

# Provider Insider

Alabama Medicaid Bulletin

October 2009

The checkwrite schedule is as follows:

10/02/09 10/23/09 11/06/09 11/20/09 12/04/09 12/18/09

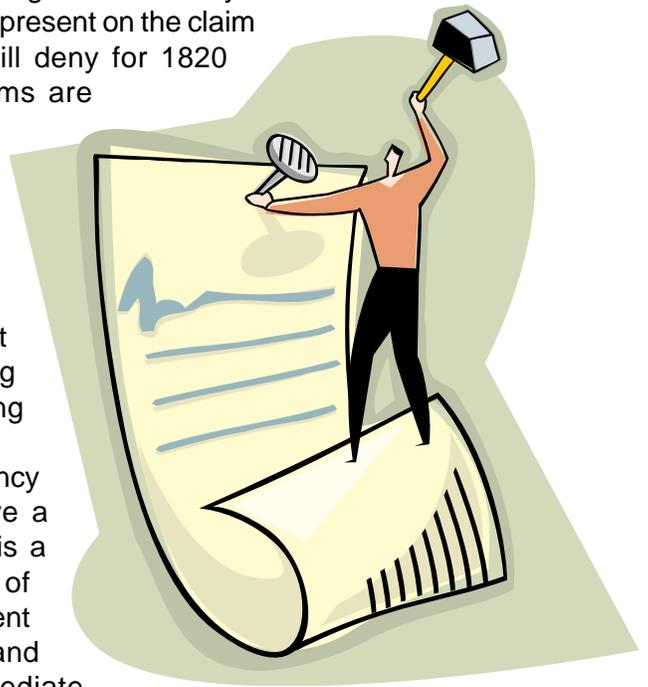
As always, the release of direct deposits and checks depends on the availability of funds.

## EDS Identifies Top Five Denials for Physician Claims

EDS has conducted a recent review of the Top 5 denials for physician claims. Denial Code 1820 (Patient 1st claim requires a referral) remains a top denial. Please remember, a referral must be obtained for services when a referral is required. A list of services requiring a referral may be found in chapter 39 of the provider billing manual. The referral must be present on the claim when it is billed. If a referral is not present, the claim will deny for 1820 (Patient 1st claim requires a referral). A top reason claims are denying for a Patient 1st referral is when the claim is originally being filed, the referral is being omitted from the claim. Claims are then corrected and re-filed using the appropriate Patient 1st referral. This rejection could be prevented by including the referral on the claim upon first submission.

If a physician or hospital uses an outside billing company to perform billing services, it is imperative that a communication system exist to provide the billing company with appropriate referral information prior to billing claims.

Hospitals and physicians which provide certified emergency services in the emergency room are not required to have a referral from the PMP. Please note a certified emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses 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.



(Continued on page 2)

## In This Issue...

EDS Identifies Top Five Denials for Physician Claims .....	1
Review of Neonatal Critical Care Codes .....	2
Friendly Reminder Regarding Procedure D4355 .....	2
Attention DME Providers .....	2
New Adolescent Protection: Part Three .....	3
Flu Season is Here! .....	3
Alabama Medicaid: In the Know - What is a BPA Error .....	4
New Dismissal Form for Patient 1 <sup>st</sup> Providers on Website .....	5
Essure Follow-up Procedures and the Plan First Recipient .....	5
COBA Denial Explanation .....	6
Synagis Criteria for 2009-2010 Season .....	6
Attention DME Providers Billing Procedure Code E1399 / E1399-EP .....	7
Claims Suspending for Edit 3306 .....	7
State Fiscal Year 2010-2011 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 \_\_\_\_\_

## **Review Of Neonatal Critical Care Codes**

A neonatologist is allowed to bill for one visit per day for a patient. However, provisions are made to allow an initial hospital care (procedure codes 99221, 99222 or 99223) to be billed on the initial date of service with a critical care code OR in lieu of the initial hospital code, an EPSDT Screening (99233-EP) may be billed in addition to the appropriate critical care code. HOWEVER, BOTH AN INITIAL HOSPITAL CARE AND EPSDT SCREENING CANNOT BE BILLED. One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes. There is no provision for an EPSDT screen and a subsequent pediatric critical care visit (99469) to be paid on the same date of service. These guidelines are outlined in Chapter 28 of the Provider Manual.

