

Provider Insider

Alabama Medicaid Bulletin

November 2008

The checkwrite schedule is as follows:

11/07/08 11/21/08 12/05/08 12/12/08 01/02/09 01/16/09

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

New Paper Medicaid/Medicare Related Claim Form Available in January

Medicaid is revising the paper Professional Medicaid/Medicare related claim form (form 340) effective January 1, 2009 to accommodate the NDC for the top twenty multi-source drugs and to allow for billing provider information on the paper claim form.

Cutoff date to order current form 340:

The last date providers may order the current form 340 is November 14, 2008. The new form 340 will be available December 1, 2008.

Cutoff date for EDS to receive paper claims on the current form 340 for processing:

All claims on the current form 340 must be received by December 5, 2008. Any claims on the current form 340 received after December 5 will be returned to the provider without being processed.

Implementation date of the revised form 340:

Beginning on December 8, 2008, all paper professional Medicare crossover claims must be on the revised form 340. Paper claims received between December 8 and December 31 will be held until 8 am January 1, 2009, when processing will begin on the revised form 340.

EDS will be converting to cut sheets forms for the revised form 340.

If you require the pin fed forms, please contact the Provider Assistance Center and advise you need pin fed forms. EDS will then determine if a need exists to order pin fed forms.



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Sample of New Medicaid/Medicare Related Claim Form (Form 340)

For your review, a copy of the revised 340 form is below. You must order the claim forms beginning on December 1, 2008. The form 340 must be on original red drop-out ink, copies are not accepted.

MEDICAL MEDICAID/MEDICARE RELATED CLAIM

Do not write in this space. Do not use red ink to complete this form.

RECIPIENT INFORMATION

Medicaid ID	
First Name	
Last Name	
Med. Rec. #	
Patient Acct. # (Optional)	

OTHER INSURANCE INFORMATION

Covered by other insurance? Enter Y if yes (Except Medicare)		
Name of other insurance company (Except Medicare)		
Insurance Company. Carrier Code		
If payment was received from other insurance, post that amount here. (Do NOT put Medicare payment here.)		\$

If other insurance rejected, attach rejection to completed claim and mail to EDS. * See remarks.

Diagnosis Codes

1 st DX	2 nd DX	3 rd DX	4 th DX
-----------------------	-----------------------	-----------------------	-----------------------

	Dates of Service		POS	NDC	Mod	Unit	Charges	Medicare				
	From	Thru		Procedure Code				Allowed	Coins.	Deductible	Paid	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
TOTALS												

SAMPLE

Remarks	
	<i>*Enter TPL Denied (MM/DD/YY)</i>

Billing Provider Name				
Billing Provider ID	NPI	Taxonomy	Qu	Secondary ID
Performing Provider Name				
Performing Provider ID	NPI	Taxonomy	Qu	Secondary ID

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment date is less than 120 days old.

Provider mailing address required in block below:

Submit completed claim to:

**EDS
Post Office Box 244032
Montgomery, AL 36124-4032**

Form 340 Revised 12/08

Medical Medicaid/Medicare-related Claim Filing Instructions

This form is required for all medical Medicare-related claims in lieu of the CMS-1500 claim form and the Medicare EOMB. The only required attachments are for third party denials. The Medicare EOMB is not required.

Field Description	Guidelines
Medicaid ID #	Enter the recipient's 13-digit RID number.
First Name	Enter the recipient's first name.
Last Name	Enter the recipient's last name.
HIC#	Enter the recipient's Medicare HIC number.
Patient Account #	Enter recipient's patient account number (to be referenced on the Remittance Advice (RA) for patient identification). Up to 20 characters may be entered into this field.
Covered by other insurance?	Enter a "Y" here if recipient has a commercial insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other commercial insurance company (except Medicare).
Insurance company carrier code	Not used at this time.
If payment was received from other insurance, place that amount here.	Enter the amount the other insurance company paid in this block. Do not include Medicaid copayment amounts.
1 st DX, 2 nd DX, 3 rd DX, 4 th DX	Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.
Dates of service	Enter the from and through dates in MMDDYY format.
POS	Enter the two-digit place of service as filed to Medicare.
NDC	Enter the National Drug Code (NDC) for the procedure, if required.
Procedure Code	Enter the five-digit procedure code.
Modifiers	Enter the modifiers for the procedure code. Enter up to 4 modifiers.
Units	Enter the number of units of service.
Charges	Enter the charge for each line item.
Allowed diem encounter rate	Enter the Medicare allowed amount for each line item. *FQHC, PBRHC, and IRHC should enter the per established by Medicaid for the facility for each line item.
Coinsurance	Enter the Medicare coinsurance amount for each line item. Do not enter Medicaid copayment amount. Do not enter Medicare payments.
Deductible	Enter the amount applied to the Medicare deductible for each line item.
Paid	Enter the Medicare paid amount for each line item. *FQHC, PBRHC, and IRHC should enter the Medicare per diem paid amount for each line item.
Totals	Total each column.
Billing Provider Name	Enter the billing/payee provider name.
Billing Provider ID	NPI: Enter the NPI of the billing/payee provider Taxonomy: Enter the taxonomy code of the billing provider (optional) Qual: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, indicator ID should be used. Secondary ID: Enter the secondary identifier for the billing provider ID. The secondary identifier should be the legacy Medicaid provider number. This is an optional field, but is required for providers with multiple service locations.
Performing Provider Name	Enter the name of the provider which performed the service.
Performing Provider ID	Enter the NPI of the provider which performed the service. Taxonomy: Enter the taxonomy code for the provider which performed the service. (Optional) Qual: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, indicator ID should be used Secondary ID: Enter the secondary identifier for the billing provider. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
Provider Mailing Address	Enter the billing address, city, state, and zipcode for the rendering (performing) provider.
Remarks	Enter Medicare Paid/Denial Date (MMDDYY).

New Paper Medicaid/Medicare Related Claim Form Available in January

(Continued from page 1)

Obtaining the revised form 340:

Providers may begin placing orders for the new claim form on December 1, 2008.

Claim forms can be ordered through one of the following options:

- Complete and fax the attached form to: (334) 215-4140 (See page 12 for order form).
- Request the forms on-line using the following link:
<http://www.medicaid.alabama.gov/billing/forms.aspx>
- Contact the Provider Assistance Center at 1-800-688-7989*.

*EDS encourages you to fax your request forms to ensure prompt service. There is no cost associated with ordering form 340.

Electronic Claims:

There are no changes to electronic claims submission, which will continue through normal processes. As always, the fastest way to receive reimbursement on your claims is to file electronically.

If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.



NDC Now Mandatory for Top 20 Drugs for UB-04 and CMS-1500 Claims

Effective for dates of service August 1, 2008, the top 20 physician-administered multiple source drugs identified by CMS must be reported with the appropriate NDC for CMS-1500 claims.

Effective for dates of service September 1, 2008, the top 20 physician-administered multiple source drugs identified by CMS must be reported with the appropriate NDC for UB-04 claims. Inpatient hospital claims are exempt from this requirement; however, outpatient claims will require the use of the NDC number on the claim.

If you receive an informational denial code during the grace period, you must take action to prevent your claim from denying now that the NDC is mandated.

For more information concerning the NDC number, see the July 2008 edition of the Provider Insider. Be aware that the list posted in this July issue is out of date. The NDC's are updated quarterly and the following link will take you to CMS's website to find the most up to date NDC changes:

<http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice>

Attention Eye Care Providers

When submitting a prior authorization for lens, it is not necessary to use an LT (left) or RT (modifier). The claims processing system is designed to read two lens when submitted on the same date of service. Additionally, it is not required to use a modifier on the lens when submitting your claims.

Attention

Clarification on Change In Medicaid Release of Funds

Alabama Medicaid has changed the payroll date for the release of provider payrolls effective with the October 17, 2008 checkwrite. This is a permanent change for the release of funds.

This means that the funds previously released on Wednesdays after the checkwrite date will not be released until the Friday following the checkwrite date at midnight. This means funds will not be available until 12:01 AM on Saturday.

