

# Provider Insider

Alabama Medicaid Bulletin

July 2013

07/05/13 • 07/19/13 • 08/02/13 • 08/16/13 • 09/06/13 • 09/13/13 • 10/04/13 • 10/18/13 • 11/01/13 • 11/15/13  
12/06/13 • 12/13/13 • 01/03/14 • 01/17/14 • 02/07/14 • 02/21/14 • 03/07/14 • 03/21/14 • 04/04/14 • 04/18/14

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

## Copayment Changes Effective July 1, 2013

Effective for dates of service July 1, 2013, and thereafter, copayments for Medicaid covered services will be based on the federally approved maximum amounts shown below (including Medicare crossovers):

- **Office Visit** (including visits to physicians, optometrists, nurse practitioners):  
The copayment amount is:  
\$3.90 for procedure codes reimbursed \$50.01 and greater  
\$2.60 for procedure codes reimbursed between \$25.01 and \$50.00  
\$1.30 for procedure codes reimbursed between \$10.01 and \$25.00

The following CPT codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

90847, 90849, 90853, 90865, 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- **Federally Qualified Health Center (FQHC)**  
The copayment amount is \$3.90 per visit (encounter)
- **Rural Health Clinic (RHC)**  
The copayment amount is \$3.90 per visit (encounter)
- **Ambulatory Surgical Center**  
The copayment amount is \$3.90 per visit.
- **Outpatient Hospital**  
The copayment amount is \$3.90 per visit.
- **Inpatient Hospital**  
The copayment amount is \$50.00 per admission.



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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 \_\_\_\_\_

## **Drug Enforcement Administration (DEA) Validation for Controlled Substances**

Medicaid extended the May 13, 2013, implementation date of the DEA validation of controlled substance prescription claims to July 8, 2013. Effective July 8, 2013, Medicaid will **DENY** any claim for a controlled drug written by a prescriber who does not have their DEA number registered with the Department of Justice (DOJ) and on file at Medicaid.

### **What action needs to be taken to prevent claims from denying on July 8, 2013?**

Physicians – Make sure your DEA number is registered with DOJ and is on your enrollment file at Medicaid.

See ALERT on Medicaid's website dated May 16, 2013, for more details.

## **Eligibility Verification Enhancement-Providers Can Now Check to See the Status of a Recipient's Application**



Providers can now check the application status for recipients to see if an application for Medicaid has been received. Using the Medicaid Secure Website, providers should go to eligibility, enter the recipient's Name and Date of Birth, or Name, Date of Birth and Social Security Number, and select Recipient Eligibility Status. The system checks application status for families, family planning, pregnancy (TXIX SOBRA), assistance with paying premiums and elderly and disabled. It will let the provider know if the application is pending, approved, or denied. This will help prevent duplicate applications and let a provider know the patient has applied for Alabama Medicaid.

## **Copayment Changes Effective July 1, 2013** *(article continued from page 1)*

- **Durable Medical Equipment (DME)**  
*(examples of DME: canes, crutches, walkers, wheelchairs, hospital beds, and oxygen equipment)*

The copayment amount is:

\$3.90 for item reimbursed \$50.01 and greater  
\$2.60 for item reimbursed between \$25.01 and \$50.00  
\$1.30 for item reimbursed between \$10.01 and \$25.00

- **Medical Supplies and Appliances**  
*(example of supplies: syringe with needle, alcohol wipes, ostomy pouch, tape, gauze)*  
*(example of appliances: hearing aids, orthoses (braces, supports, and other devices) and prostheses (replacement limbs and facial parts))*

The copayment amount is:

\$3.90 for item reimbursed \$50.01 and greater  
\$2.60 for item reimbursed between \$25.01 and \$50.00  
\$1.30 for item reimbursed between \$10.01 and \$25.00  
\$0.65 for item reimbursed less than \$10.00

- **Prescription Drugs**

The copayment amount is:

\$3.90 for prescription reimbursed \$50.01 and greater  
\$2.60 for prescription reimbursed between \$25.01 and \$50.00  
\$1.30 for prescription reimbursed between \$10.01 and \$25.00  
\$0.65 for prescription reimbursed less than \$10.00

### **Copayment does not apply to services provided:**

- to pregnant women
- to nursing facility residents
- to recipients less than 18 years of age
- to Native American Indians with an active user letter from Indian Health Services (IHS)
- for Emergencies
- for Family Planning

***The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (co-payment) amount imposed.***



## Primary Care Physician Rate Increase (BUMP) to comply with ACA

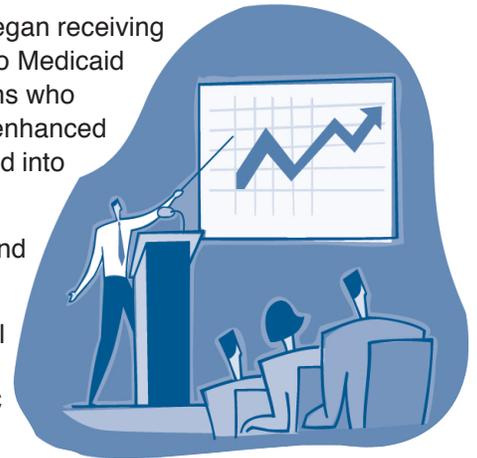
As the result of the Affordable Care Act (ACA), eligible primary care physicians began receiving increased payments on June 8, 2013, for certain primary care services provided to Medicaid recipients between January 1, 2013 and December 31, 2014. Qualifying physicians who submitted their self-attestation to HPES on or after June 8, 2013, will be paid the enhanced reimbursement for dates of service beginning with the date the attestation is entered into the system by HPES.