### **Resuscitation / Standby / Attendance At Delivery**

Standby (99360), or resuscitation (99465), or attendance at delivery (99464) may be billed in addition to critical care. Only one of these codes may be billed in addition to neonatal intensive care critical care codes on the initial date of service. Chapter 28 of the Provider Manual details these codes and the visit codes.

### **Friendly Reminder Regarding Procedure D4355**

Procedure code D4355 is covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation.

## **REMINDER**

**This is a reminder that the annual ICD-9-CM update will be effective for dates of service on or after October 1, 2009.**

## **Attention DME Providers**

Effective October 1, 2009, all Medicare DME providers are required to have Medicare accreditation and meet the Medicare Surety Bond requirement as of October 2, 2009. Alabama Medicaid Agency's DME providers must comply with Medicare rules and regulations in order to become a Medicaid provider or continue enrollment in the Durable Medical Equipment (DME) Program. Medicare DME providers are required to have a \$50,000 Surety Bond. Failure of Medicare DME providers to comply with these requirements will result in their termination from the Alabama Medicaid Program.

All Medicaid DME providers must submit copies of their Medicare Accreditation and their Medicare Surety Bonds by October 31, 2009, to the Alabama Medicaid Agency at the following address:

Alabama Medicaid Agency  
Long Term Care Policy Advisory Unit  
Attention: Dodie Teel  
501 Dexter Avenue  
Montgomery, Alabama 36104-3744

Effective October 1, 2010, all Alabama DME providers will be required to acquire a \$50,000 Medicaid Surety Bond for each of their DME store locations.

Prior authorization requests for wheelchairs and other DME items received with Julian date July 1, 2009, and thereafter, will no longer require providers to submit signed delivery tickets for wheelchairs and other DME items to Alabama Medicaid before the prior authorization (PA) request is placed in an approved status in the Alabama Medicaid Interchange PA System. However, a signed delivery ticket must be in the recipient's record for auditing purposes. If a recipient's record is audited and there is no signed delivery ticket showing proof of delivery of the wheelchair and other DME items, Alabama Medicaid will recoup all monies paid for the wheelchair and other DME items.

If you have additional questions or need further clarification, please contact Ida Gray at (334) 353-4753 or Robin Arrington at (334) 353-4754.

### **EDS Identifies Top 5 Denials for Physician Claims**

(Continued from page 1)

When sending certified emergency information electronically through a vendor the information must be in the following loop for 837 claims:

Service Authorization Exception Code - Loop 2300 - Segment REF

When using Provider Electronic Solutions for professional claims (837P), a service authorization indicator of a 3 must be selected from the Header 2 tab. Selecting the emergency indicator of a Y on the Detail one header will not certify your claim as an emergency. When using Provider Electronic Solutions for institutional outpatient claims (837I), a service authorization indicator of a 3 must be selected from the Header 3 tab.

When using the Medicaid Interactive Web Portal for professional claims (837P), a service authorization code of a 3 must be selected from the header portion of the claim form. Selecting the emergency indicator of a Y on the detail line will not certify your claim as an emergency. When using the Medicaid Interactive Web Portal for institutional outpatient claims (837I), a service authorization indicator of a 3 must be selected from the header portion of the claim form.

