

Provider Insider

Alabama Medicaid Bulletin

September 2008

The checkwrite schedule is as follows:

09/05/08 09/12/08 10/03/08 10/17/08 11/07/08 11/21/08

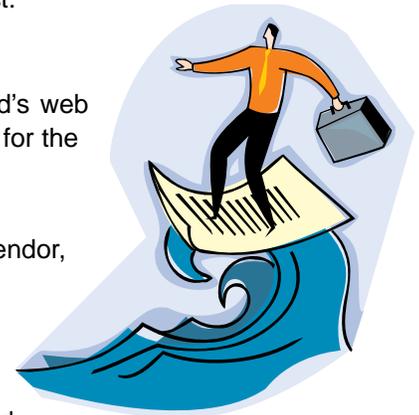
As always, the release of direct deposits and checks depends on the availability of funds.

Important Information for Providers Submitting Crossover Claims

Medicaid/Medicare Paper Crossover Claim Forms

The only time you **must** submit a paper crossover claim form is when Medicare denies the claim. All other crossover claims may be filed electronically. EDS is in the process of updating the crossover claim forms to allow the NDC and secondary identifier information on the paper crossover claims. Until the forms are updated you must:

- **NDC:** Use the NDC attachment form found on the Medicaid website at:
<http://www.medicaid.alabama.gov/billing/forms.aspx>
- **Secondary Identifier:** File your claims electronically through a vendor, Medicaid's web portal or Provider Electronic Solutions. Paper crossover claim forms are not an option for the secondary identifier information.



Electronic Claims Submission

The most efficient way for providers to submit claims is electronically, either through a vendor, Interactive Medicaid Web Portal, or Provider Electronic Solutions.

- **Vendor:** EDS recognizes not all vendors allow for secondary claims processing electronically.
- **Interactive Medicaid Web Portal:** Allows claims submission one at a time for real time claims processing. The one page screen allows for simple navigation and immediate claim response. You can access the web portal by using the green web portal PIN letter mailed to your office in late January 2008 at the following link:
<https://www.medicaid.alabamaservices.org/ALPortal/Home/tabId/36/Default.aspx>
- **Provider Electronic Solutions Software:** Allows batch claims processing, which allows for multiple claims submission at once. If you need to request a duplicate copy of your web portal letter, please e-mail at the ECM helpdesk at alabamasytemsemc@eds.com. You can access Provider Electronic Solutions at the following link:
<http://www.medicaid.alabama.gov/billing/pes.aspx?tab=6>

For more information on the following, contact your Provider Representative at 1-800-688-7989 to:

- Request a trading partner ID to use Provider Electronic Solutions,
- Obtain instructions on how to enter crossover forms using the web portal,
- Obtain instructions on using Provider Electronic Solutions to submit your crossover claims.

For assistance with installing Provider Electronic Solutions, please contact the EMC Helpdesk at 1-800-456-1242 or e-mail at alabamasytemsemc@eds.com

(Continued on page 2)

In This Issue...

Important Information for Providers Submitting Crossover Claims	1
Fees for Form Completion Must Follow Medicaid Guidelines	2
DME Medical Criteria Update	2
Alabama Medicaid Policy for Modifier "JW"	2
Guidelines for Organ Transplants	2
Expanded Requirements of Tamper-Resistant Prescription Pads	3
Important Mailing Addresses	3
In-State Inpatient Hospital Claims Must Follow PHP Payment Guidelines	4
Inpatient Admission After Outpatient Hospital Services	4
NDC Now Mandatory on UB-04 and CMS-1500 Claims	4
Reminder to Hospitals and ER Physicians	5
Synagis Criteria for 2008-2009 Season	6
Medicaid is Not Recognizing Retroactive Awards for Long Term Care	6
What To Do If Your Claim Is In a Suspended Status	6
EDS Provider Representatives	7
State Fiscal Year 2009-2010 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 _____

Important Information for Providers Submitting Crossover Claims

On the crossover claim form, the provider address is required. The address information should be placed in the block below the heading: **Provider Mailing Address Required in Block Below.**

Failure to include your address may result in your claim not being processed. Without the address information, if you have more than one service location, EDS cannot determine what address to return the claim.

If you have any questions relating to completing form 340, please contact your Provider Representative at (800) 688-7989.

