

# Provider Insider

Alabama Medicaid Bulletin

May 2008

## Medicaid Requires a Dispense as Written Override

Effective May 1, 2008, the Alabama Medicaid Agency will require an override for a brand name drug with an exact generic equivalent submitted with a Dispense as Written (DAW) code of 1.

Currently, a pharmacist submitting a DAW code of 1 requires brand medically necessary (BMN) certification written on the face of the prescription in the physician's own handwriting. Beginning May 1, 2008, for a brand name drug that has an exact generic equivalent to be approved, the provider must request an override that documents medical necessity for the need of the brand rather than the available generic equivalent. This override applies to those instances where the prescriber has written a prescription for a brand name drug when a pharmaceutically and therapeutically equivalent drug product is available generically.

For approval, a Pharmacy Override Request Form 409 along with a Food and Drug Administration (FDA) MedWatch Form 3500 must be submitted including the clinical basis for the reason the generic equivalent is not clinically appropriate. Completed MedWatch forms will be forwarded to the FDA to report issues relating to the quality, authenticity, performance, or safety of the medication. A provider's unwillingness to complete a form or a patient's unwillingness to take generic drugs do not constitute appropriate clinical basis. Overrides may be approved for up to 12 months; renewals will not require an additional FDA MedWatch form to be submitted. Excluded from this process are carbamazepine, levothyroxine, phenytoin, and warfarin products. Override forms and more information on criteria can be found on the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov); click on Programs / Pharmacy Services / Override Criteria and Forms.

Override request forms can be 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

Providers with policy questions concerning the DAW override may contact:

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



## In This Issue...

Medicaid Requires a Dispense as Written Override .....	1
Eyeglasses "New Lenses Only" .....	2
CPT "Unlisted Services and Procedures" .....	2
Requirements for Hospital Cost Reports .....	2
Attention Nursing Home Providers .....	2
VTC With Third Party and Medicaid Coverage .....	2
IV/GA Permit for Dental Providers .....	2
2006 ADA Claim Form Required for Paper Dental Claims .....	3
Pulse Oximetry Information .....	3
EDS Provider Representative Contact Information .....	3
State Fiscal Year 2008-2009 Checkwrite Schedule .....	4

## 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 \_\_\_\_\_

## **Eyeglasses “New Lenses Only”**

Recipients who have old frames that meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lenses only.

Physicians should include the following statement in the recipient’s record: “I hereby certify that I used this patient’s old frames and that I did not accept any remuneration therefore.”

## **CPT “Unlisted Services and Procedures”**

Unlisted CPT codes require prior authorization before services are rendered. Whenever unusual procedures are performed and there is no exact descriptive CPT code, AMA requires the most appropriate CPT code be utilized with a modifier 22.

## **Requirements for Hospital Cost Reports**

Alabama Medicaid will be amending its State Plan to require that hospitals must submit electronic versions of the Medicare cost report with Medicare as well as Medicaid sections completed beginning with the fiscal years ending in 2008 and thereafter. These must be submitted electronically to *Terry.Bryant@medicaid.alabama.gov*. If there are any questions, please contact Terry Bryant at 334-242-2301.

## **Attention Nursing Home Providers**

Providers are submitting two sided page layouts of the Minimum Data Set (MDS) as part of the documentation requirements for the monthly audit to APS. Once the document is faxed in to APS it is being scanned and converted to an electronic document. Only one side of the document is being captured. Effective immediately, please fax only single pages to APS. If you have any questions please contact Nancy Headley at (334) 242-5684.

## **VFC with Third Party and Medicaid Coverage**

The following information summarizes the use of Vaccinations for Children (VFC) vaccines and billing procedures:

1. Children, who have vaccination coverage through a third party carrier (with or without deductibles), and do not have Medicaid, must file on their primary insurance and would not be considered “VFC eligible”.
2. Children who do not have vaccination coverage through a third party carrier, and do not have Medicaid, are considered under insured and would qualify for vaccinations through the VFC Program. This service would be provided at FQHCs, RHCs, etc... for these individuals.
3. Children who have traditional insurance such as Blue Cross/Blue Shield (with or without deductibles), and have Medicaid coverage, are eligible to receive vaccinations through the VFC Program. Providers may bill Medicaid for the appropriate administration fee without having to bill the third party carrier first.
4. Children who are covered with an HMO and Medicaid qualify for vaccination with a VFC vaccine. However the provider must file with the primary insurance first before billing Medicaid.

## **IV/GA Permit for Dental Providers**

According to Chapter 13 in the Alabama Medicaid Provider Manual Dental providers are required to have a current state board IV/GA permit to bill for procedures D9220 and D9241. Also the Alabama Medicaid Provider Enrollment Application Check List indicates that Dental providers must submit a copy of their IV Sedation/GA permit with the provider application. Effective June 1, 2008, the IV/GA permit will be required for reimbursement of procedures D9220 and D9241. You may mail a copy of your permit to EDS Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124.



## **SPECIAL NOTICE**

### **Patient 1<sup>st</sup> Providers**



**F**or Patient 1<sup>st</sup> providers who electronically receive the initial Patient 1<sup>st</sup> report and the enrollment roster, and you want to continue to receive the reports together you must:

- Use your trading partner ID issued through ECS or your software vendor, or obtain a managed care trading partner ID

## 2006 ADA Claim Form Required for Paper Dental Claims

Effective June 1, 2008, all Medicaid dental providers must use the 2006 version of the American Dental Association (ADA) Dental Claim Form for claims which are filed on paper. Any paper claim received which is not on this form will be returned to the provider without being processed. Forms can be ordered from any vendor which supplies the 2006 version of the ADA Dental Claim Form.

Dental providers are encouraged to file all claims electronically. Exceptions for electronic filing include but are not limited to:

- Claims with Third Party Liability denials must come on paper with the remittance advice from the other insurance attached
- Claims that need an override for the root canal when root canal is not in the Medicaid system must come on paper with the x-ray attached.

Providers have several options to file claims electronically. Provider Electronic Solutions or Medicaid's Interactive Web Portal is available at no charge for electronic claims submission. Providers may also choose a software vendor for claims submission.

Any questions about using Provider Electronic Solutions or the Interactive Web Portal should be directed to your Provider Representative at 1-800-688-7989.

The attached instructions outline the fields required by Medicaid for the ADA Dental Claim Form for all claims received on or after June 1, 2008. Please note that these guidelines are now the same as the ADA guidelines for completing the paper dental claim form. In the future, Medicaid will follow any changes set forth by ADA guidelines.

### Pulse Oximetry Information

Non-invasive ear or pulse oximetry services (procedure codes 94760-94762) are considered bundled services and, therefore, are not separately reimbursable. The only time these services are separately payable are when they are medically necessary and there are no other services payable under the physician fee schedule billed on the same date by the same provider. Non-invasive ear or pulse oximetry services are subject to post-payment review and adjustment.

## EDS Provider Representative Contact Information

To speak to a provider representative, providers can call the toll-free number and request the appropriate group category for the provider. The toll-free number is 1-800-688-7989 and the group categories are listed below:

### Group 1

Nurse Practitioners  
Podiatrists  
Chiropractors  
Independent Labs  
Free Standing Radiology  
CRNA  
EPSDT (Physicians)  
Dental  
Physicians  
Optometric  
(Optometrists and Opticians)



### Group 2

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  
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

### Group 3

Ambulatory Surgical Centers  
ESWL  
Home Health  
Hospice  
Hospital  
Nursing Home  
Personal Care Services  
PEC  
Private Duty Nursing  
Renal Dialysis Facilities  
Swing Bed



**Revised State Fiscal Year 2008-2009 Checkwrite Schedule**

10/05/07	01/04/08	04/04/08	07/11/08
10/19/07	01/18/08	04/18/08	07/25/08
11/02/07	02/08/08	05/02/08	08/08/08
11/16/07	02/22/08	05/16/08	08/22/08
12/07/07	03/07/08	06/06/08	09/05/08
12/14/07	03/21/08	06/20/08	09/12/08

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Medicaid  
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