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

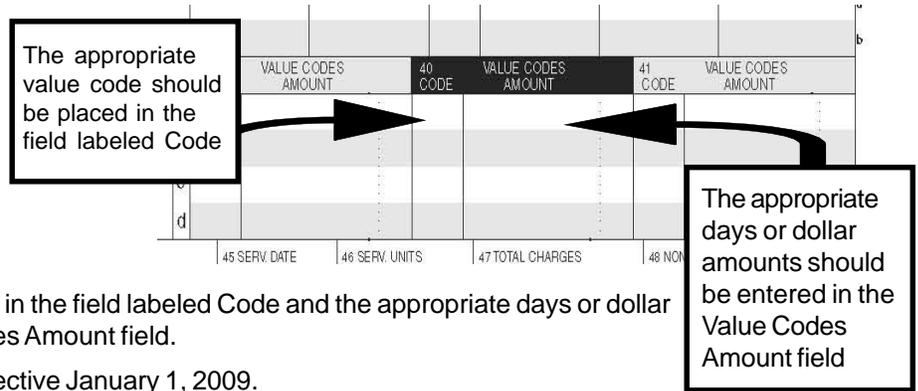
Medicaid Eliminating Paper UB-04 Medicaid/Medicare Related Claim Form

Medicaid will be **eliminating** the paper UB-04 Medicaid / Medicare related claim form for institutional billers effective January 1, 2009.

How will I file my paper crossover claims?

Value codes will be reported in form locaters 39-41 of the UB-04 claim form.

- 80 = Covered Days
- 81 = Non-Covered Days
- 82 = Co-insurance Days
- 83 = Lifetime Reserve Days
- 73 = Medicare Paid Amount
- 74 = Medicare Allowed Amount
- A1 = Medicare Deductible Amount
- A2 = Medicare Co-insurance Amount



The appropriate value code should be placed in the field labeled Code and the appropriate days or dollar amounts should be entered in the Value Codes Amount field.

This change applies to all claims received effective January 1, 2009.

To prepare for this change, all claims on the current Institutional UB-04 Medicaid/Medicare related claim form must be received for processing at EDS by December 5, 2008. After December 5, 2008, claims received on the UB-04 Medicaid/Medicare related claim form will be returned without being processed. The last date to order the current claim forms will be November 14, 2008.

If you have any questions, please contact your Provider Representative at 1-800-688-7989.

ICN Number Changes

When trying to adjust/void a claim with an internal control number (ICN) from the legacy system (prior to Feb 25, 2008) the first two digits of the old ICN should be replaced with the region codes of the new Alabama Medicaid Management Information System (AMMIS), based on the chart provided below:

Example:

OLD 1008017228613
NEW 4108017228613

Old	New
05	40 (converted region 05 electronic claims)
10	41 (converted region 10 tape claims)
22	42 (converted region 22 cap claims –system generated)
33	43 (converted region 33 special batch)
50	44 (converted region 50 online adjustments)
51	45 (converted region 51 reversals and mass adjustments)
52	46 (converted region 52 provider adjustments)
98	47 (converted region 98 paper claims)

Plan First Family Planning Program Extended Through September 2011



Plan First, Alabama Medicaid's nationally-recognized family planning program has been approved for extension by the Center for Medicare and Medicaid Services (CMS) through September 30, 2011. The program began in October 2000 to provide family planning services to uninsured women ages 19 to 44 who would not qualify for Medicaid unless pregnant. This three year extension expands coverage through age 55. To qualify for the program, an applicant's family income must be at or below 133 percent of the Federal Poverty Level. Approximately 67,000 women are currently enrolled in the program which is jointly operated by Medicaid and the Alabama Department of Public Health.

Trading Partner IDs

All providers and vendors were issued new trading partner IDs (submitter ID in the legacy system) for the new AMMIS. These new IDs are 9-digit numbers that allow providers and vendors to upload batch files to the AMMIS for processing. Since implementation, many batches have been submitted with incorrect trading partner IDs, which fail and are not processed. A TA1 acknowledgement is sent to the submitter for files that fail for this reason. All submitters requesting a trading partner ID for the new AMMIS are provided a trading partner ID and personal identification number (PIN) to setup an account on the new web portal. When entering account information, the web portal has a web user ID field, which can be setup to the submitter's specifications. However, this web ID **should not be** substituted for the trading partner ID. The web user ID is for logging onto the web portal and the trading partner ID is sent within batches to identify who is trading files with the AMMIS.

Examples of incorrect trading partner IDs received:

```
ISA*00*      *00*      *ZZ*ABC123      *ZZ*752548221
*080919*0845*U*00401*423458738*1*P*:
GS*HC*ABC123*752548221*20080919*0845*423458737*X*004010X098A1
```

```
ISA*00*      *00*      *ZZ*WEBUSERNAME *ZZ*752548221
*080919*0845*U*00401*423458738*1*P*:
GS*HC*WEBUSERNAME*752548221*20080919*0845*423458737*X*004010X098A1
```

Example of correct trading partner IDs:

```
ISA*00*      *00*      *ZZ*300000001    *ZZ*752548221
*080919*0845*U*00401*423458738*1*P*:
GS*HC*300000001*752548221*20080919*0845*423458737*X*004010X098A1
```

If there are any questions concerning the use of these IDs, please contact the EMC Help Desk at:

EMC Help Desk

Fax: (334) 215 – 4272

Phone: (800) 456 – 1242

(334) 215 – 0111

Email: AlabamaSystemsEMC@eds.com



Claim Status Response File (CSR)

Prior to implementation of the new AMMIS providers and vendors received a Claim Status Response File (CSR) for every batch of claims uploaded to the AMMIS, but this response was discontinued as of February 25, 2008. A new claim status response file is currently under construction and will be available by the end of the year. A more accurate implementation date will be provided once construction and testing have been completed. This new document will mimic the old CSR, but has been revised to meet the standards of the new AMMIS. The new Batch Response File (BRF) will communicate the pre final adjudication results, which will return error codes and error messages for claims that are suspended or denied. There will be one standard proprietary batch response file for the 837 Dental, Professional and Institutional transactions. This batch response will only be returned to the trading partner that uploads a batch of claims. The Batch Response File Companion Document is now available for review on the Medicaid website. This is a living document and is subject to change prior to implementation, so be aware of the version numbers and updates made.

http://www.medicaid.alabama.gov/billing/npi_companion_guides.aspx?tab=6

Questions concerning this new transaction should be directed to Sarah Hataway at sarah.hataway@eds.com

Urinalysis No Longer a Requirement of an EPSDT Screening

The American Academy of Pediatrics (AAP) has recommended that a urinalysis (UA) no longer be performed as a routine part of any examination. Effective October 1, 2008, Medicaid is dropping the urinalysis requirement component of an Early Periodic Screening Developmental Testing (EPSDT) visit at five years of age and at each visit between 11 and 20 years of age. Urine screenings no longer need to be performed at the time of an EPSDT screening unless it is clinically indicated.

EDS Provider Representatives

G R O U P 1



kiki.hinton
@eds.com
334-215-4155



debbie.smith
@eds.com
334-215-4142



gayle.simpson-jones
@eds.com
334-215-4113



misty.curlee
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334-215-4159

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



mark.bonner
@eds.com
334-215-4132

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



jennifer.hatmaker
@eds.com
334-215-4199

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



savannah.brimhall
@eds.com
334-215-4158

G R O U P 3

Ambulatory Surgical Centers
ESWL
Home Health
Hospice
Hospital
Nursing Home



linda.hanks
@eds.com
334-215-4130



ann.miller
@eds.com
334-215-4156



shermeria.harvest
@eds.com
334-215-4160

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

New Transformation Initiatives Office Established

Medicaid has recently made some organizational changes to support its continued efforts to improve the Medicaid program. Effective October 1, 2008 Kim Davis-Allen became Director of the new Transformation Initiatives Office. She will continue to administer the Together for Quality project and the Patient 1st Program. Nancy Headley was appointed Director of the Medical Services Division. The Medical Services Division also welcomes Kaye Melnick to the EPSDT Program to replace Debbie Flournoy and Theresa Thomas to the Institutional Services Program to work with the radiology and laboratory programs.

Eustachian Tube Inflation

Effective August 25, 2008 procedure codes 69400-69401 are restricted to physicians with specialties of EENT and Otorhinolaryngology.

