

Provider Insider

Alabama Medicaid Bulletin

July 2010

The checkwrite schedule is as follows:

07/09/2010 07/23/2010 08/06/2010 08/20/2010 09/10/2010 09/17/2010

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

Web Portal Session Timer

A new feature has been added to the Web Portal that will notify users how long they have until a session will expire logging them off. A message displaying the amount of time a user has until the session expires is displayed in the upper right corner of the website on all pages. A session expires after 20 minutes of inactivity, which is defined by a user sending a request to the web server. A request is sent to the web server when the user causes the screen to refresh, such as by clicking a button, selecting a search link or navigating between menu items. Simply entering data into a field does not send a request to the web server and therefore does not cause the 20 minute timer to reset. A warning message is displayed when 3 minutes remain and another message is displayed when the session has expired.

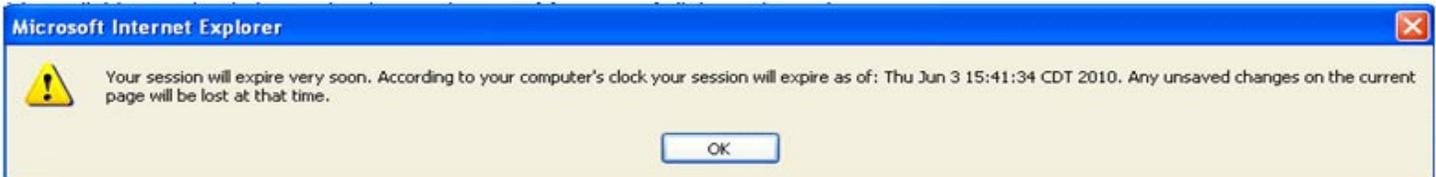
Session Timer Display



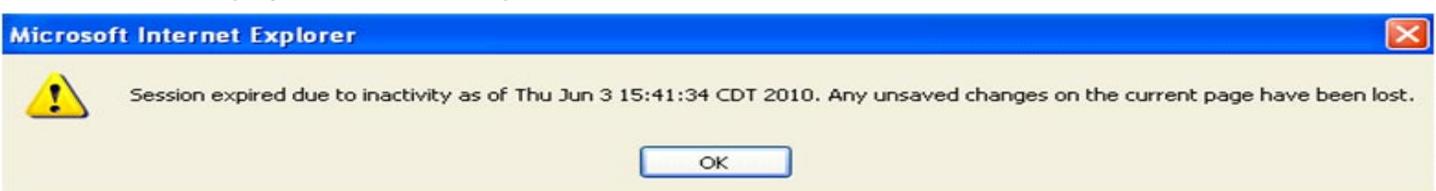
Thursday, June 03, 2010

You have approximately 19 minutes until your session will expire.

Session Timer Display – 3 minute warning



Session Timer Display – Session has expired



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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 _____

Important Changes for DME Providers

Effective March 1, 2010, specialty walkers for children up to the age of 21 covered through the EPSDT Program should be billed using procedure code E0140 (walker with trunk support, adjustable or fixed height, any height, any type). **Modifier U8** is no longer required when billing this code.

Effective May 1, 2010, Alabama Medicaid began reimbursing Durable Medical Equipment (DME) providers the amounts listed for the following procedure codes:

E0149 - \$161.00 (Walker, heavy duty without wheels, rigid or folding any type, each) Recipient's weight, width and height must be submitted with prior authorization requests.

E0168 - \$191.50 (Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each) Recipient's weight, width and depth must be submitted with prior authorization requests.

E0303 - \$2,037.00 (Hospital bed, heavy duty extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any typeside rails, with mattresses)

E0304 - (Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattresses) Medicaid will reimburse for this code based on provider's invoice price plus 20%.

Recipient's weight must be submitted with prior authorization requests for procedure codes E0303 and E0304.

E0911 - \$523.40 (Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar)

E0912 - (Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar) will be covered and Medicaid will reimburse for this based on provider's invoice price plus 20%.

Recipient's weight and width must be submitted with prior authorization requests for procedure codes E0911 and E0912.

Effective June 1, 2010, The National Registry of Rehabilitation Technology Supplier (NRRTS) or the Rehabilitation Engineering Assistive Technology Society of North America (RESNA) certified professional must have direct, in person involvement in the wheelchair selection for the recipient. RESNA certifications must be updated every two years. NRRTS certification must be updated annually. Prior authorization requests will be denied if the NRRTS or RESNA professional's certification is not current; the contractor will deny the PA request.

Effective June 1, 2010, Alabama Medicaid began coverage of procedure code K0005 (ultra lightweight wheelchair).

Effective June 1, 2010, the procedure codes used for the billing of Prosthetic, Orthotic and Pedorthic devices for Adults age 21 - 64 will no longer require prior authorization. DME providers of Prosthetics, Orthotics and Pedorthics devices for adults must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics. A copy of the provider's license must be maintained in the recipient's file for auditing purposes. The provider must be practicing as a Prosthetic, Orthotic or Pedorthic Practitioner in the state of Alabama at an accredited facility. The Occupational Therapist (OT) or the Physical Therapist (PT) performing the wheelchair assessment may not be employed by the DME company or contracted with the DME company requesting the physical therapy evaluation.

Effective July 1, 2010, the current blood glucose test strips and lancets policy for non-insulin dependent recipients will change as follows:

The number of blood glucose test strips will be changed from two boxes each month to one box each month and lancets from one box per month to one box every two months for non-insulin dependent diabetics. If more than one box of blood glucose test strips or lancets is needed, the provider should submit the request for the additional strips or lancets with medical documentation from the primary physician to the LTC Medical Quality and Review Unit for review and approval.

Effective August 1, 2010, Alabama Medicaid will require DME providers to complete Invacare's Seating/Mobility Evaluation Form as an attachment to the Alabama Medicaid Prior Review and Authorization form (Form 342). Invacare's Seating/Mobility Evaluation Form will replace Alabama Medicaid's Motorized/Power Wheelchair Assessment Form (Form 384). The Invacare Seating/Mobility Assessment Form will be accessible on the Alabama Medicaid website at [www.medicaid.alabama.gov/billing/forms/prior authorization forms](http://www.medicaid.alabama.gov/billing/forms/prior%20authorization%20forms).

(continued on page 4)

Consent Forms

It is the responsibility of the performing surgeon to submit a **legible completed** copy of the sterilization/hysterectomy consent form **after** the surgery to:

HP
P.O. Box 244032
Montgomery, AL 36124-4032
Attn: Desiree' Nelson (Do Not Fax consent forms)

Consent forms should not be submitted to HP prior to the surgery date. Providers other than performing surgeon **should not** submit a copy of consent form to HP. Receipt of multiple consent forms slows down the consent form review process and payment of claims.

Top Reasons for Sterilization/Hysterectomy Consent Forms Returned to Provider:

1. Consent form not legible.
2. Consent form is incomplete.
3. Incorrect consent form submitted.
4. Consent form sent prior to surgery.
5. Wrong or missing surgery date.
6. Missing, invalid or incomplete recipient ID.
7. Expected date of delivery is missing in cases of premature delivery on sterilization consent form.
8. Physician signature and/or date are missing.
9. Interpreter's Statement does not contain N/A if an interpreter was not used on the sterilization consent form.
10. Missing ICD.9 code and stated diagnosis on hysterectomy consent form.

Top Reasons for Consent Form Denial:

1. Missing, incomplete or obscured signature/date.
2. Stamped signature missing initials.
3. Recipient not 21 years old when sterilization consent was obtained.
4. Person obtaining sterilization consent signed before recipient or the same date of surgery or after.
5. Less than 30 days elapsed from recipient signature date to surgery date and/or premature delivery date is less than 30 days from signature date.