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

## ***New Adolescent Protection: Part Three***

**V**accination against tetanus, diphtheria, and pertussis has greatly reduced the number of cases and deaths among all U.S. age groups. Approximately 10-20% of tetanus cases and 5-10% of diphtheria cases resulted in death. In 2005, 72 cases of pertussis were reported in Alabama. Tetanus differs from other vaccine preventable disease (VPDs) in that it is not contagious. Tetanus is an acute disease of the nervous system caused by an exotoxin produced by the bacterium *Clostridium tetani*. *C. tetani* usually enters the body through a wound or break in the skin. *C. tetani* spores are widely distributed in soil and the intestines and feces of dogs, cats, rats, guinea pigs, chickens, horses, cattle, and sheep. The incubation period depends upon the site of injury in proximity to the central nervous system (CNS). In general, the farther the injury site is from the CNS, the longer the incubation period. Three forms of tetanus involving the cranial nerves have been described: local, cephalic and generalized. Cephalic tetanus is rare. Local tetanus is uncommon affecting persistent contraction of muscles in the same anatomic area as the injury. Generalized tetanus is the most common type (80%) in which the disease usually presents with a descending pattern (moving from jaw to neck to rigidity of abdominal muscles). There is no laboratory findings characteristic of tetanus and the diagnosis is entirely clinical.

In addition to tetanus, adolescents must be properly vaccinated against diphtheria. Diphtheria is an acute toxin-mediated disease caused by the bacterium *Corynebacterium diphtheriae*. Transmission is through direct intimate respiratory contact. Diphtheria clinical features may involve any mucous membrane and is based on site of infection since it is imperative to begin presumptive therapy quickly. Classical sites of infection are anterior nasal (mucopurulent nasal discharge), pharyngeal/tonsillar (insidious onset of exudative pharyngitis with exudate spreading within 2-3 days), laryngeal (fever, hoarseness, barking cough), cutaneous (scaling rash or ulcers with demarcated edges), ocular (conjunctiva), and genital (vulvovaginal). Laboratory diagnosis confirmation is done through culture of the lesion although diagnosis is made on clinical presentation. Another common VPD is pertussis. Pertussis, or whooping cough, is an acute disease caused by the bacterium *Bordetella pertussis* and is highly contagious. The bacteria attach to cilia of the respiratory epithelial cells and ultimately interfere with the clearing of pulmonary secretions. Transmission occurs through direct contact with discharges from infected respiratory mucous membranes.

The three stages of the clinical course of the illness are catarrhal (insidious onset of coryza, sneezing), paroxysmal (cough stage in which diagnosis is usually suspected, posttussive vomiting), and convalescence (recovery is gradual usually 2-3 weeks). The diagnosis is based on a clinical history (cough for more than 2 weeks with whoop, paroxysms, or posttussive vomiting) and a variety of laboratory tests (culture, polymerase chain reaction [PCR], direct fluorescent antibody [DFA] and serology). Although a culture is considered the gold standard laboratory test, growth requirements for *B. pertussis* are difficult to culture. Specimens must be collected correctly (posterior nasopharynx). Cultures are variably positive (30-50%) and take as long as 2 weeks. In comparison to a culture, the PCR test has an increased sensitivity and faster reporting of results. PCR should be used in addition to a culture. No PCR product has been FDA approved. Like a culture, PCR is also affected by specimen collection.

Tetanus-diphtheria-acellular pertussis vaccine (Tdap) is an improvement to the conventional Td booster, because it adds protection from whooping cough while still maintaining protection from tetanus and diphtheria. Tdap is administered intramuscularly. All adolescents 11-18 years of age should get one booster dose of Tdap. Adolescents who have already gotten a booster dose of Td are encouraged to get a dose of Tdap for protection against pertussis. Waiting at least 5 years between Td and Tdap is encouraged, but not required. A dose of Tdap is recommended for all adolescents at their 11 or 12 year old check-up if 5 years have elapsed since last dose DTaP/DTP. Adolescents who did not get all their scheduled doses of DTaP or DTP as children should complete the series using a combination of Td and Tdap. Please call 1-866-674-4807 with the Vaccines for Children program for additional information or visit the Alabama Department of Public Health, Immunization Division at [www.adph.org](http://www.adph.org).

## ***Flu Season is Here!***

**A**nnual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Flu vaccination is a covered service for eligible recipients. According to the CDC, the following changes or updates are recommended for 2009:

- Annual vaccination of all children aged 6 months—18 years should begin as soon as the 2009-2010 influenza vaccine is available. Annual vaccination of all children aged 6 months – 4 years and older children with conditions that place them at increased risk for complications from influenza should continue to be a primary focus of vaccination efforts as providers and programs transition to routinely vaccinating all children.
- The 2009-2010 trivalent vaccine virus strains are A/Brisbane/59/2007 (H1N1)-like, A/Brisbane/10/2007 (H3N2)-like, and B/Brisbane 60/2008-like antigens.
- Most seasonal influenza A (H1N1) virus strains tested from the United States and other countries are now resistant to oseltamivir. Recommendations for influenza diagnosis and antiviral use will be published later in 2009. CDC issued interim recommendations for antiviral treatment and chemoprophylaxis of influenza in December 2008, and these should be consulted for guidance pending recommendations from CDC's Advisory Committee on Immunization Practices (ACIP). The interim recommendations are available at <http://www2a.cdc.gov/HAN/ArchivesSys/ViewMsgV.asp?AlertNum=00279>.

# ALABAMA MEDICAID

## *In The Know*

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

## What is a BPA Error?

When billing a claim, some of the terminology may be confusing to providers. The following is a list of terms and their definitions to help providers understand why claims are denying:

**BPA** – Benefit Plan Administration – Identifies a specific group of audits used in claims processing.

**RP** – Recipient Plan – The type of Medicaid coverage a recipient is eligible to receive. Based on eligibility criteria, recipients may be eligible for full Medicaid benefits, or for certain services only. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid programs or services. Additionally, a recipient's history of Medicaid benefits may render him or her eligible or ineligible for specific programs or services. For these reasons, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Chapter 3 of the provider billing manual provides additional information on recipient eligibility

**PC** – Program Code or Provider Contract – Providers are assigned contracts and specialties which allow procedures to be reimbursed by provider type. Assignments are made based on certifications and licensure information. Chapter 2 of the provider billing manual provides additional information on becoming a Medicaid provider

**RR** – Reimbursement Rules – Rules established regarding reimbursement for a procedure. This includes restrictions by provider type, provider specialty or claim type.

**DIAG** – Diagnosis codes – The diagnosis code billed is not covered for the service rendered. This could be based on the recipient plan or procedure code. This could also include restrictions on the recipient benefit plan or procedure code

**ICD9** – The ICD-9 surgical procedure codes – the audit is addressing the requirements for billing these codes

**MOD** – Modifiers – The modifier being billed is not allowable or not valid for the service performed

**NDC** – The National Drug Code assignment – The NDC being billed is not valid or non-covered

**PROC** – The HCPC or CPT-4 Procedure codes – The audit is addressing the requirements for the procedure code being billed

Listed below are some examples of BPA errors that may occur on a remittance advice:

#### **Example 1: BPA – RP – PROC – No coverage**

This error is stating no coverage for the procedure code billed based upon the recipient's benefit plan. This could be an error received by a hospital when trying to bill an emergency room visit for a Medicaid recipient with Plan First coverage.

#### **Example 2: BPA – PC – PROC – No coverage**

This error is stating no coverage for the procedure billed based upon the provider's contract with Alabama Medicaid. An example would be a doctor billing for an EPSDT screening without a contract on file to perform screenings.

#### **Example 3: BPA – RR – No Reimb Rule**

This error is stating the reimbursement rule is not associated with the procedure or HCPC being billed. The procedure code or HCPC could be non-covered or not updated in the Medicaid claims processing system.

#### **Example 4: BPA – PC – REV – Assignment Plan Restriction**

This error is stating an incorrect revenue code is being billed for the recipient's Level of Care Assignment Plan. An example may include a nursing home billing for services when a recipient has not been added to the Level of Care file, or possibly billing incorrect revenue codes for services.

A BPA error may occur for different reasons on an RA. The denial description provides information on how to correct the error.

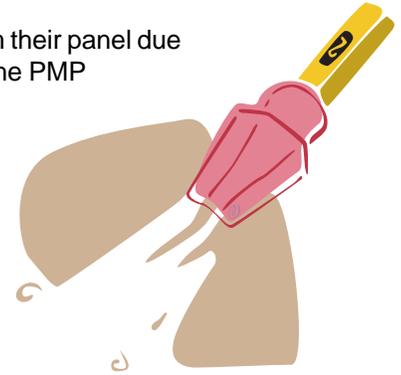
(Continued on page 5)

## ***New Dismissal Form for Patient 1<sup>st</sup> Providers on Website***

**A** Primary Medical Provider (PMP) may request dismissal (removal) of a recipient from their panel due to good cause. The PMP is responsible for sending a letter of dismissal to the enrollee. The PMP should provide the enrollee 30 days notice from the first date of the month in which you are dismissing the enrollee.

In addition, the PMP should fill out the Dismissal Form (Form 450) and mail or fax the form to the Alabama Medicaid Agency, Attention: Patient 1<sup>st</sup> Program, 501 Dexter Avenue, Montgomery, AL 36103.

The fax number is (334) 353-3856. If you have questions about the above requirements contact Gloria Wright, at (334) 353-5907.



## ***Essure Follow-up Procedures and the Plan First (Family Planning Only) Recipient***

**O**nce a sterilization claim is processed for a Plan First recipient, her financial eligibility is systematically ended. Currently, a claim for a Plan First recipient for Essure related follow-up procedures (58340 and 74740) would deny due to no financial eligibility.

The providers rendering services should submit claims for procedures 58340 and 74740 to:

Plan First Program Manager  
501 Dexter Avenue  
Montgomery, Alabama 36103

The claims will be researched and considered for a manual lump sum payment. If there is a paid claim in history for the Essure procedure then the claim for the follow up procedures will be processed.

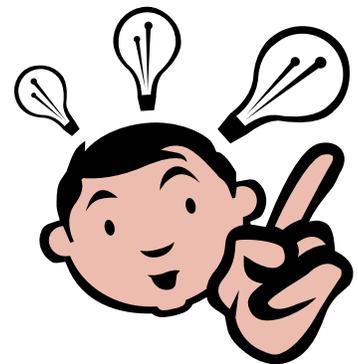
## **What is a BPA Error?**

(Continued from page 4)

The following is a guide on how to decipher BPA denials and explains what each portion of the denial code represents:

### **Example: BPA – RP – PROC – Age Restriction (if applicable)**

- BPA: identifies the denial as a benefit plan administration audit
- The second portion provides details on the denial
  - \* PC=Provider Contract
  - \* RP=Recipient Plan
  - \* RR=Reimbursement Rule
- The third portion provides additional information on the denial, when applicable
  - \* DIAG=Diagnosis Code
  - \* ICD-9 ICD-9 surgical procedure code
  - \* MOD=Modifier
  - \* NDC=NDC code
  - \* PROC = CPT-4 or HCPC procedure code
- The fourth portion provides additional information for assistance in correcting the denial
  - \* Age Restriction
  - \* Gender Restriction
  - \* No Reimb Rule (No reimbursement Rule)
  - \* Place of Service Restriction
  - \* Diagnosis Restriction
  - \* Assignment Plan Restriction (note this error usually only occurs with Long Term Care recipients)
  - \* No Coverage



## COBA Denial Explanation

**A**ttention providers receiving 1825 denial (COBA denial-do not crossover). This denial means EDS does not have information on file for your claims to automatically crossover from Medicare to Medicaid. To eliminate this denial, send in a copy of the Medicare notification letter received when you became a Medicare provider to EDS Provider Enrollment. The letter should contain your NPI number as well as secondary identifiers for all service locations. Once this letter is received, information will be updated and claims should begin to crossover; eliminating this denial.

The following provider types should not submit Medicare notification letters because claims should never automatically crossover from Medicare to Medicaid.

- FQHC
- Rural Health Clinics
- Dialysis

The contact information for Provider Enrollment is the following:

FAX: (334) 215-4298  
EDS Provider Enrollment  
PO Box 241685  
Montgomery, AL 36124-1685



## Synagis® Criteria for 2009-2010 Season

**T**he Alabama Medicaid Agency has updated its prior authorization criteria for Synagis®.

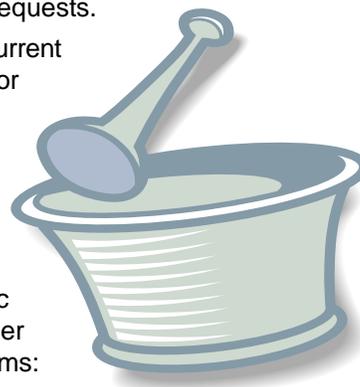
### Highlights of the updated criteria include:

- The approval time frame for Synagis® will begin October 1, 2009 and will be effective through March 31, 2010.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in 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.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2009 (for an October 1 effective date).
- A copy of the hospital discharge summary from birth is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

### Criteria

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. The form and complete updated criteria specific to Synagis® are available on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Pharmacy Forms: Synagis®.

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



## Claims Suspending for Edit 3306

Claims may suspend for edit 3306 if total charges are over a specified threshold amount. The claims will remain in suspense until the provider is contacted by EDS to verify the claim amount. Providers who are billing monthly for their services and are receiving this edit may want to bill weekly. This will lower the claim total and may prevent the claim from suspending for this edit. If EDS is unable to reach the provider and verify charges, the claim will deny.

### Attention DME Providers Billing Procedure Code E1399 / E1399-EP

A recent internal audit has revealed when prior authorization requests were approved for E1399/E1399-EP; the prior authorizations were not entered into the prior authorization system correctly. The time period when the prior authorizations were entered incorrectly was June 2008 through December 2008. The issue has been corrected, but some prior authorizations may be outstanding and require action on the behalf of the provider.

#### What steps should your office take to determine if prior authorizations for E1399/E1399-EP have processed incorrectly?

Conduct a self audit of Prior Authorizations with this procedure code/modifier combination. Review your accounts to see if payments for services has been received. Payment will range from \$1 to \$5, which is much less than the reimbursement amount for the services provided. Providers can review Remittance Advise information or may log onto the web portal to check claim status to ensure proper payment.

#### If our office determines claims have not processed correctly, what action should be taken to correct the problem?

Write down all your prior authorization numbers which have claims incorrectly processed against them. Contact your Provider Relations Representative. Your Provider Relations Representatives are aware of the issue, and can evaluate your specific circumstance and advise what corrective action will need to occur to ensure proper payment. You may contact your Provider Representative at 1-800-688-7989, ask for a Durable Medical Equipment Provider Representative.

#### In the future, how should prior authorization requests be completed for E1399/E1399-EP?

Providers may refer to Chapter 4 of the provider manual for specific instructions on completing the prior authorization requests. When submitting line item information for E1399 / E1399-EP, one line item should be requested, with one unit, adding the items into one lump sum dollar amount. This should be done even if multiple items are to be dispensed. The text portion of the prior authorization form should be used to describe the items requested. If additional dollars or items are required to be dispensed, and a prior authorization is already approved for that time period, a request to add additional items or dollars should be sent to the prior authorization department at EDS. Use the Prior Authorization approval letter and write the information in the remarks sections explaining what additions are necessary and fax the form to EDS. **An additional prior authorization request should not be sent in for approval.**

#### How should claims be filed for E1399/E1399-EP one prior authorization is granted?

Information on completing a claim form can be found in the Provider Billing Manual. Appendix P, page P-28 states:

1. The procedure code must be entered on the claim as one line item.
2. The units billed must be entered as "1" unit.
3. The dollar amount billed must be the "total" dollar amount for all items approved on the prior authorization for the date of service on the claim. In other words, the money amounts for multiple items approved on a prior authorization request for E1399 or E1399 (EP) must be combined and the total money amount must be billed as one lump sum. The total units for all items must be billed as "one" unit. If each approved item for E1399 or E1399 (EP) is billed on separate lines or if more than one unit is billed, for the same dates of service, the claim will be denied.



**State Fiscal Year 2010-2011 Checkwrite Schedule**

10/02/09	01/08/10	04/02/10	07/09/10
10/23/09	01/22/10	04/16/10	07/23/10
11/06/09	02/05/10	05/07/10	08/06/10
11/20/09	02/19/10	05/21/10	08/20/10
12/04/09	03/05/10	06/04/10	09/10/10
12/18/09	03/19/10	06/18/10	09/17/10

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