Home Moisture Exchange System

Effective October 1, 2008, the Home Moisture Exchange (HME) System will be covered using procedure code A7509. Effective October 1, 2008, the HME will no longer be covered using procedure code E1399. This code will require prior authorization (PA). All preexisting PAs approved under procedure code E1399 for the HME System will be honored.

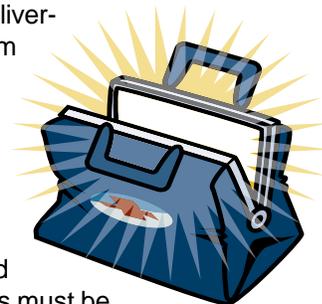
Measles And Rubella Vaccination Coverage Discontinued

Procedure Code 90708 for MR (Measles and Rubella) vaccination will no longer be designated as a Vaccines For Children (VFC) immunization effective September 17, 2008. The change in designation will be made in the January 2009 Alabama Provider Billing Manual, Appendix A. Please refer to Appendix A for a listing of immunization codes designated as VFC immunizations.

Home Infusion Therapy Policy

The Alabama Medicaid Agency has developed a Home Infusion Therapy (HIT) policy. The HIT policy is effective for dates of service October 1, 2008, and thereafter. This policy will replace currently used procedure code A9999 (supplies used in the IV Administration kit).

HIT includes administered infusion therapy and supplies provided to Medicaid recipients residing in a private residence. Infusion therapy is a procedure that involves the insertion of a catheter into a blood vessel that provides a painless way of drawing blood and delivering drugs and nutrients into a patient's bloodstream over a period of weeks, months, or even years. Common uses for intravenous therapy are intravenous antibiotic treatment, chemotherapy, and hydration.



HIT components can be provided and billed by enrolled DME Pharmacies and Durable Medical Equipment (DME) providers only as described in the HIT policy. Home Infusion DME providers must be accredited by nationally recognized accrediting body to be reimbursed for home infusion therapy services. This accreditation must occur before October 1, 2009. If providers are audited and it is found that they are not accredited, Alabama Medicaid will recoup all monies paid for home infusion services for all dates of service beginning October 1, 2009, and thereafter. Effective October 1, 2009, all prior authorization requests submitted for procedure code S9379 must also contain a copy of the provider's accreditation.

HIT must be prescribed by the attending physician as a medically necessary health care service to correct or ameliorate a defect, physical or mental illness, or a condition (health problem). Medical documentation must justify the need for the service. The physician's orders must clearly document the starting date for care, expected duration of therapy, the amount and types of services required. If the recipient requires multiple drug therapies, the therapies must be provided by the same agency. The medication administration record and or the nursing documentation should coincide with the billing based on the time of completion and discontinued use of the drug that required the need for durable medical supplies.

HIT services billed using the "S" codes include, antibiotic, antiviral or antifungal therapy (S9500; S9501; S9502; S9503; S9504), hydration therapy (S9373), chemotherapy (S9330), pain management therapy (S9326), specialty infusion therapies such as anti-coagulant (S9336), antiemetic (S9351), epoprostenol (S9347) and catheter care (S5498; S5501; S5520; S5521). These "S" codes include administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment. Drugs and nursing visits are billed separately. The "S" codes listed in this paragraph do not require prior authorization.

Procedure code S9379 (Home infusion therapy not otherwise classified) does require prior authorization. The LTC Medical Quality and Review Unit will consider authorization of home infusion therapies not otherwise classified on an individual basis. These special requests will require supportive documentation from peer reviewed medical literature and medical reviews.

Changes to the Patient 1st Program

The Patient 1st Program continues to be a success in meeting its goal of creating a medical home for our recipients. We have just completed the requisite waiver documents and want to thank the participation of our Patient 1st Advisory Council and various PMP's as the Agency has searched for ways to improve and to more clearly support the Medical Home model.

One action taken to accomplish this goal has been to revise the case management fee components and performance measures for the time period, January 1, 2009 – December 31, 2010. These changes were a reflection of providers indicating they would like to have measures of greater practice significance and more quality oriented. The central theme throughout the planning process was for the measures to be realistic, important to the overall enhancement of patient care and considered valuable across all physician peer groups.

The changes in the case management fee will require a reenrollment of all Patient 1st PMPs. New contracts, along with the revised Provider Manual, will be mailed in the first week of November. In addition, a detailed description of the Performance Measures including the algorithm for determining the measure will be part of the enrollment packet.

Case Management Fee components

- 24/7 Voice-to-Voice Phone Coverage - \$1.00
This is a requirement of program participation and not optional. PMPs must have a voice-to-voice telephone coverage for their recipients.
- Radiology Management - \$.50
The Agency is implementing a prior approval process for Radiology services (CT Scans, MRI, MRA, PETS and CTA) for 2009. All Medicaid providers, regardless of program participation, will be required to request radiology services through prior approval.
- Administrative fee - \$.10
To offset the extra time the PMP and staff spend on completion of referrals, consultations, prior approvals, In-Home monitoring enrollment forms, Review of Care Coordination reports, etc.
- InfoSolutions/QTool (Electronic Health Record) - \$1.00
Use of InfoSolutions until such time as the QTool becomes available in the counties. QTool is Medicaid's web based electronic health record that is currently being piloted in 9 counties. Once QTool becomes available in a county; then requires use of the QTool for 25% of patient visits the first 3 months and 50% of visits from then on to earn the fee for this component. This is an optional component.

Patient 1st
Health Care Close To Home

Performance Measures

Shared savings are based on the ability for the program to demonstrate measureable program savings as a result of the Patient 1st Program. For the waiver period the measures are: Generic Drug Use, Certified Emergency Room Use and Unique Office Visits. In addition, there will also be the efficiency score based on costs. The Agency will begin working to determine the program savings for the waiver period ending December 31, 2008. It is anticipated that any shared savings will be distributed April 2009.

For the upcoming waiver period (1/1/09 -1/31/10), the performance measures will be as follows:

- Emergency Room visits (certified and non-certified)
- Number of Hospital days per 1000 patients
- Percent of Generics Utilized
- Percent of Asthma patients who have had one or more ER visits with the primary diagnosis of Asthma
- Percent of Diabetic patients who have had at least one HbA1c test during review period
- EPSDT Visits for 0-5 population
- Office Visits per Unique Enrollee

The Agency looks forward to your continued participation and support of the Patient 1st program. Please watch your mail for enrollment information. If you have any questions or if you have not received an enrollment packet by November 30, 2008, please contact Amber Gladson at (334) 353-4301 or email to amber.gladson@medicaid.alabama.gov.

Controlled Dose Drug Delivery System

Alabama Medicaid Pharmacy Program currently covers the drug, Ventavis (20mcg/2ml) with NDC codes 10148010200 and 10148010100. This drug may only be delivered by the controlled dose inhalation drug delivery system (K0730). This drug delivery system will only be covered for eligible Medicaid recipients currently receiving the drug Ventavis and Alabama Medicaid must currently be reimbursing for this drug for these recipients.

Effective November 1, 2007, Alabama Medicaid began covering procedure code K0730 (Controlled dose inhalation drug delivery system). Procedure code K0730 will require prior authorization. This procedure code will be a ten-month capped rent to purchase item and at the end of the ten-month rental period the device will be a purchased item for the recipient. The drug delivery system will be limited to one per recipient every two years. Repairs for procedure code K0730 will be covered using procedure code E1399. All repair cost must be submitted with itemized providers invoice cost. Repairs will be reimbursed at the provider's invoice cost plus 20%. Providers will be required to bill with diagnosis code 416.8 when submitting claims for the controlled dose drug delivery system.

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

Implementation of Additional VFC Codes

The Advisory Committee on Immunization Practices (ACIP) has approved three vaccinations that are available through the VFC program. All three vaccines have achieved Food and Drug Administration (FDA) status.

The CPT code revisions will be reflected in the 2009 CPT codebook. Also, Appendix A of the Provider Billing Manual has been updated to reflect the addition of these codes. In the table below is a description of the CPT-4 codes, the immunizations and the dates of implementation for the three new VFC immunizations.

