

Provider Insider

Alabama Medicaid Bulletin

January 2010

The checkwrite schedule is as follows:

01/08/2010 01/22/2010 02/05/2010 02/19/2010 03/05/2010 03/19/2010

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

HealthSpring Ends Medicare Advantage Contract with Alabama Medicaid

Medicaid providers who currently accept HealthSpring enrollees should be aware that HealthSpring has ended its contract with the state effective January 1, 2010.

Current HealthSpring enrollees can choose to stay with HealthSpring, switch to another Medicare Advantage plan, or disenroll from HealthSpring and roll back to regular Medicare coverage. If they choose to stay with HealthSpring, they may be required to pay a monthly premium and other out-of-pocket costs.

If the patient has full Medicaid coverage or QMB-only coverage, they must be treated by a Medicaid-enrolled provider in order for Medicaid to cover the plan's co-pays or deductibles. If the doctor they currently use within HealthSpring's network does not accept Medicaid, the patient will need to switch to a Medicaid-enrolled provider in order for Medicaid to be billed for the co-pays or deductibles. If the patient chooses to remain with a non-Medicaid provider, the individual will be responsible for any plan co-pays or deductibles.

Providers with questions about HealthSpring's requirements should call HealthSpring directly. Recipients with questions about switching to another Medicare Advantage plan should call the Alabama State Health Insurance Assistance Program (SHIP) toll free at 1-800-243-5463 for assistance.



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Pass It On!

Everyone needs to know the latest about Medicaid.

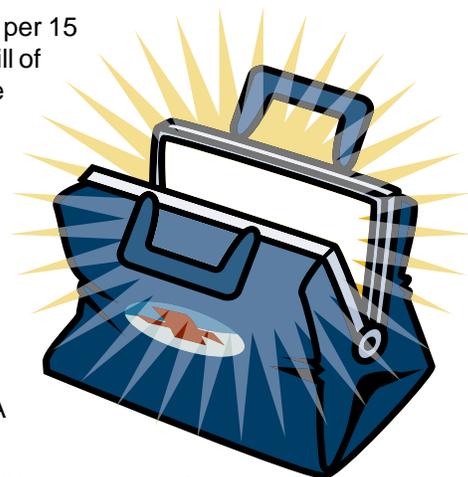
Be sure to route this to:

- Office Manager
- Billing Dept.
- Medical/Clinical Professionals
- Other _____

DME Medical Criteria Update

Effective April 4, 2009, CMS deleted procedure code E1340 (Repair for DME, per 15 minutes, repair or non routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) and replaced it with procedure code K0739 (Repair/SVC DME non oxygen equipment, repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes).

Alabama Medicaid is deleting procedure code E1340 in the Interchange System on December 31, 2010. This will allow all existing PA's approved for date of service April, 2009 through December 31, 2010 to process and pay. Effective January 1, 2010, all PA requests for Repair/SVC DME non oxygen equipment, repair or nonroutine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes must be submitted using procedure code K0739. Alabama Medicaid will not accept any PA requests submitted for procedure code E1340 after December 31, 2009.



Effective September 1, 2009, the quantity restriction for procedure code A7526 will increase from 4 units per month to 31 units per month (1 per day). This update will be included in Chapter 14 and Appendix P of the DME Provider Manual. This information will also be placed on the Medicaid DME List Serv and the ADMEA List Serv.

Effective December 1, 2009, most of the tracheostomy (trach) supplies currently billed using procedure code E1399 will now be billed with a procedure code corresponding to the tracheostomy supply item. Procedure codes A4605, A7012, A7010, A7008, S8999 and A9990 will not require prior authorization but there are quantity restrictions. Procedure code S8189 will require prior authorization. Any other trach supply items requested must be submitted using procedure code E1399. The procedure codes listed below will be used to bill tracheostomy supply items:

TRACH SUPPLY	HCPC CODE	PRICE	HCPC DESCRIPTION
Delee	A4605 (4 per mo.)	\$13.12 ea.	Tracheal suction catheter closed system
Drain Bag	A7012 (4 per mo.)	\$3.18 ea.	Water collection device, used with large volume nebulizer
Aerosol	A7010 (per 100 ft.)	\$16.04	Corrugated tubing disposable used with large volume nebulizer
Neb Adapters	A7008 (4 per mo.)	\$7.48 ea.	Large volume nebulizer, disposable prefilled used with aerosol compressor
Resuscitation Bags	S8999 (2 per yr.)	\$36.00 ea.	Disposable ambu bag
Suction Machine Bacteria Filters	A9900 (2 per yr.)	\$6.00 ea.	Miscellaneous DME Supply
Customized/ Specialty Trachs (ex. Bivona)	S8189		Tracheostomy Supply Requires PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%
Peep Valves	E1399		Requires PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%
RespiGuard Filters	E1399		Requires PA, medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse at provider's invoice plus 20%
Twill Tape	E1399		Medicaid no longer covers twill tape. Medicaid increased trach collars from 4 per month to 31 per month. Trach collars replaced twill tape years ago

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

Monovalent H1N1 Vaccines Available

The Office for Disease Control and Prevention at ADPH has issued the following information regarding the monovalent 2009 H1N1 vaccine:

Alabama physicians may still order 2009 monovalent H1N1 vaccine by going to the adph.org web site, clicking on "Log In" and then choosing "ORDER." The department fills requests as vaccine becomes available, and so not every provider who has requested vaccine has received it yet. Providers must report each week the number of administered doses. Based on the amount of 2009 H1N1 vaccine distributed in Alabama, the Department of Public Health now recommends providers offer vaccine to all individuals in the ACIP target groups. Monovalent 2009 H1N1 vaccine is thus recommended for (1) persons aged 25 through 64 years who have medical conditions that put them at higher risk for influenza-related complications, (2) all persons aged 6 months through 24 years, (3) pregnant women, (4) persons who live with or provide care for infants less than 6 months of age, and (5) healthcare workers and emergency medical services personnel. The Department will continue to distribute 2009 H1N1 vaccine to providers as additional vaccine is made available.

Reimbursement for Administration of Seasonal Influenza and H1N1 Vaccines

Effective November 2, 2009, Alabama Medicaid began reimbursing Medicaid-enrolled pharmacy providers for the administration of the influenza and H1N1 vaccines for eligible recipients age 19 and older. Alabama Medicaid will also continue to reimburse pharmacies for the seasonal influenza vaccine but will not reimburse pharmacies for the H1N1 vaccine because the H1N1 vaccine is being supplied by the Alabama Department of Public Health at no charge to the provider.

- Beginning November 2, pharmacy providers may bill the following NDC numbers on a pharmacy claim for reimbursement of vaccine administration:
 - NDC 99999-9999-10 for seasonal influenza vaccine administration
 - NDC 99999-9991-11 for H1N1 vaccine administration
- Reimbursement will be \$5 per administration with no dispensing fee or co-pay applied.
- Claims should be submitted with a dispense quantity of 1 for vaccine administration. There will be a maximum quantity of 1 injection allowed per recipient per year for each vaccine.
- To facilitate coordination of care, Pharmacy providers are instructed to inform (via phone, fax, e-mail, mail) each recipient's Primary Medical Provider (PMP) upon administration of the vaccine(s). Documentation must be kept on file at the pharmacy of the notification to the PMP. If the PMP is unknown, the pharmacy may call the Alabama Medicaid Automated Voice Response System (AVRS) system at 1-800-727-7848 to obtain the PMP information. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website at http://www.medicaid.alabama.gov/programspharmacy_svcspharmacy_services.aspx.
- Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.



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 HP has received the 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 should process within two checkwrites. Resubmitting the claim could possibly cause the claim to suspend longer, because the subsequent submissions will also require manual review.

Proper Claim Filing for Unclassified Drugs

When a provider administers a physician drug not listed, the following J Codes should be utilized:

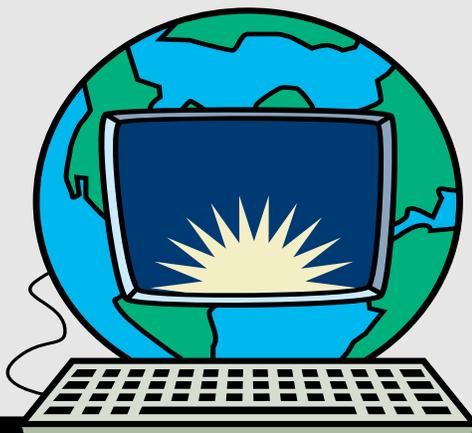
J3490 - Unclassified drugs

J9999 - Not otherwise classified, antineoplastic drugs

The claim must be sent on paper with a description of the drug attached. Providers should submit a claim with the complete name of the drug, dosage and a National Drug Code (NDC) number. Please be sure to search the Physician Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to: HP, Attn: Medical Policy, PO Box 244032, Montgomery, AL 36124-4032. HP will determine the price of the drug.

Modifier "76"

Modifier "76" is used for repeat procedures only and should not be billed unless the procedure is actually a repeat procedure. This modifier should never be billed to obtain additional billing units for procedures that have restricted billing units (example; injectable drugs). Providers that have used this modifier inappropriately in the past should adjust those claims, and note that this issue is subject to post payment review and recovery.



www.medicaid.alabama.gov

Procedure for Billing Bilateral Procedures

The following is the correct process for billing bilateral procedures. Please refer to the Alabama Medicaid Provider Manual, Chapter 28 for details and examples.

- Bill the appropriate procedure code on 2 separate lines with RT and LT modifier, or other appropriate anatomical modifier
- Modifier 50 will be used for informational purposes only and is no longer a pricing modifier
- The payment will be 100% of Medicaid fee schedule for first line and 50% for second line
- Claims will be subject to multiple surgery payment adjustments for multiple procedures

Example: **Line 1: 27558 RT**
 27558 LT

Alabama Medicaid utilizes Medicare's RVU file to determine whether a 50 modifier should be allowed with the procedure code billed. When an inappropriate procedure code is billed with modifier 50, the claim will deny.

Distinct Procedural Service (Modifier 59)

Modifier 59 may be used to indicate a service was performed on the same date of service but was distinct from the primary service provided the same day. Examples of when Modifier 59 would be appropriate to use include (but not limited to), different procedure or surgery, different site or organ system, separate incision/excision, which would not ordinarily be performed on the same day by the same physician.

Medical record documentation and diagnoses must support Modifier 59 utilization. When diagnoses alone do not support appropriate Modifier 59 utilization, the claim will be denied. When receiving a Modifier 59 or Multiple Surgery denial, a paper claim with an attached Operative Report (record "Op Report Attached" in block 19) must be submitted to HP for reconsideration. The reconsideration should occur before a written appeal is made to the Alabama Medicaid Agency.



EXAMPLES

- Surgical debridement/shaving is normally considered an integral part of the primary surgical procedure (bundled). However, there are times when the debridement/shaving occurs at a different site or location during the same surgical session and it may be necessary to append a Modifier 59 to indicate a "separate and distinct service."
- When filing for a secondary procedure code 29877 for bilateral debridement/shaving of articular cartilage electronically, append Modifier RT (right) and Modifier 59 on the first line and on the second line append Modifier LT (left) and Modifier 59. Diagnoses must support the procedures billed.
- If the electronic claim rejects, then a paper claim (indicating RT/LT with mod. 59) should be forwarded to HP, with the appropriate OP Report attached. The paper claim form should have block 19 marked indicating that the Op Report is attached.

Top Five Denials for Nursing Home Claims

HP has conducted a review of denials received by nursing homes in the past year. The top 5 denials are as follows:

EOB Code 5013, Our records show this service for the date(s) of service billed is a duplicate. This denial is received if the submitted claim is an exact duplicate of a claim previously paid.

EOB Code 573, Total days on claim conflict with dates shown. This denial is received if the calculated number of days do not equal the days billed. The days are calculated as the number of days in the from and to dates of service fields. The date of discharge is not counted except when the patient status is between 30 and 39. If the patient status is between 30 and 39 the last day is counted.

EOB 570, Total days less than covered days. This denial is received if the total of detail units billed for accommodation revenue codes is not equal to the number of days calculated at the header from and to dates of service. The date of discharge is not counted except when the patient status is between 30 and 39. If the patient status is between 30 and 39 the last day is counted.

EOB 2504, File shows other insurance. Submit to other carrier. This denial is received if the recipient is covered by a private insurance. The claim should be submitted hardcopy with a copy of the denial from the other insurance or the claim can be submitted electronically using a delay reason code of 9. If the delay reason code of 9 is submitted the provider must have documentation on file that the other insurance does not cover nursing home services.

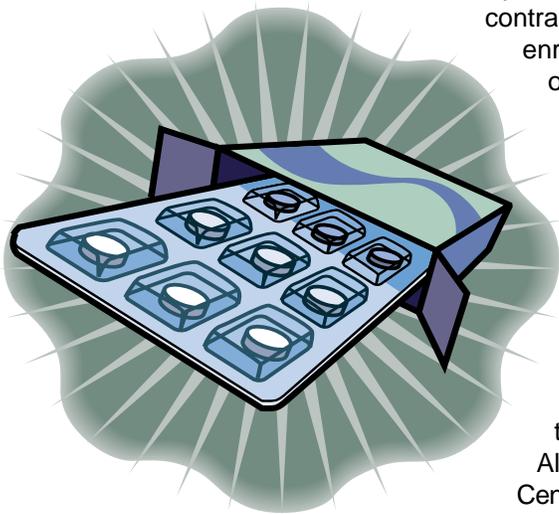
EOB 1065, Provider name mismatch. This denial is received if the provider name submitted on the claim does not match the name on the provider file. When processing claims the first 2 letters of the provider name is compared to the provider file.

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



Plan First Recipients Prescription Information

In an effort to improve recipients' access to covered contraceptive products, the Alabama Medicaid Agency has expanded the number of locations Plan First recipients can fill prescriptions.



Implemented November 1, the change allows women on Plan First to obtain oral contraceptives, the contraceptive ring, or the contraceptive patch at a Medicaid-enrolled community/outpatient pharmacy at a Federally-qualified Health Center or at the public health department. This is in addition to the contraceptive products already available at pharmacies, such as injectable contraceptives and diaphragms.

Medicaid Pharmacy Services Director Kelli Littlejohn, RPh. PharmD., emphasized that Plan First recipients who wish to fill their prescriptions at a community or outpatient pharmacy must have received the prescription from a private provider enrolled in the Plan First program. Oral contraceptives, the contraceptive ring, or the contraceptive patch are limited to one month's supply per fill.

"Women who prefer the convenience of getting a 12-month supply of oral contraceptives, the contraceptive ring, or the contraceptive patch at one time will still have the option of receiving family planning services from the Alabama Department of Public Health or from a Federally-qualified Health Center (FQHC). However, to receive contraceptive products from ADPH or a FQHC, the Plan First-eligible patient must have been seen first by the health department or

the FQHC", Dr. Littlejohn said.

Community and outpatient pharmacies should be aware that there is no change for SOBRA-eligible women who receive a prescription for a contraceptive product when they are discharged from the hospital after giving birth. These women must continue to fill their contraceptive prescriptions at a Medicaid-enrolled pharmacy. After the 60-day postpartum period, these women will automatically become Plan First recipients. At that time, they may elect to obtain family planning services from an enrolled Plan First private provider, or directly from the Alabama Department of Public Health.

Questions regarding this change should contact Leigh Ann Hixon, Plan First Program Manager at leighann.hixon@medicaid.alabama.gov or call (334) 353-5263.

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.

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.

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. 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

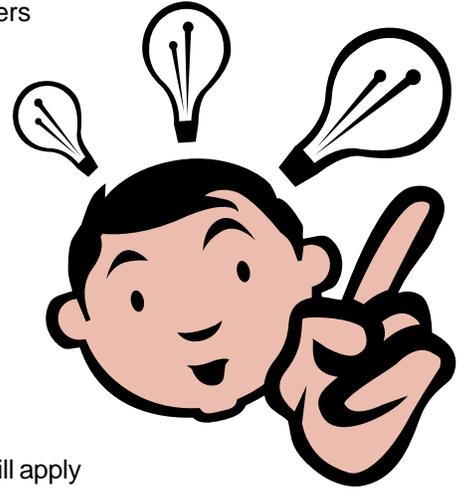
No Coverage

Assignment Plan Restriction (note this error usually only occurs with Long Term Care recipients)

QTool Now Available to Info Solutions Providers

Medicaid has been working to transition current Patient 1st PMPs utilizing InfoSolutions to Medicaid's Electronic Health Record, QTool. InfoSolutions, currently hosted through Blue Cross/Blue Shield will be discontinued December 31, 2009. Providers currently using InfoSolutions will now have access to QTool. QTool allows you to see not only medication and procedure history but also offers information on past diagnoses, providers of care, allergies, lab results, vital signs, and even personal history. In addition, QTool offers an e-prescribing component to participating providers all at no cost. PMPs will be required to use QTool in order to receive the \$1 in the monthly case management fee.

QTool was developed for use by Medicaid providers through a Medicaid Transformation Grant. A component of the grant is an evaluation of the effectiveness of the information available. In order to protect the integrity of the evaluation, QTool will not be available to PMPs in the following counties until April 1, 2010. (Counties postponed until April 1, 2010: Baldwin, Butler, Choctaw, Covington, Etowah, Lee, Madison, Marion, Morgan, Randolph and Walker). Medicaid will be working with these providers during the coming months to meet the April 1, 2010 start date. PMPs in these counties will continue to receive their additional case management fee until April 1, 2010 if they have historically used InfoSolutions.



1. For those providers required to use QTool, the following usage requirements will apply to receive the additional case management fee: During the time period January 1, 2010 – March 31, 2010, no minimum usage will be required.
2. During the time period of April 1, 2010 – June 30, 2010, your office will be required to use QTool for 25% of the unduplicated Medicaid patients seen in your office.
3. If the 25% usage requirements have been met at the end of this quarter (measured in July), then you will continue to qualify for your dollar reimbursement fee for the next two months (August-Sept).
4. During this next period (July- Sept), the required usage of the QTool increases to 50% of the unduplicated Medicaid patients seen in the office.
5. If the 50% usage requirements have been met at the end of this quarter, then you will continue to qualify for your dollar reimbursement for the subsequent quarters.
6. If the requirements are not met during a specific quarter/time period, the additional case management fee will be suspended for the next quarter/time period.
7. Usage during the suspended quarter will be measured and if minimum requirements are met, then the case management fee will be reinstated for the upcoming quarter.
8. As a reminder, each patient only counts once during each quarter. Multiple look-ups on the same patient will only count as one unduplicated patient for the monitored quarter.

If you have questions or would like to receive training on QTool, please contact: Janice.oneal@medicaid.alabama.gov or by phone (334) 353-4771 OR kim.davis-allen@medicaid.alabama.gov by phone (334) 242-5011. Policy questions can be directed to Paige Clark at paige.clark@medicaid.alabama.gov.

EDS Is Now HP Enterprise Services

In August 2008, Hewlett Packard (HP) acquired EDS, claims processor for the Alabama Medicaid program. On Wednesday, September 23, 2009 the EDS business unit of HP changed its name to HP Enterprise Services in most locations across the country and around the world.

How will that affect health care providers in Alabama? You probably won't notice much of any change. You'll begin to see the HP logo or the HP Enterprise Services name on correspondence. You'll begin to receive e-mails from an @hp.com e-mail address rather than an @eds.com address and you'll hear the hp name when calling the Montgomery office. Think of it as a sports team changing jerseys. The same players are on the field working hard to deliver the outstanding medicaid services you've come to expect from a trusted business ally.

While the EDS name and logo are being phased out, the technology services equity we've built over the past five decades will remain. This includes the attitude, expertise and commitment to delivering excellence that defined EDS. The new name reflects HP's commitment to the longtime success of its clients. It also reminds our clients of the enhanced value they now get from the combination of EDS' proven operational excellence plus the best in class technology of HP.



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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