Fees for Form Completion Must Follow Medicaid Guidelines

While the Alabama Medicaid Agency does not reimburse providers for completing forms for school, family medical leave or other purposes not requested at the time of service, providers may charge patients for this service under certain conditions.

As is the case with other non-covered services, providers are asked to confer with and inform recipients prior to the provision of services about their responsibilities for payment of services not covered by the Medicaid program. Additionally, the charge must be one that is applied across the board to all patients, not just those on Medicaid. Additional information on billing for non-covered services is available in Chapter 7.1.7 of the Medicaid Provider Manual.



www.medicaid.alabama.gov

DME Medical Criteria Update

The medical criteria listed below for procedure codes E0148 (Heavy Duty Walkers without wheels, rigid or folding, any type, each) and E0149 (Heavy Duty walkers wheeled, rigid or folding, any type, each) and E0168 (Extra Wide Heavy Duty Stationary Commode Chair) will be effective September 1, 2008 and thereafter.

Medicaid will approve heavy duty walkers to accommodate weight capacities greater than 250 pounds and extra wide and/or heavy duty commode chairs with or without arms for weight capacities greater than 300 pounds.

The extra wide and/or heavy duty commode chairs and the stationary or mobile extra wide commode chairs with or without arms and/or heavy duty walkers with wheel or without wheels will require prior authorization. Providers must submit recipient's weight, depth and width for the extra wide and/or heavy duty commode chairs (E0168) and weight, width and length for the extra wide heavy duty walkers. A physician's prescription and medical documentation must be submitted justifying the need for the equipment.

Extra wide/and or heavy duty commode chairs, stationary or mobile with or without arms and heavy duty walkers with wheels and without wheels are limited to one per recipient every two years.

Effective August 1, 2008 procedure code B4087 (gastrostomy/jejunostomy tube, standard, any material, each) will be reduced from 15 units per month per recipient to 4 units per month per recipient.

Effective August 1, 2008 procedure code E1161 (manual adult wheelchair, includes tilt n space) will be covered for all Medicaid recipients.

Effective August 1, 2008 Alabama Medicaid procedure code A6531 (gradient compression stockings, below the knee, 30-40 mm Hg, ea) will be covered by Alabama Medicaid.

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

Alabama Medicaid Policy for Modifier "JW"

Modifier "JW" is used to identify unused drugs or biologicals from single use packages or vials that are discarded. Medicaid reimburses providers for discarded drugs within the parameters of the Alabama Medicaid Provider Manual, Appendix H but does not require the use of the JW modifier on claims submitted for services rendered to recipients which are covered by Medicaid only. However, Medicare contractors are required to use this modifier in order to receive reimbursement for unused drugs or biologicals that are discarded. This modifier is identified as an informational only modifier in the Medicaid system.

Guidelines for Organ Transplants

Please note the following guidelines for all Medicaid covered organ transplants (with the exception of cornea) that is being referred to an out-of-state facility or provider for possible transplantation:

- The patients referring physician must contact the appropriate transplant specialist at UAB to ensure that the transplant cannot be performed in-state.
- After the determination is made by UAB's transplant specialist that the transplant cannot be performed in-state, the recipient is referred by their physician to an out-of-state facility with the understanding that the out-of-state facility must coordinate the approval and reimbursement of the transplant with UAB's Transplant Services Coordinator

If you have additional questions regarding this information, please call Brenda Fincher at 334-242-5455

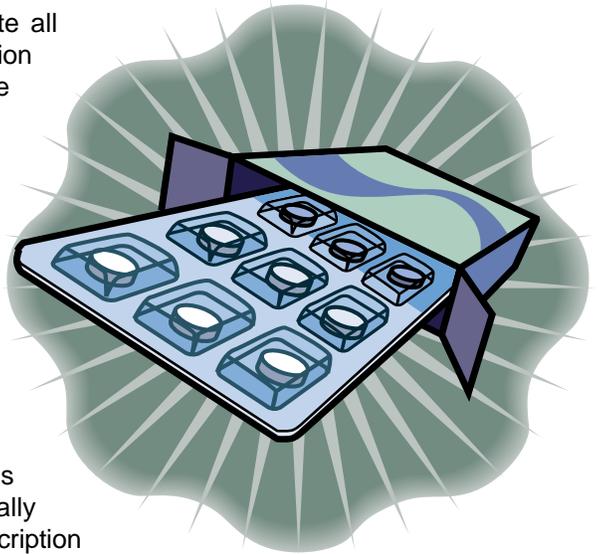
Expanded Requirements of Tamper-Resistant Prescription Pads Mandated by October 1, 2008

Effective October 1, physicians must use prescription pads with three federally required characteristics for written prescriptions to Medicaid recipients. The new requirements are the second phase of a new federal law to prevent unauthorized or fraudulent use of prescription pads. The first phase, implemented April 1, 2008, only required use of one of the three characteristics.

