

# Provider Insider

Alabama Medicaid Bulletin

September 2006

The checkwrite schedule is as follows:

07/07/06 07/21/06 08/04/06 08/18/06 09/08/06 09/15/06

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

## New Version of Provider Electronic Solutions Software Is Now Available

**E**DS has released a new version of the Provider Electronic Solutions software. The new version (2.06) is now available, and contains the following enhancements:

- Nursing Home Providers: The **EDIT ALL** feature now updates the 'date of service' (service Tab) on all associated claim-details using the 'from' date of service on the header tab.
- Users can now archive Household Inquiry forms.
- Account Number requirement was removed from Eligibility Verifications (270 Transactions).
- Account Number requirement was removed from NCPDP Claim reversals.
- Communication Log message was repositioned to display all parts of messages returned to users.
- The untimely 'archive your claims' message was removed.

Provider Electronic Solutions version 2.06 (full install and upgrade) can be downloaded from the Alabama Medicaid website. To download the software, go to the Alabama Medicaid website at:

<https://almedicalprogram.alabama-medicaid.com/secure/logon.do>. Click on WEB Help, scroll down to the software download section, and download the software. If you currently have any software version prior to 2.05 installed, you must upgrade to 2.05 **BEFORE** attempting to upgrade to 2.06. For further assistance, or to request the software on CD, please contact the ECS helpdesk at 1-800-456-1242.



## In This Issue...

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

PA Request for Ambulance .....	3
Sleep Studies Must be Billed With Correct Provider Number .....	4
An Oral Health Reminder .....	4
New Procedure for Billing Bilateral Procedures .....	4
Alabama Medicaid: In The Know .....	5
Attention DME Providers .....	6
Revised Billing Instructions for ESDST Referred Services .....	6
Important Mailing Addresses .....	6
Patient 1 <sup>st</sup> Recipient Dismissals .....	7
Patient 1 <sup>st</sup> InfoSolutions .....	7
State Fiscal Year 2006-2007 Checkwrite Schedule .....	8

## Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- Office Manager
- Billing Dept.
- Medical/Clinical Professionals
- Other \_\_\_\_\_

## **Prior Authorization Needed For Orenzia and Kineret**

Effective September 1, 2006, injectable drugs Orenzia and Kineret will require prior authorization as Biologicals through Health Information Designs (HID) prior to treatment. Although these drugs have not been assigned HCPCS codes, you must request the Prior Authorization using procedure code J3490. After receiving authorization from HID, a CMS-1500 paper claim must be submitted to EDS including the dosage and NDC number. The letter of approval from HID must be attached to the claim, and "attachment" in block 19. These drugs must be approved through HID prior to administering and billing. HID may be contacted at 1-800-748-0130. The Prior Authorization forms are located on our website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

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

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

## **Lead Poison Screening is Essential**

Remember, it is essential to screen all children at ages 12 and 24 months for lead poisoning. Report ALL levels > 10ug/dL to the Health Department using the ADPH-FHS-135 form. Forms and educational materials are available at the Health Department's website [www.adph.org/ac1ppp](http://www.adph.org/ac1ppp). For any questions, please call 1-334-206-2966 or 1-800-545-1098. Keep Alabama's kids lead free!



[www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

## **Change In Definition Of Global Surgical Packages**

Effective for dates of adjudication October 1, 2006 and thereafter, Medicaid will adopt Medicare's RVU file designation for global surgical days. In the past and through September 30, 2006 adjudication, Medicaid has used a **62 day** post op period after major surgeries.

Effective for dates of adjudication October 1, 2006 and thereafter, Medicaid will use a zero, 10 day, and 90 day post op period for routine surgical care. Please refer to the Alabama Medicaid Agency Provider Manual, Chapter 28, for a revised listing of the 10 day post op codes.

The codes listed for the 10 day post op period should **not** be billed with an office visit within 10 days of surgery, for routine care. Claims for these services will be subject to post payment review.

