

Provider Insider

Alabama Medicaid Bulletin

January 2013

01/04/13 • 01/18/13 • 02/08/13 • 02/22/13 • 03/08/13 • 03/22/13 • 04/05/13 • 04/19/13
05/03/13 • 05/17/13 • 06/07/13 • 06/21/13 • 07/05/13 • 07/19/13 • 08/02/13 • 08/16/13 • 09/06/13 • 09/13/13

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

Attention Physicians

Effective for dates of service on or after 10/24/2012: Audit 5664, Initial office visit/ prior visit contra, has been established to deny the reimbursement of an initial office visit procedure (99201 - 99205) when billed for the same recipient, by the same billing provider, same rendering provider specialty, within 3 (three) years after any subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499).

Effective for dates of service on or after 10/24/2012: Audit 5665, Prior visit/initial office visit contra, has been established to deny the reimbursement of subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499) when billed for the same recipient, by the same billing provider, same rendering provider, provider specialty, anytime within 3 (years) prior to an initial office visit procedure (99201 - 99205).

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



Vendor Survey on ICD-10 Readiness

Providers: Please pass this information along to your software vendors.

Alabama Medicaid and HP would like software vendors to log on to the Medicaid website between January 2 and January 21, 2013 to complete a brief survey on ICD-10 readiness. The surveys should take less than five minutes to complete and will provide Medicaid with information on provider and vendor readiness to implement ICD-10. The survey is located at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.1.1_ICD-10_Surveys.aspx.

A similar survey for providers will be available between February 14 and March 5, 2013.

Our goal is to implement changes related to ICD-10 on or before October 1, 2013, but not accept ICD-10 codes until October 1, 2014. Please stay abreast of updates by visiting the ICD-10 page on the Medicaid website located at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx. If you have any questions about ICD-10 please send an email to alabamaictesting@hp.com.

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Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- Office Manager
- Billing Department
- Medical/Clinical Professionals
- Other _____

ICD-10 Email Notifications

To receive email notifications concerning ICD-10 changes, please log on to the Alabama Medicaid Provider Web Portal and update your Account Maintenance email address.

If more than a single person is to receive these notifications, **create a single email distribution address within your own email server. Enter this single email address on the Account Maintenance page.**

Providers and Trading Partners may update their email by logging onto the Provider Web Portal. Website: <https://www.medicaid.alabamaservices.org/ALPortal/default.aspx>
Navigation: Account > Account Maintenance.

Changes to Initial Office Visit, Subsequent Office, Hospital Evaluation, Nursing Home Evaluation and Management Service Billing

Effective October 24, 2012, Medicaid made changes to comply with the Current Procedural Terminology Manual (CPT). Providers may no longer bill for any subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499) and an initial office visit procedure (99201 - 99205) for the same recipient, by the same billing provider, same rendering provider specialty, within a three-year time frame. Please refer to current CPT guidelines for clarification.

Attention Eye Care Providers

The Medicaid Secure website is currently not displaying eye care benefit limitations (frames, lens, exam and fit) correctly at this time for children under the age of 21. To verify eligibility for eye care limitations (frames, lens, exam and fit) for recipients under the age of 21, providers should call the Provider Assistance Center at 1-800-688-7989. Providers will be notified when they may resume using the Medicaid Secure Website to verify eligibility.

Clarification on Recent Changes Related to Claims With Another Insurance Primary

A new TPL attachment form has been created for submitting paper claims and reporting the following other payer information: paid amount, deductible amount, coinsurance amount and co-pay amount. This form will be required with the CMS 1500 form when third party applies to a claim. The forms are available free of charge and may be ordered by calling the Provider Assistance Center at 1-800-688-7989.

When Should This Attachment Be Used?

This attachment should only be used when a provider must submit a claim on paper and the provider needs to submit information regarding the amounts processed by the other payer: paid amount, deductible amount, coinsurance amount, co-pay amount (For example, third party PAID or applied all the allowed charges to patient responsibility but an administrative review is needed on the claim). **Please remember, Medicaid requires claims be submitted electronically unless an administrative or manual review is required. The majority of these claims will continue to be submitted electronically.**

Claims with third party denials should continue to be submitted in this fashion:

- Indicate TPL denial on the claim in the appropriate block/form locator (for example, Block 19 of CMS-1500 claim form)
- Attach TPL denial to the error free claim for processing

Providers should now be able to submit more claims electronically when the other payer paid **or when the other payer applied the charges to patient responsibility.** A provider can now submit a claim for TPL electronically when the other payer pays zero, but the patient responsibility is greater than zero.

This can include:

- If any amount greater than zero is entered in the other payer co-pay field, and/or
- If any amount greater than zero is entered in the other payer deductible field, and/or
- If any amount greater than zero is entered in the other payer coinsurance field

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible.

Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer). When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for professional claims only. All other claim types will continue to price as usual at this time.

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

PSYCHIATRIC SERVICES 2012 TO 2013 CROSSWALK

To: All Psychologists and Rehabilitation Option Providers

Due to recent CPT code changes by the American Psychiatric Association (APA), the Alabama Medicaid Agency will implement the following CPT coding changes effective for dates of service January 1, 2013, and thereafter. Incorrectly coded claims will deny on or after this date.

For Psychology Providers

Code 90792 will not be a covered service for psychologists.

2012			2013		
Service	CPT Code	2013 Status	Service	CPT Code	Report with interactive complexity (+90785)
Diagnostic					
Diagnostic interview examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	90792	
Interactive diagnostic interview examination	90802	DELETED	Diagnostic evaluation (no medical)	90791	Yes
			Diagnostic evaluation with medical	90792	
Psychotherapy					
Individual psychotherapy 20-30 min	90804, 90816	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
45-50 min	90806, 90818		45 (38-52*) min	90834	
75-80 min	90808, 90821		60 (53+*) min	90837	
Interactive individual psychotherapy 20-30 min	90810, 90823	DELETED	30 (16-37*) min	90832	Yes
45-50 min	90812, 90826		45 (38-52*) min	90834	
75-80 min	90814, 90828		60 (53+*) min	90837	

For Rehabilitation Option Providers

Code 90792 will be a covered service for the physician (psychiatrist) only.

The Family and Group Therapy codes 90846, 90847, 90849, and 90853 remain unchanged.

2012			2013		
Service	CPT Code	2013 Status	Service	CPT Code	Report with interactive complexity (+90785)
Diagnostic					
Diagnostic Interview Examination	90801	DELETED	Diagnostic evaluation (no medical)	90791	When appropriate
			Diagnostic evaluation with medical	90792	
Individual psychotherapy 20-30 min	90804	DELETED	Psychotherapy 30 (16-37*) min	90832	When appropriate
			45 (38-52*) min	90834	
			60 (53+*) min	90837	

For additional information in reference to the current behavioral health CPT code changes, click on the following link: <http://www.psychiatry.org/practice/managing-a-practice/cpt-changes-2013> and go to the documents listed in the Additional Coding Resources section.

If you have further questions, you may contact the HP Provider Assistance Center at (800) 688-7989.

SPECIAL ATTENTION

Hospitals Designated as 340-B Entities

Effective for claims submitted on October 1, 2012, and thereafter, hospitals designated as 340-B entities may bill 'total charges' on the UB-04 claim form when billing for outpatient pharmacy charges. For any questions, contact Jerri Jackson via e-mail at jerri.jackson@medicaid.alabama.gov or via phone at 334-242-5630.

Hospital - Based Physician Clinics

Effective for dates of service on or after October 1, 2012, Medicaid will allow revenue code 51X, clinic, to be billed with evaluation and management procedure codes 99201-99215. For any questions, contact Jerri Jackson via e-mail at jerri.jackson@medicaid.alabama.gov or via phone at 334-242-5630.

Chlamydia and Gonorrhea

Effective for dates of service on or after September 1, 2012, chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead. For any questions, contact Toni Hopgood via e-mail at toni.hopgood@medicaid.alabama.gov or via phone at 334-353-4724.

Hospital Billers and Quality Assurance Case Managers

Medicaid will no longer require in state and border hospital providers to report dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy on the UB-04 claim form. Medicaid will continue to utilize the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes. This criteria can be found on the following link: http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.6_Hospital_Services/4.4.6_Inpatient_Care_Criteria.pdf. For any questions, contact Jerri Jackson via e-mail at jerri.jackson@medicaid.alabama.gov or via phone at 334-242-5630.

EPSDT Periodicity Schedule

Periodic screenings must be performed annually (per calendar year) through 20 years of age beginning with the third birthday. For any questions, contact Toni Hopgood via e-mail at toni.hopgood@medicaid.alabama.gov or via phone at 334-353-4724.

Medicaid's Quantitative Drug Screening Policy

Medicaid's Quantitative Drug Screening Policy was implemented January 1, 2012. This policy is referenced in Medicaid's Independent Laboratory Provider Manual Chapter 20 and is applicable to any provider that bills Medicaid for drug screens. For any questions, contact Toni Hopgood via e-mail at toni.hopgood@medicaid.alabama.gov or via phone at 334-353-4724.

Newborn Screening Policy

Medicaid's Newborn Screening Policy has been updated in Appendix A - 'Well Child Check-Up'. This was an outdated policy and revisions were made to include revised Newborn Screening tests. These revisions were coordinated with the Alabama Department of Public Health. For any questions, contact Toni Hopgood via e-mail at toni.hopgood@medicaid.alabama.gov or via phone at 334-353-4724.

Renal Dialysis Facilities and Independent Laboratories

This is a reminder that per treatment, weekly and monthly lab values are considered part of the composite rate billed by renal dialysis facilities for hemodialysis and peritoneal dialysis. These lab values should not be billed separately from the composite rate by an independent laboratory or the renal dialysis facility. These lab tests are listed in Chapter 35, Renal Dialysis Facility, of the Provider Manual. For any questions, contact Jerri Jackson via e-mail at jerri.jackson@medicaid.alabama.gov or via phone at 334-242-5630.

"Policy change to J9035, Avastin"

Effective for dates of service January 1, 2013, Alabama Medicaid will no longer reimburse providers for the breast cancer diagnosis for J9035, Avastin. This decision has been made as a result of the FDA withdrawing approval for use of Avastin for breast cancer and after consulting with Clinical Oncologists at both UAB and USA.

Alabama Medicaid will continue to reimburse providers for recipients who have received Avastin for breast cancer within the past twelve calendar months. Claims for recipients who have never received Avastin for breast cancer will be denied. Claims for recipients who have not received Avastin for breast cancer within the past twelve calendar months will also be denied.

All other approved diagnosis will continue to be covered.

SPECIAL ATTENTION



Policy Reminder for Physicians Writing Prescriptions

If a prescription to be paid by Medicaid exceeds the drug's maximum unit limit allowed per month, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the recipient can be charged as a cash recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be "split billed" (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied. A prescriber should not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process. Note: A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service. For more information, this policy can be found in the Alabama Medicaid Provider Billing Manual, Chapter 27.

Physician- Employed Practitioner Reminder



Physician Assistants (PAs) or Certified Registered Nurse Practitioners (CRNP) who are legally authorized to furnish services and who render services under the supervision of an employing physician must enroll with the Alabama Medicaid Agency and receive a NPI number with the employing physician as the payee. The employing physician must be a Medicaid provider in active status. Covered services furnished by the PA or CRNP must be billed under the PA's or CRNP's name and NPI. The PA's or CRNP's employing physician is responsible for the professional activities of the PA or CRNP and for assuring that the services provided are medically necessary and appropriate for the patient. Services billed outside a PA or CRNP scope of practice and/or collaborative agreement is subject to post-payment review.

Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers

Claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied effective for claims received January 1, 2013, and thereafter.

Federal law requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable only if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict).

An enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section: http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

HPES Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

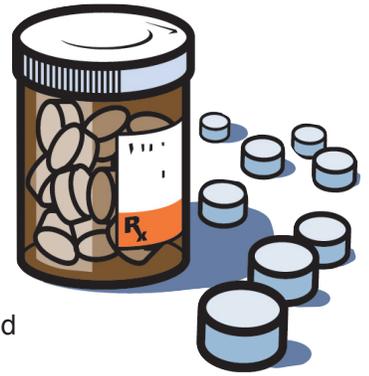
NO-SHOW FEE

A Medicaid recipient may not be charged or billed for a cancelled or missed appointment.

Attention Pharmacy Providers Billing for Compound Drugs

The following changes will be effective January 1, 2013:

- When compound drugs are being billed to Medicaid, an additional NDC must be billed with the compound drug.
- A compound drug with a reimbursable amount over \$200 requires a prior authorization prior to being billed.
- A compound drug which exceeds \$200 that is submitted without a prior authorization on file will be denied.
- Pharmacy claims filed for bulk chemicals should only be billed when the claim is billed as a compound drug, and must meet the criteria outlined above.



“Payer of Last Resort” Rule Maximizes Taxpayer Dollars for Medicaid

Alabama Medicaid recipients often have private health insurance as well as Medicaid. To maximize state taxpayer dollars, the Alabama Medicaid Agency’s Third Party Division is responsible for ensuring that Medicaid is the “payer of last resort.” Generally, this means that providers are responsible for filing for reimbursement from the primary insurance prior to billing Medicaid. However, there are some federally required exceptions to this rule:

1. When the service is a preventive pediatric service
2. When the service is for prenatal care provided outside of managed care

Under these federal exceptions, Medicaid is required to pay the claim if Medicaid is billed first as the primary insurance. Medicaid then bills the other insurance plan for reimbursement—a process known as “pay and chase.” Please NOTE: The federal rule is a Centers for Medicare and Medicaid (CMS) requirement for Medicaid to pay if they are billed first. This is not a federal requirement for the health care provider. Providers may choose to bill preventive pediatric services (such as EPSDT screenings and preventive dental services) to the other insurance plan first before billing Medicaid. Billing the other insurance plan first is acceptable and eliminates the need for Medicaid to “pay and chase” the claim.

Procedure codes with modifier EP **are** used for billing EPSDT screenings and are included in the preventive pediatric services “federal exception” group. These codes include:

Well Office Visit Preventive Procedure Codes-Modifier

- 99381-EP – New Patient (under 1 year of age)
- 99382-EP – New Patient (1 through 4 years of age)
- 99383-EP – New Patient (5 through 11 years of age)
- 99384-EP – New Patient (12 through 17 years of age)
- 99385-EP – New Patient (18 through 20 years of age)
- 99391-EP – Established Patient (under 1 year of age)
- 99392-EP – Established Patient (1 through 4 years of age)
- 99393-EP – Established Patient (5 through 11 years of age)
- 99394-EP – Established Patient (12 through 17 years of age)
- 99395-EP – Established Patient (18 through 20 years of age)

Dental Procedure Codes included in “pay and chase” as a preventive pediatric service include:

- | | |
|-------|-------|
| D0110 | D1351 |
| D0120 | D1510 |
| D1110 | D1515 |
| D1120 | D1520 |
| D1203 | D1525 |
| D1204 | D1550 |
| D1330 | |

Providers with questions regarding benefit coordination, filing procedures, or other billing issues should contact HP Provider Assistance Center at 1-800-688-7989.



Important Changes for Providers Performing Reconstructive/Cosmetic Procedures

Effective January 1, 2013, the Alabama Medicaid Agency will:

Require prior authorization to determine medical necessity before services are rendered to the recipient for the following CPT codes:

21740 (Reconstructive repair of pectus excavatum or carinatum; open), **21742** (Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach, without thoracoscopy), **21743** (Reconstructive repair of pectus excavatum or carinatum; minimally invasive approach, with thoracoscopy), **56620** (Vulvectomy simple; partial), **56625** (Vulvectomy simple; complete), **64821** (Sympathectomy; radial artery), **64822** (Sympathectomy; ulnar artery), **64823** (Sympathectomy; superficial palmar arch), and **97033** (Application of a modality to 1 or more areas; iontophoresis, each 15 min).

Require prior authorization to determine medical necessity before services are rendered to the recipient for ages **5 and older** for the following Strabismus Surgery CPT codes:

67311 (Strabismus surgery, recession or resection procedure; 1 horizontal muscle), **67312** (2 horizontal muscles), **67314** (1 vertical muscle), **67316** (2 or more vertical muscles), **67318** (Strabismus surgery, any procedure, superior oblique muscle), **67320** (Transposition procedure, any extraocular muscle), **67331** (Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles), **67332** (Strabismus surgery on patient with scarring of extraocular muscles), **67334** (Strabismus surgery by posterior fixation suture technique, with or without muscle recession), **67335** (Placement of adjustable suture(s) during strabismus surgery), and **67340** (Strabismus surgery involving exploration and/or repair of detached extraocular muscles).

Continue coverage of the following CPT codes for Crossover and QMB claims only:

11200 (Removal of skin tags), **11201** (Removal of skin tags; each additional 10 lesions), **15819** (Cervicoplasty), **15820** (Blepharoplasty, lower lid), **15821** (Blepharoplasty, lower lid; with extensive herniated fat pad), **15832** (Excise excessive skin tissue; thigh), **15833** (Excise excessive skin tissue; leg), **15834** (Excise excessive skin tissue; hip), **15835** (Excise excessive skin tissue; buttock), **15836** (Excise excessive skin tissue; arm), **15837** (Excise excessive skin tissue; forearm or hand), **15838** (Excise excessive skin tissue; submental fat pad), **15839** (Excise excessive skin tissue; other area), **17360** (Chemical exfoliation for acne), **30120** (Excision or surgical planning of skin of nose for rhinophyma), **64650** (Chemodenervation of eccrine glands; both axillae), **64653** (other area(s) per day), and 96912 (Photochemotherapy; psoralens and ultraviolet A).

End coverage of the following CPT codes:

11950 (Subcutaneous injection of filling material; 1 cc or less), **11951** (Subcutaneous injection of filling material; 1.1 to 5.0 cc), **11952** (Subcutaneous injection of filling material; 5.1 to 10.0 cc), **11954** (Subcutaneous injection of filling material; over 10 cc), **15788** (Chemical peel, facial; epidermal), **15789** (Chemical peel, facial; epidermal; dermal), **15792** (Chemical peel, nonfacial; epidermal), **15793** (Chemical peel, nonfacial; dermal), **15824** (Rhytidectomy; forehead), **15876** (Suction assisted lipectomy; head and neck), **15877** (Suction assisted lipectomy; trunk), **15878** (Suction assisted lipectomy; upper extremity), **15879** (Suction assisted lipectomy; lower extremity), **17380** (Electrolysis epilation, each 30 minutes), and **96904** (Whole body integumentary photography).

Continue coverage of the following CPT codes for **female recipients ages 0 – 20 years for medical necessity**:

56805 (Clitoroplasty for intersex state), **57291** (Construction of artificial vagina; without graft), **57292** (Construction of artificial vagina; with graft), **57295** (Revision of prosthetic vaginal graft; vaginal approach), and **57296** (Revision of prosthetic vaginal graft; open abdominal approach).

CPT Codes 12011 – 12015 (Simple repair of superficial wounds) will be denied when billed for **ear piercing complications**. Earlobe repair, or repair of a body site piercing, to close a stretched pierced hole in the absence of traumatic injury is considered cosmetic and therefore not medically necessary.

Provider Electronic Solutions (PES) Software Version 3.02 is Now Available

Please refer to Appendix C Change Log in the PES User Manual for a full list of the changes included in the new PES version. Please note the following:

- PES version 3.02 includes changes for ICD-10.
- The upgrade process will set all previous Claim and Prior Authorization ICD versions to ICD-9 ('9').
- The ICD version field on new Claims and Prior Authorizations will default to ICD-9 ('9').
- The Procedure/HCPCS list has been split into multiple lists:
 - Procedure HCPCS (non-surgical procedure codes)
 - Procedure ICD-9 (surgical procedure codes)
 - Procedure ICD-10 (surgical procedure codes)
- Procedure codes currently entered on the 'Procedure/HCPCS' list will be moved to both 'Procedure HCPCS' AND "Procedure ICD-9" when an upgrade to version 3.02 is performed. Users will need to remove invalid codes from each respective list.
- The Diagnosis list has been split into multiple lists:
 - Diagnosis ICD-9
 - Diagnosis ICD-10
- Diagnosis codes currently entered on the diagnosis list will be moved to the new 'Diagnosis ICD-9' list when an upgrade to version 3.02 is performed.
- Users may begin building ICD-10 lists now. ICD-10 codes should not be submitted until the CMS mandated date of October 1, 2014.

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