Enacted in 2007, the new federal law required physicians to write all paper, non-electronic Medicaid prescriptions on tamper-resistant prescription pads, which contain features preventing unauthorized or fraudulent use in order to be reimbursed by the federal government. The law applies only to written prescriptions for covered outpatient drugs. Prescriptions transmitted from the prescriber to the pharmacy verbally, by fax, or through an e-prescription are not impacted by the statute. The law applies whenever Medicaid pays any portion of the cost of a prescription.

The three required characteristics are industry-recognized features designed to prevent:

- 1) Unauthorized copying of a completed or blank prescription form
- 2) The erasure or modification of information written on the prescription pad by the prescriber
- 3) The use of counterfeit prescription forms. Some of these features include special ink that highlights erasures or changes, sequentially numbered forms, and special patterns or words that appear if the prescription is copied.



Prior guidance from CMS for printed prescriptions generated from Electronic Medical Records (EMR) or ePrescribing applications stated that special copy resistant paper would likely be required for printed prescriptions to be in compliance as of October 1, 2008. However, CMS has clarified this statement, and has now determined that while special paper may be used to achieve copy resistance, it is not necessary. EMR or ePrescribing generated prescriptions may be printed on plain paper and be fully compliant with all three categories of the tamper-resistant regulations presuming they contain at least one feature from each of the three categories.

CMS has determined that at least two such features utilized to prevent passing a copied prescription as an original can also be incorporated into plain paper computer generated prescriptions. The first of these is microprinting, which is the use of very small font that is readable when viewed at 5x magnification or greater, and illegible when copied. The second feature is a "void" pantograph accompanied by a reverse "Rx", which causes a word such as "Void," "Illegal," or "Copy" to appear when the prescription is photocopied. (Except where state law mandates the word "Void" or "Illegal", it is recommended that the pantograph show the word "Copy" if the prescription is copied.)

For more information on tamper-resistant prescription pads, visit:

http://www.medicaid.alabama.gov/programs/pharmacy_svcs/tamper-resistant_Rx_pads.aspx?tab=4.

REMINDER

Integumentary System Surgical Graft

Effective 4/1/2007, Integumentary System Surgical Graft procedure codes (15040 thru 15431) no longer reflect age restrictions.

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

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.

Claims that span September 30, 2008 and October 1, 2008 must be split billed due to the PHP year-end. Claims should be filed as soon as possible after the September 30, 2008, year-end.

Effective for dates of service October 1, 2008 and there after, inpatient hospital claims will be paid fee-for-service by Medicaid.



Inpatient Admission After Outpatient Hospital Services

If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services. If the patient was transferred to another hospital or facility; then the outpatient visit could be billed.

If an outpatient claim is paid in history, and the inpatient claim comes into the system, the inpatient claim will be denied with EOB code 5018. The provider will need to recoup the outpatient claim and resubmit all charges on the inpatient claim.



NDC Now Mandatory on UB-04 and CMS-1500 Claims

Effective for dates of service August 1, 2008, the NDC numbers will be mandatory for claims processing and payment for CMS-1500 claims.

Effective for dates of service September 1, 2008, the NDC numbers will be mandatory for claims processing and payment 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.

Reminder to Hospitals and ER Physicians

Emergency room services are subject to post payment review by Medicaid and will be recouped if medical records do not support the service as a certified emergency. If fraud is suspected, a referral will be made to the Attorney General's Medicaid Fraud Control Unit. A hospital or physician may perform their own self audit to ensure that services billed were appropriately "certified" by the physician. The following is a reminder of the policy regarding 'Emergency Hospital Services' which can be found in the Alabama Medicaid Provider Manual, Hospital, Chapter 19:

Emergency Hospital Services

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician at the time the service is rendered and documented in the medical record if the claim is filed as a "certified emergency."