The 90 day post op period codes will not be published in the Provider Manual. Post operative office, hospital, or outpatient visits for routine surgical care should **not** be billed as, they are considered inclusive of the global surgical package.



## **SSI Certified Women and Unborn Numbers**

Since the SSA certifies women for SSI, Medicaid is unable to assign unborn numbers for them. There were 937 births in Alabama for SSI women for FY 2005.

The Medicaid Agency has a form that is currently being used, Newborn Certification Form 284. Care coordinators, SOBRA eligibility workers and all hospitals have access to this form. They have been instructed to assist SSI women in completing this form.

Newborn charges in the day after the child's birth when the mother is still in the hospital may be billed using the mother's Medicaid number include:

1. Routine newborn care (99431, 99433, and discharge codes 99238 and 99239)
2. Circumcision (54150 or 54160)
3. Newborn resuscitation (99440)
4. Stand-by services following a caesarian section or a high-risk vaginal delivery (99360)
5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99436)

Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or non-delivering OB-GYN is on stand-by in the operating or delivery room during a caesarian section or a high-risk vaginal delivery. Attendance of the stand-by physician in the hospital operating or delivery room must be documented in the operating or delivery report.

Use CPT codes when filing claims for these five kinds of care.

If the services are billed under the mother's name and number and the infants are twins, indicate Twin A or Twin B in Block 19 of the claim form.

Any care other than routine newborn care for a well baby, before and after the mother leaves the hospital, must be billed under the child's name and number.

## **Clarification: TPL Policy On EPSDT / Preventive Services**

Alabama Medicaid is a secondary payer to all available third party resources. If the patient is enrolled in a HMO or Medicaid pays the provider on an encounter or capitation basis, the patient's other insurance must be filed first when billing for any type of EPSDT screening.

If the patient is not enrolled in a HMO or Medicaid does not pay the provider on an encounter or capitation basis, EPSDT screenings (99381EP-99385EP and 99391EP-99395EP) and immunizations may be billed to Medicaid first.

Interperiodic screenings (procedure codes 99391-99395-without an EP modifier) must always be filed with the patient's other insurance first. If the primary insurance is a HMO, the age appropriate interperiodic screening code must be submitted. Once the claim has been paid/denied, Medicaid may then be billed utilizing the interperiodic screening code that was submitted to the HMO.

If the primary insurance is not a HMO, bill the appropriate "office visit" code. Once the claim has been paid/denied from the patient's other insurance, a claim may be filed with Medicaid utilizing the same "office visit" code. When billing an office visit code for an interperiodic code, the following referral information must be on the claim form filed to Medicaid, in order to bypass benefit limitations:

Block 17 – Patient 1<sup>st</sup> or EPSDT provider name

Block 17a – Patient 1<sup>st</sup> or EPSDT provider number

Block 24h – If the child is assigned a PMP, then enter a "4"

If the child is not assigned a PMP, then enter a "1"

### **PLEASE NOTE: VERY IMPORTANT**

If any other treatments are provided the same day (injections, lab, etc.), a "1" or "4" must also be reflected in Block 24h, **on each line item**, or the claim will deny.

## **PA Requests for Ambulance**

Please note the following billing instructions for submitting a PA request:

A Prior Authorization is not required for services provided to QMB only recipients (Aid Category 95) since Medicaid is only responsible for the co-insurance and/or deductible. You must file the service to Medicare then if the service does not automatically crossover from Medicare to Medicaid, then you submit the Medicaid/Medicare related claim to Medicaid. (For additional information regarding the different Aid Categories for Medicaid eligibles, please refer to Medicaid Provider Manual, Chapter 3, Verifying Recipient Eligibility.

All PA requests must be submitted within 30 business days from the date of service with the exception of those involving Retro eligibility. If not submitted within this time frame, it is considered by the Alabama Medicaid Agency to be a provider correctable error, and the recipient must not be billed.

If additional information is required, please contact Carol Akin @ 334-242-5580 or Janice O'Neal at 334-353-4771. For billing instructions please call Karen Hutto at 334-215-4158 or Laquita Thrasher at 334-215-4199.

## **Changes for Interactive Transactions will Affect Users and Vendors**

Currently the Provider Electronic Solutions software permits users to submit an interactive transaction to Alabama Medicaid by pressing a 'submit' button on the related screen. Beginning May 23, 2007 interactive transactions will no longer be available through Provider Electronic Solutions or through a vendor software which currently utilizes the interactive toll-free dial-up service. The following interactive transaction types are currently permitted:

Eligibility inquiry

Claim status inquiry

Household inquiry

NCPDP drug claim submission, reversal and eligibility inquiry

### **Impact to PES users**

Beginning May 23, 2007, Provider Electronic Solutions will only be utilized for batch transactions. Dial-up interactive transactions will be accommodated in the following three ways:

Users without an Internet Service Provider may connect to the Remote Access Server (RAS) with an Internet browser such as Microsoft Internet Explorer or Netscape as outlined by chapter 17 within the current Provider Electronic Solutions User Manual. Once connected to the RAS server, the user may access the new Web Portal and perform the same interactive transactions listed above by means of an interactive form to enter and submit such requests. The RAS dial-up connection will also become a toll-free line.

- Users with an internet service provider may connect directly to the new Web Portal to perform these transactions.
- Users may contract with a clearinghouse to perform these interactive transactions.

User Training will be made available in 2007. This training will include changes made to Provider Electronic Solutions as well as instructional guidance to complete an interactive transaction using the forms available on the new Web Portal.

### **If you use a software vendor**

Software vendors are also being notified of this change. If you have a question about whether this change will impact your vendor supplied software, please contact your vendor.



# ALABAMA MEDICAID

## ***In The Know***

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

#### ***Guidelines Regarding the Alabama Medicaid Agency Referral Form***

The following are guidelines regarding the Agency Referral Form (form 362) including cascading referrals. There are up to six different types of referrals.

1. A **Patient 1<sup>st</sup> referral** is for a recipient who is assigned to a Patient 1<sup>st</sup> provider (PMP). This type of referral is for Patient 1<sup>st</sup> recipients only.
2. A **Lock-in referral** is for a recipient that is locked into one physician/pharmacy and must have a referral to see anyone other than their lock-in physician.
3. An **EPSDT referral** is for a referral resulting from an EPSDT screening (for the diagnoses suspected/made during the exam) of a recipient who is not enrolled in the Patient 1st program
4. A **Patient 1<sup>st</sup>/EPSDT referral** is for a recipient who is assigned to a PMP and has received an EPSDT screening. In this case, a recipient is being referred by the PMP or on behalf of the PMP to another provider for diagnoses suspected/made during the EPSDT exam.
5. A **Case Management referral** – is for a recipient being referred to a case manager for “at risk” recipients. A list of care coordinators is available on the Agency’s website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).
6. **Other referral** – is used when a Medicaid provider is referring any recipient to another provider. The blank space under “Type of Referral” may be used for this purpose.

Important things to keep in mind about referrals are:

- A written referral is required and indicates approval for a consultant/specialist to see a patient for further diagnosis and/or treatment. A written referral must be completed and furnished to the consultant/specialist within 72 hours if oral authorization is given. Failure to provide a written referral form may prevent the consultant/specialist from being paid.
- It is possible for more than one referral to be checked in the “Type of Referral” field – e.g., Patient 1st and Case Management/Care Coordinators.
- Date of screening (which is the **date the actual screening was performed**) needs to be indicated if an EPSDT or Patient 1<sup>st</sup>/EPSDT referral is being authorized. This is a **mandatory field**.
- The referral date may be different from the date of the screening.
- A copy of a referral form must be kept in a recipient’s medical record for each provider who renders service(s).
- A cascading referral is used in situations where a physician thinks more than one consultant may be needed to provide treatment for identified condition(s). When this situation arises, the original referral form is generated from the PMP. If the first consultant determines a recipient should be referred to another consultant/specialist, it is his responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission.
  - ◆ The appropriate block to mark on the referral form for a cascading referral for a **single** condition is labeled “Referral to other provider for identified condition”. The appropriate block to mark on the referral form for a cascading referral for **multiple** conditions is labeled “Referral to other provider for identified conditions”.
- All consultants should furnish written results of findings to the referring provider or PMP (if different) promptly. Patient 1<sup>st</sup> and EPSDT providers are responsible for appropriate referrals and follow-up.

Lastly, the Agency is in the process of updating the current referral form for clarification purposes. Please continue to monitor the Provider Insider for future updates and notifications. If you have any questions, please visit our website address listed above or you may contact the Outreach & Education Unit at 334-242-5203.

## **Attention DME Providers**

Effective August 1, 2006, reimbursement for home blood glucose monitors are limited to one per recipient every five years. The home blood glucose monitor no longer requires prior authorization.

For recipients with insulin dependent diabetes, blood glucose test strips or reagent strips are limited to 3 boxes (50 per box) each month. Lancets are limited to 2 boxes (100 per box) each month. For recipients with non insulin dependent diabetes, blood glucose test or reagent strips are limited to 2 boxes (50 per box) each month. Lancets are limited to 1 box (100 per box) each month.

When providing diabetic supplies for Medicaid patients who also have Blue Cross Blue Shield (BC/BS) of Alabama coverage it is important to verify the specific plan coverage. Some plans cover diabetic supplies through the Pharmacy only. If the recipient is covered by a BC/BS plan which requires diabetic supplies to be billed through the pharmacy program using a NDC the recipient and your business is not enrolled as a pharmacy you should refer the patient to a local pharmacy. Any questions regarding plan coverage should be referred to the plan, not Medicaid.

Procedure code A4256 (Normal, low high calibrator solution/chips) is now limited to 4 units per year per recipient.

Currently procedure code E0480 (percussor) is covered as a rental to purchase item.

Effective September 1, 2006, procedure code E0480 will be reimbursed as a purchase item.

Effective September 1, 2006, procedure code A9900 (miscellaneous DME supply, accessory, and/or service component of another HCPC code) will be deleted as a covered by Alabama Medicaid.

Effective October 1, 2006, DME provider will no longer be reimburse for CPT code 99503 (respiratory therapist visit).

If you have any additional questions or need further clarification, please contact Ida Gray, at (334)-353-4753.

**[www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)**

## **Revised Billing Instructions for EPSDT Referred Services**

If you file hard copy claims on the UB-92, you must complete the following fields:

- Block 2 – Enter the screening provider's nine-digit provider number
- Block 24 – Enter "A1" to indicate EPSDT

If you file electronically on the UB-92 (837 Institutional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's nine-digit Medicaid provider number
- Block 24h – Enter "1" to indicate EPSDT

If you file electronically on the CMS-1500 (837 Professional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

### **For Patient 1<sup>st</sup> and EPSDT Referred Services**

If you file claims on the **UB-92**, you must complete:

- Block 2 – Enter the referring PMP's nine-digit provider number
- Block 24 – Enter "A1" to indicate EPSDT and managed care

If you file electronically on the UB-92 (837 Institutional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of referring PMP
- Block 17a – Enter the referring PMP's nine-digit Medicaid provider number
- Block 24h – Enter "4" to indicate EPSDT and managed care

If you file electronically on the CMS-1500 (837 Professional) using EDS Provider Electronic Solutions software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

**Please note: Each line item on the claim form must have an indicator in block 24 or 24h if billing for a referred service.**

**For example: If the first line is an office visit and the indicator in block 24 or 24h is a "4", all additional services for that date of service must also have an indicator of "4" in block 24 or 24h or the claim will deny.**

### **Important Mailing Addresses**

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

## Patient 1<sup>st</sup> Recipient Dismissals

At times, the need may arise for Primary Medical Providers (PMPs) to dismiss recipients from their panel. Please be aware a PMP may request removal of a recipient from their panel for good cause. According to the guidelines listed in the 1915(b)(i) waiver of the Social Security Act which allows operation of the Patient 1<sup>st</sup> program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a Patient 1<sup>st</sup> recipient may be dismissed for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the recipient.

Any dismissals made to the PMP's panel should be with the understanding no individuals eligible to enroll in Patient 1<sup>st</sup> will be discriminated against on the basis of health status or the need for health care services. Further, the PMP must accept individuals in the order in which they apply without restriction up to the limits set by the PMP and the Agency.

It is the responsibility of the PMP to inform both the recipient and Medicaid of the intended dismissal. The PMP should send a letter of dismissal to the recipient indicating the reason for the dismissal and include a copy of the letter as an attachment to documentation sent to Medicaid. The copy sent to the Agency should include the Provider's name and provider number (as enrolled in the Patient 1<sup>st</sup> program) the recipient's Name (if not the addressee) and Medicaid number. The dismissal letter should be addressed to the recipient or responsible party and signed by the PMP or their approved designee.

Another PMP, not one in the same group as the original PMP, will be selected for the recipient. The recipient will be given the opportunity to change the selected PMP before the active assignment date to the new PMP. **The original PMP must continue to provide services and/or make referrals for services on behalf of the recipient until such time the reassignment to another PMP becomes effective.**

Dismissal requests should be faxed to Medicaid at (334) 353-3856.

## Patient 1<sup>st</sup> InfoSolutions

The Agency has partnered with Blue Cross/Blue Shield to offer InfoSolutions to Patient 1<sup>st</sup> and other Medicaid providers. InfoSolutions is a product that can provide physicians with pharmacy information about assigned recipients on their Patient 1<sup>st</sup> panel. This information can be accessed through a desktop system or be synchronized with a PDA. Additionally, information is available on Epocrates which includes Medicaid information on drug coverage, prior approval and overrides.

InfoSolutions is made available to assist in achieving the Agency goal of reducing pharmacy expenditures through appropriate utilization and knowledge of Medicaid's Preferred Drug List (PDL). Use of this product is voluntary, however; an additional fifty cents is included in the monthly case management fee for each recipient on a provider's panel when this service is utilized.

Medicaid monitors the use of this product by participating Patient 1<sup>st</sup> providers on a quarterly basis. If program monitoring shows the product has not been utilized in three (3) or more months the case management fee associated with this product will be suspended. If continuing monitoring of the program shows future usage by the provider, the case management fee will be reinstated for this component. Below is the quarterly schedule for suspension/reinstatement of the InfoSolutions case management fee:

January/February/March	Review usage in April	Suspend/Reinstate in May
April/May/June	Review usage in July	Suspend/Reinstate in August
July/August/September	Review usage in October	Suspend/Reinstate in November
October/November/December	Review usage in January	Suspend/Reinstate in February

If you are a Medicaid provider who is not currently using this product and you want more information about InfoSolutions or a participating Patient 1<sup>st</sup> provider who is having problems accessing InfoSolutions, please visit the InfoSolutions website at [www.infosolutions.net](http://www.infosolutions.net) or contact Paige Clark at (334) 242-5148.

**State Fiscal Year 2006-2007 Checkwrite Schedule**

10/06/06	01/05/07	04/06/07	07/06/07
10/20/06	01/19/07	04/20/07	07/20/07
11/03/06	02/09/07	05/11/07	08/10/07
11/17/06	02/23/07	05/25/07	08/24/07
12/08/06	03/09/07	06/08/07	09/07/07
12/15/06	03/23/07	06/22/07	09/14/07

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