COBA Denial-Do Not Crossover Denial 1825

What does denial 1825 "COBA Denial – Do Not Crossover" Mean?

This denial means HP does not automatically accept for payment your crossover claims from Medicare.

Changes to COBA Indicators on Provider File

Effective August 1, 2010, HP will turn all Coordination of Benefits Agreement (COBA) indicators on our provider file from "No" to "Yes". The "Yes" status means all claims will automatically crossover from Medicare to Medicaid and will process according to established Medicaid guidelines, without being denied for error 1825. Claims automatically crossing over from Medicare are identified with ICN beginning with "30".

What to do if you do not want your COBA indicator turned to "Yes"

If you do **not** want your COBA indicator turned to a "Yes" status, please send a letter on official office letterhead to HP Provider Enrollment.

The letter should state: *"I do **not** want my COBA indicator turned on to allow claims to automatically crossover."* Please include your NPI and all associated secondary identifiers.

The letter may be faxed to (334) 215-4298.

EXCEPTION: Providers whose COBA Indicators will remain "No"

The following providers' COBA indicators will **not** be turned on since their claims should never crossover from Medicare to Medicaid because of the difference in billing and reimbursement for services:

- Federally Qualified Health Centers
- Rural Health Clinics
- Renal Dialysis Facilities

Crossover claims from Medicare for these providers will continue to receive error 1825.

Important Changes for DME Providers

(continued from page 2)

Alabama Medicaid DME and medical supply providers will be required to have a \$50,000.00 Surety Bond for each NPI by **October 1, 2010**. A DME provider who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested will be exempt from the Alabama Medicaid \$50,000.00 Surety bond requirement.

A DME and Medical Supply business is exempt from surety bond requirements if the DME and Medical supply business:

- (a) Is a DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety, and whose refund requests have been repaid as requested; or
- (b) Is a government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); or
- (c) Is a state-licensed orthotic and prosthetic personnel in private practice making custom-made orthotics and prosthetics; or
- (d) Are physicians and non-physician practitioners, as defined in Section 1842(b)(18) of the Social Security Act; or
- (e) Are physical and occupational therapists in private practice; or
- (f) Are providers who received \$100,000 or less Medicaid payment in the past two calendar years; or
- (g) Are pharmacy providers; or
- (h) Are phototherapy providers who only provide phototherapy services for infants; or
- (i) Are Federally Qualified Health Centers.

DME suppliers who have been a Medicaid provider for five years or longer who are initially exempted from the Medicaid Surety Bond requirement as referenced in Rule (12)(a) of Administrative Code, Chapter 13, will be subject to the Surety Bond requirement if the Medicaid Agency identifies a consistent problem with improper billing or fraudulent activity.

DME providers requesting initial enrollment as an Alabama Medicaid provider will be required to have a \$50,000.00 Surety Bond for three years before qualifying for the \$100,000.00 two year exemption.

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

DME Consignment

DME will not be reimbursed if it is consigned. DME should be provided in accordance with Medicaid policy governing participation in the Alabama Medicaid DME Program (see page 14-2 of the Medicaid DME Provider Manual.) You will note that “DME providers must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. Additionally, there must be one person to conduct business at the physical location. Answering machine and/or answering services are not acceptable as personal coverage during normal business hours. Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, however the satellite could enroll with a separate NPI.” It is the position of the Alabama Medicaid Agency that equipment consigned to a clinic or physician office does not meet this requirement.

Clarification for Non-Oxygen DME Repairs/Parts (K0739, E1399)

Alabama does not require a PA for K0739 (repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes), however, a maximum of four units (1 unit = 15 minutes) for non-oxygen related repairs requiring the skill of a technician is allowed. Any repair request that requires labor exceeding the four units must be submitted to the LTC Medical Quality and Review Unit for review and approval. Replacement parts are reimbursed based on the procedure code and fee schedule pricing. In situations where there are no procedure codes or fee schedule reimbursement for the repair item(s), the provider must submit procedure code E1399 (durable medical equipment, miscellaneous) with an itemized list of the needed repair items with invoice pricing for each item. Alabama Medicaid will reimburse for these repair items based on provider's invoice price plus 20%.

AAC Drug Pricing, Dispense Fee Increase Pending Before CMS

Thanks to ongoing stakeholder involvement and support, Alabama Medicaid is now on schedule to implement a new pharmacy reimbursement system this summer that not only provides a transparent, timely and accurate pricing method for the state but meets federally-mandated requirements to pay providers based on true estimated acquisition costs.

The Agency filed a State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) in May that would remove Average Wholesale Price (AWP) from the “lower of” reimbursement methodology now in use, and add the invoice-based Average Acquisition Cost (AAC) method for brand and generic drug ingredient costs.

The proposed State Plan change pending before CMS also includes a companion request to increase the Agency’s dispensing fee from \$5.40 per prescription to \$10.64 per prescription based on an independent Cost of Dispensing (COD) survey. The cost of dispensing modification and the drug pricing changes are also being submitted through state’s Administrative Code process which includes a public comment period. Pending state and federal approvals, the changes are projected to be effective in August 2010.

According to Alabama Medicaid Commissioner Carol Steckel, the decision to move away from AWP pricing is directly related to a recent Alabama Supreme Court decision that reversed three verdicts that said Alabama Medicaid had been overcharged by drug manufacturers. In reversing the lower court verdicts, the Alabama Supreme Court criticized the state for not changing its pricing methodology since taking issue with the pharmaceutical manufacturers’ price reporting methods.

“As AWP has been found to be inflated in both state and national litigation, our Agency must move away from fraudulent AWP pricing and toward reimbursement logic based on true estimated acquisition costs as mandated in federal guidelines,” she said.

The Agency has contracted with Myers & Stauffer, a nationally recognized accounting firm, to conduct the semi-annual invoice surveys needed to calculate AAC for each drug. Each individual pharmacy will be randomly selected once during a two-year period and required to submit one month’s worth of invoices. Pharmacies may submit invoices by mail, fax, or electronically, or may choose to have their wholesalers coordinate directly with Myers & Stauffer. Continuing with the Agency’s current policy, drug prices will be updated on a weekly basis, and providers may submit specific pricing issues for research 24 hours a day through a web-based submission process.

“Our Agency has been studying ways to improve this system long before the lawsuits were filed in 2005. We have been fortunate to have the active involvement of pharmacy provider associations throughout this process to help us move to more accurate and fair reimbursement process based on the actual cost of dispensing and the actual drug ingredient cost,” said Kelli Littlejohn, Pharm.D., Director of Pharmacy Services for Alabama Medicaid.

In a recent meeting to update all pharmacy provider associations and representatives on the status update of the AAC and COD progress, Dr. Littlejohn reported positive feedback from informal discussions with CMS regarding the proposed changes.

She also announced the Agency is looking forward to beginning work on the third phase of the reimbursement modification, which includes expanding the “Medical Home” concept by incorporating pharmacy providers into “medical neighborhoods.” The “Medical Neighborhood” would allow pharmacies to be reimbursed for professional services while providing patient-centered coordinated care, and to participate in a “shared savings” effort similar to one offered within the Agency’s Patient 1st Program.

“We very much appreciate the continuing support offered by pharmacy providers throughout this process. While this third phase is very preliminary in concept, the Agency will be coordinating with all pharmacy associations during the development process. We will continue to keep all associations apprised of our progress,” she said, noting that a June meeting is scheduled for initial discussions.

Claims for Emergency Ground Transport

Claims for emergency ground transport must include one of the diagnosis codes listed in Chapter 8 of the Provider Manual. If not, your claim will be denied for edit 4580 – BPA-RP-PROC-DIAGNOSIS RESTRICTION-GROUP. System changes have been made that will ensure that this policy is enforced.

Effective May 14, 2010, Medicaid will no longer reimburse the full coinsurance and deductibles for Medicare/Medicaid crossover claims. Claims for dates of service thru 05/13/10 will continue to pay the full coinsurance and deductibles.

Effective May 14, 2010, mileage reimbursement (A0425) increased to \$3.85 per mile. Providers with questions can contact one of their Provider Representatives at 1-800-688-7989.

Changes to Chapter 34 of the Alabama Medicaid Provider Manual

Please note the following changes to Chapter 34 of the Provider Manual:

Effective for dates of service July 1, 2010, and thereafter, the units of measure for Diagnostic Testing Codes 96101 – 96103 and 96118 – 96120 can be billed in 30-minute fractional units. When billing claims, .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers cannot bill less than a 30-minute increment.

The time started and time ended of service delivery will not include time spent for interpretation of tests at this time.

Service documentation requirements have been further clarified and expounded.

Modifiers will be appended to procedure codes when services are performed by eligible allied mental health professional staff. The reimbursement rate for services performed and billed with a modifier will be 75% of the allowable rate. Services performed by an allied mental health professional but not billed with the modifier will be subject to recoupment on post payment review.

If you have further questions, you may contact Karen Smith via e-mail at Karen.watkins-smith@medicaid.alabama.gov or telephone at 334-353-4945.

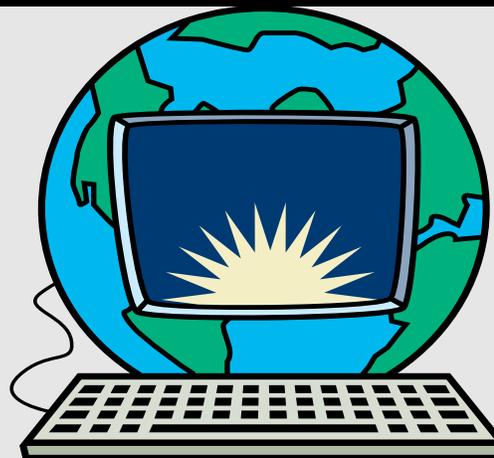


Certified Registered Nurse Practitioner (CRNP)

The CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician, or to satisfy current regulations as physician visits. This requirement includes procedure code 99462 (Subsequent Hospital Care, per day, for evaluation and management of normal newborn).

Visit Alabama Medicaid

ONLINE



***www.medicaid.
alabama.gov***

HP Provider Representative Contact Information

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

G R O U P 1



Misty Curlee

misty.curlee@hp.com
334-215-4159



Mark Bonner

bonner@hp.com
334-215-4132



Gayle Simpson-Jones

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



Michelle Patterson

katherine.patterson@hp.com
334-215-4155

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



Debbie Smith

debbie.smith2@hp.com
334-215-4142

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



Aleetra Adair

aleetra.adair@hp.com
334-215-4158



Ashley Webb

ashley.r.webb@hp.com
334-215-4158



Nawanya Stroud

nawanya.l.stroud@hp.com
334-215-4161

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

linda.hanks@hp.com
334-215-4156



Ann Miller

ann.miller2@hp.com
334-215-4156



Shermeria Hardy-Harvest

shemeria.harvest@hp.com
334-215-4160

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

State Fiscal Year 2010-2011 Checkwrite Schedule

1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
10/08/10	01/07/11	04/01/11	07/08/11
10/22/10	01/21/11	04/15/11	07/22/11
11/05/10	02/04/11	05/06/11	08/05/11
11/19/10	02/18/11	05/20/11	08/19/11
12/03/10	03/04/11	06/03/11	09/09/11
12/17/10	03/18/11	06/17/11	09/16/11

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