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

A certified emergency is an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

- The case should be handled on a situational basis. Take into consideration the recipient, their background, extenuating circumstances, symptoms, time of day, and availability of primary care (if a weekend, night or holiday).
- Determine whether the presenting symptoms as reported would be expected to cause the patient to believe that a lack of medical care would result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.
- If it is not an emergency, do not certify the visit as one. Follow-up care (such as physical therapy, suture removal, or rechecks) should not be certified as an emergency.
- Children or adults brought to the emergency department for exam because of suspected abuse or neglect may be certified as an emergency by virtue of the extenuating circumstances.

Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. The claim form for a certified emergency must have an "E" in field 73 on the UB-04 claim form.

UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment. Refer to Section 19.5.3, Procedure Codes, and Modifiers, for level of care codes for emergency department services.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450.

Non-certified visits to the emergency room are considered outpatient visits and count against the three outpatient hospital visits allowed per calendar year.

Only one emergency room visit per day per provider will be reimbursed by Medicaid.

Again, physician certification without supporting medical documentation may result in recoupment and/or referral to the Attorney General's Office in the case of suspected fraud and abuse.



Synagis® Criteria for 2008-2009 Season

Alabama Medicaid has updated its prior authorization criteria for Synagis®. The approval time frame for Synagis® will begin October 1, 2008 and will be effective through March 31, 2009. A total of up to five doses will be allowed per recipient in this timeframe. There are no circumstances that will allow for approval of a sixth dose. If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.

For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season. Providers are to submit requests for Synagis® on a separate prior authorization form (Form 351) to Health Information Designs and may be accepted beginning September 1, 2008. The form and complete updated criteria specific to Synagis® are available on the Agency's website at www.medicaid.alabama.gov under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Forms: Criteria/Instruction Booklet for Prior Authorization Forms.

Medicaid accepts the following as American Academy of Pediatrics risk factors for infants less than six months old with gestational age of 33-35 weeks:

- § Childcare attendance
- § School-age siblings
- § Congenital abnormalities of the airways
- § Severe neuromuscular disease
- § Exposure to environmental air pollutants (Environmental air pollutants will not include second-hand smoke. Environmental air pollutants must include instances where a child is constantly exposed to particulate air matter.)

Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.



Medicaid is Not Recognizing Retroactive Awards for Long Term Care

The Alabama Medicaid Claims Payment System is currently not recognizing nursing home financial eligibility segments for recipients who receive a retroactive award from the Medicaid District offices. If you are submitting your long term care admission dates through the Long Term Care Admission Notification software and are receiving a rejection of "no financial eligibility" and you have an award notice that covers the submission date, please contact the Long Term Care Medical and Quality Review Services Unit at (334) 242-5149 for assistance.

You may fax an explanation of the problem, a copy of the award notice, and a copy of the rejection notice to the Long Term Care Medical and Quality Review Services Unit at (334) 353-4909.



What To Do If Your Claim Is In a Suspended Status



If you have claims in "Suspended" status, you do not need to do anything at this point. A suspended claim means EDS has received this claim and the claim is under review, but has not been finalized yet. Once the claim is finalized, it will appear as either paid or denied. **DO NOT RESUBMIT CLAIMS THAT ARE IN SUSPENDED STATUS.**

Suspended claims have been one of our main concerns with the implementation of the new Medicaid Claims Processing System on February 25, 2008. We have a large volume of suspended claims. Medicaid's two highest suspense audits are the "suspect duplicate" and the "multiple surgery."

Please be patient with us as we are working very diligently in resolving the suspended claims volume.

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
@eds.com
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

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

State Fiscal Year 2009-2010 Checkwrite Schedule

10/03/08	01/02/09	04/03/09	07/10/09
10/17/08	01/16/09	04/17/09	07/24/09
11/07/08	02/06/09	05/01/09	08/07/09
11/21/08	02/20/09	05/15/09	08/21/09
12/05/08	03/06/09	06/05/09	09/04/09
12/12/08	03/20/09	06/19/09	09/11/09

Post Office Box 244032
Montgomery, AL 36124-4032

**Alabama
Medicaid
Bulletin**



PRRST STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL