ups is subject to post-payment reviews to ensure children are receiving comprehensive services as specified in Appendix A of the Provider Manual.

## **New Code for Dental Providers**

CDT2005 has been published and only requires one change for dental providers. D7281 Surgical exposure of impacted or unerupted tooth was deleted. Medicaid replaced this code with D7280 Surgical access of an unerupted tooth with the same reimbursement of \$116.00.

## **Medicaid Payment for Health Insurance Premiums**

When it is cost effective to do so, Medicaid is paying individual and group health insurance premiums for Medicaid-eligible individuals who have a high cost medical condition and can not longer continue to pay their premiums. This includes individuals who lose their job or are unable to continue working due to a medical condition and who are eligible for continuation of their health insurance through COBRA. Because individuals only have sixty days to elect COBRA coverage, we encourage providers to refer patients who meet the criteria for coverage to Medicaid as quickly as possible. For more information about Health Insurance Premium Payment Program or to request a presentation, please contact Ozenia Patterson at (334) 242-3722.

## **Update - Emergency Services for Non-Citizens**

### **Miscarriages**

Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid continue to be processed manually, until further notice. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the Sobra worker, who determines eligibility; then forwards information to Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.

### **Delivery Services Billable Through EDS**

Procedure code 01967 has been added to the list of codes billable through EDS for medical claims.

The Type of Admission restriction for type of admission "1" has been removed for UB-92 inpatient claims.

For CMS-1500 (formerly HCFA-1500) medical claims, the following procedures are covered:

- 59409 – vaginal delivery only
- 59612 – vaginal only, after previous c-section
- 59514 – c-section only
- 59620 – c-section only, after attempted vaginal, after previous c-section
- 01960 – vaginal anesthesia
- 01961 – c-section anesthesia
- 01967 – neuraxial labor analgesia/anesthesia
- 62319 – epidurals

For UB-92 inpatient claims, the following per diem is covered:

- Up to 2 days per diem for vaginal delivery
- Up to 4 days per diem for c-section delivery

Allowable diagnoses code for CMS-1500 or UB-92:

- |               |              |     |
|---------------|--------------|-----|
| V270 – V279   | V300 – V3921 | 650 |
| 65100 – 65993 | 6571 – 6573  |     |

Allowable surgical codes for UB-92 are 740 – 7499.



## **REMINDER**



### **Notice for EPSDT Providers**

Preventive health services are only available to eligible children under 21 years of age. Preventive health services are well child check-ups (EPSDT screenings) and immunizations. Well child check-up services are reimbursable if the provider has signed an agreement with Medicaid to participate in the screening program. The administration fee for immunizations designated as VFC are reimbursable if the provider has signed an agreement with the Vaccines For Children Program administered by the Department of Public Health. Annual routine physical exams are not covered for eligible recipients 21 years of age and older.

The only preventive health services the Agency reimburses for are for well child check-ups (EPSDT screenings) and immunizations. Annual routine physical exams are not covered.

# ALABAMA MEDICAID

## ***In The Know***

### **The Alabama Medicaid Agency is now Accepting Modifier 59 for Certain Procedures**

**A**ccording to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive /component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive / component coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as rebundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive / component coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled, or allowed separately, in certain situations. If the two services are performed at two different times of day or the services are performed in two different anatomical sites, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the comprehensive / component code pair unbundling, diagnoses codes and anatomical modifiers must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a copy of the Operative Report to further explain the reason for the unbundling of code pairs.

Modifier 59 should never be used in any other circumstances and is subject to post payment review. If the services performed and billed for a date of service does not include a coding pair described above, then modifier 59 is not valid or appropriate.

The Alabama Medicaid Agency does not recognize Modifier 59 for Evaluation and Management codes.

## **TPL Policy on EPSDT and Preventive Services**

Medicaid is a secondary payer to all available third party resources. Providers are not required, however, to file with a patient's insurance first if the service is for EPSDT/Preventive Services (immunizations) unless the patient is enrolled in a managed care plan/HMO or Medicaid pays the provider on an encounter or capitation basis. Medicaid will file with the patient's other coverage for these services if the provider does not do so; however, there may be instances where Medicaid will have to request additional information from the provider for claims submitted with a non-standard CPT code.

### **New Vaccine For Children (VFC) Code**

A new procedure code has been added to the VFC list of vaccines. The description for code 90656 is "Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use". The code was added 1-1-05. Appendix A (EPSDT) of the manual will be updated to reflect this addition.

### **No Changes in the Immunization Schedule**

The childhood and adolescent immunization schedule for 2005 is unchanged from that published in April 2004. The catch-up immunization schedule for (children and adolescents who start late or who are greater than 1 month behind) remains unchanged from that published in January and in April 2004.

### **Claims Processing for ICD-9 Codes have Changed**

Effective for claims processed March 1, 2005, and thereafter, Medicaid began validating the diagnosis code to the highest subdivision. ICD-9 diagnosis codes that are not to the highest subdivision will be rejected.

[www.medicaid.state.al.us](http://www.medicaid.state.al.us)

## **DME Updates Prior Authorization Changes for Diapers**

Prior authorizations approved in 2004 for diapers with procedure codes A4521, A4522, A4523, A4524, A4529, and A4530 will be honored for dates of service through December 31, 2005. Prior authorization (for diapers) requested on or after January 1, 2005 will be considered for approval using procedure codes T4521, T4522, T4523, T4524, T4529, T4530



### **Miscellaneous Durable Medical Equipment**

Procedure codes E1399 or E1399 (EP) should be entered on a claim as one line item. The money amounts for multiple items approved on a prior authorization request for E1399 or E1399 (EP) should be combined and the total money amount billed as one lump sum. If each approved item on a prior authorization request is billed as a separate line item on the same date of service, for the same prior authorization number, the claim will deny as a duplicate.

### **Male External Catheter**

Effective January 1, 2005 procedure code A4347 (male external catheter, with or without adhesive, with or without anti-reflux device, per dozen) was deleted and replaced with A4349 (male external catheter, with or without adhesive, disposable, each). If you have any question, please call Ida Gray at 334-293-5577.

### **Gloves**

Effective March 1, 2005, procedure code A4927 (gloves) will be reimbursed as follows: \$10.00 per box of gloves (100 per box), gloves will be limited to two boxes per month per recipient.

### **Oxygen**

For initial certification for oxygen, the DME supplier and its employees may not perform the ABG study or oximetry analysis used to determine medical necessity.

Effective January 1, 2005, for recertification for oxygen only following qualifying sleep study which allows for approval of nocturnal oxygen, the DME supplier may perform the oximetry analysis to determine continued medical necessity for recipients receiving nocturnal oxygen only. A printed download of oximetry results must be submitted with prior authorization request. Hand written results will not be accepted.

### **Provider Manual**

The Durable Medical Equipment information in the Medicaid Provider Manual has been divided into two sections. The first section is Chapter 14 Durable Medical Equipment (DME). The second section is Appendix P which contains Durable Medical Equipment (DME) Procedure Codes and Modifiers. If you have any questions please contact Ida Gray at (334) 293-5577

### **Billing Information Concerning IDPN**

Dialysis providers, DME providers and Pharmacy providers have inquired about billing for intradialytic parenteral nutrition (IDPN). Routine parenteral items are included in the dialysis facility composite rate (for hemodialysis) and may not be billed separately. This includes medications and supplies used in providing intradialytic parenteral nutrition. If you have any questions, please contact the Renal Dialysis Program at (334) 242-5630.

# 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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334-215-4132

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



**tracy.ingram**  
@alix.slg.eds.com  
334-215-4158

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

## G R O U P 3

Ambulatory Surgical Centers  
ESWL  
Home Health  
Hospice  
Hospital  
Nursing Home



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

**State Fiscal Year 2004-2005 Checkwrite Schedule**

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

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Medicaid  
Bulletin**



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