CPT-4 PROCEDURE CODE	IMMUNIZATION	EFFECTIVE DATE
90681	Rotavirus vaccine (RV1), human attenuated, 2 dose schedule for 2 and 4 months of age, live, for oral use.	06/25/2008
90696	Diphtheria, tetanus toxoids, acellular pertusis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), is indicated as a booster for children of 4 through 6 years of age (prior to 7 years of age).	06/26/2008
90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV) for intramuscular use. It is indicated as a primary series and first booster dose (doses 1-4) at 2, 4, 6 and 15-18 months of age.	06/26/2008

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, 2007 through September 30, 2008 that are filed after February 28, 2009 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, 2007, through September 30, 2008 that are filed after February 28, 2009 will be denied by EDS. Hospital 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, 2007 through September 30, 2008 that are filed after February 28, 2009 with third party liability action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipient 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.

High Frequency Chest Wall Oscillation Air Pulse Generator

Effective September 1, 2008, if a patient receives an air vest prior to becoming Medicaid eligible and requires a replacement, documentation in the medical record should indicate why a replacement is needed. A replacement is covered only if the patient meets the required four-month renewal Air Vest criteria. For these recipients Medicaid will make a onetime lump sum payment to providers for the replacement vest.

Four-month renewal Criteria – (the following conditions must be met)

1. The recipient continues to be eligible.
2. Medical documentation indicates:
 - a. Therapy continues to be medically necessary; and
 - b. Patient is compliant with prescribed use of air vest as documented through report from last 90 days documenting use at least 67% of time prescribed; and
3. Patient's respiratory status is documented as stable or improving.

Important Information for Providers Who Submit Crossover Claims

EDS recently implemented changes which should allow your crossover claims to crossover from Medicare to Medicaid. The changes were implemented on September 11, 2008. If your claims continue to deny for error code 1946 (multiple services locations for performing provider). Please take the following steps:

- Make sure your software vendor is submitting your zip+4 address information for the billing provider on your claims when they are sent to Medicare for processing. The billing zip+4 information can be found in the following loop:
- 2010AA – N403 It has to be 9 digits if there is no dash and 10 bytes if there is a dash. If you are unsure if the information is being sent on your claims, contact your software vendor.

While this solution will help the majority of our providers, providers which have many service locations may continue to see some denials for error code 1946 (multiple service locations for performing provider). EDS is working to implement additional system changes to allow your claims to crossover. When these changes are implemented, your zip+4 information will need to be located in the service facility location on your claims when submitted to Medicare. The service location zip+4 information can be found in the following loop:

- 2310D - Service Facility Location City/State/Zip Code - The entire 9-digit postal zip code should be submitted, without the dash.
- EDS does not have a date on the additional changes. More information will be provided in a future Insider.
- Providers may use Medicaid's Interactive Web Portal or Provider Electronic Solutions Software for submitting crossover claims until crossover issues are resolved. If you have questions on how to use the web portal or Provider Electronic Solutions, call the Provider Assistance Center at 1-800-688-7989.

New Federal Law Requires Providers to Comply with Medical Records Requests

A new federal law to combat Medicaid provider fraud and abuse will soon require Alabama Medicaid providers to comply with federal auditors' requests for medical records.

The Medicaid Integrity Program (MIP), created by the Centers for Medicare and Medicaid Services (CMS) as a result of the Deficit Reduction Act of 2005, is a national program to support, not supplant, state program integrity efforts, according to Alabama Medicaid Program Integrity Director Jacqueline Thomas. The program, now underway in a handful of states, is expected to be implemented in Alabama within the next few months.

CMS has contracted with several organizations to review Medicaid claims to assess whether fraud or waste has occurred or is likely to occur, to identify overpayments for repayment to the federal government and to educate providers concerning program integrity and quality of care. A combination of field and desk audits will be performed based on Medicaid claims data for the 2004-2008 fiscal years.

Providers are required to comply with the law by submitting any requested documentation. Failure to respond or to provide all requested documentation on a timely basis will be recorded by CMS as an overpayment, requiring the Medicaid Agency to pay back federal dollars.

**Form 340 Professional Medicaid/Medicare
Related Claim Order Form**

NPI or Provider Number: _____

Provider Name: _____

Attention: _____

Street Address: _____

City: _____ State: _____ Zip: _____

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