In July 2013, Medicaid will begin reprocessing claims paid under the old rate and should have all reprocessing completed by the end of September 2013.

The primary care services subject to the increased payment are Current Procedural Terminology (CPT) Evaluation and Management procedure codes 99201 to 99499, and Vaccine Administration codes. The Alabama Medicaid Agency requires the VFC administration fees to be billed using the specific product code (vaccine codes).

These VFC codes are: 90633, 90636, 90645, 90647, 90648, 90649, 90650, 90655, 90656, 90657, 90658, 90660, 90669, 90670, 90680, 90681, 90696, 90698, 90700, 90702, 90707, 90710, 90713, 90714, 90715, 90716, 90721, 90723, 90732, 90733, 90734, 90744, and 90748.

Increased payment is also being made for primary care services rendered by physician assistants or certified nurse practitioners working under the personal supervision of a qualifying physician. In this case, the physician must assume professional/financial responsibility and is legally liable for the quality of services provided under his or her supervision.



### Hospital UR Plans and MCE Study Reviews

Federal regulations require that hospitals submit Utilization Review (UR) Plans and Medical Care Evaluation Studies (MCE) annually as part of an ongoing quality improvement process. To that end, Alabama Medicaid has contracted with AFMC to perform annual reviews of hospital Utilization Review (UR) Plans and Medical Care Evaluation (MCE) Studies.

As the state's Quality Improvement Organization, AFMC is required to collect and maintain a copy of these documents on an annual basis. A review of 50 percent of the hospitals is to be done each year so that every hospital has a completed UR Plan and MCE Study every two years.

All in-state and border hospitals must submit MCE Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to AFMC by the date requested. The Alabama Medicaid Agency monitors provider compliance in meeting this requirement, as part of the oversight process.

For more information refer to the Provider Manual Hospital Chapter 19, page 19-13 and the Administrative Code Chapter 7 Hospitals, Rule No. 560-X-7.16 (6).

### Corrections and Addendum to January and April 2013 Article "Important Changes for Providers Performing Reconstructive/Cosmetic Procedures"

Coverage for the following CPT codes will continue without any age restriction: **57295** (Revision of prosthetic vaginal graft; vaginal approach) and **57296** (Revision of prosthetic graft; open abdominal approach).

CPT code **97033** (Application of a modality to 1 or more areas; iontophoresis, each 15 minutes) will be covered for crossover only claims effective August 1, 2013.

Photographs are not required for review when requesting prior authorization for CPT codes **54163** (Repair incomplete circumcision), **56620** (Vulvectomy simple; partial) and **56625** (Vulvectomy simple; complete). In lieu of photographs, a detailed written description documenting the condition/area to be corrected must be submitted along with other supporting documentation (progress notes, operative notes, etc.).



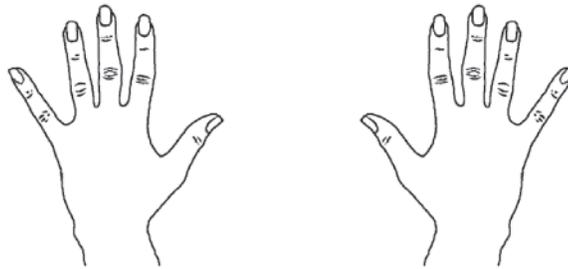
### Example of correct use of eyelid modifiers

1. 67930 E1
2. 67935 E3



When **digits** of the **hands or feet** are coded, instead of modifier RT or LT, the procedure codes should be appended with:

- FA** Left hand, thumb
- F1** Left hand, second digit
- F2** Left hand, third digit
- F3** Left hand, fourth digit
- F4** Left hand, fifth digit
- F5** Right hand, thumb
- F6** Right hand, second digit
- F7** Right hand, third digit
- F8** Right hand, fourth digit
- F9** Right hand, fifth digit



When coding procedures performed on either the right or left side of the body, the procedure codes should be appended with modifiers:

- RT** Right side
- LT** Left side

### Example of correct use of Modifiers RT and LT

1. 69436 **RT**
2. 69436 **LT**



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## ***Sterilization Consent Form***

It is the responsibility of the **performing surgeon** to submit a legible hard copy of the recipient's signed sterilization consent form to HP. Therefore, providers other than performing surgeon **should not** submit a copy of the consent form to HP. Receipt of multiple consent forms slows down the consent form review process and payment of claims. All blanks on the consent form must be completed with the only exceptions being the "Race and Ethnicity" and the "Title of the person obtaining consent" designation which is optional. Consent forms submitted to HP with missing and/or invalid information in non-correctable fields (signature and date of recipient and person obtaining consent) of the consent form will be denied by HP and not returned to the provider. Before sending the consent form to HP, it is imperative that the **date of surgery** be clarified by reviewing the operative note to remedy claim denials due to incorrect date of surgery. Consent forms should be mailed to:

HPES  
PO Box 244032,  
Montgomery, AL 36124-4032.  
Attn: Medical Policy Unit/Consent Forms

## ***Modifier 26 and CG for Physician Inpatient Professional Interpretation(s)***

Physician(s) **may** bill for inpatient professional interpretation(s), when that interpretation serves as the official and final report documented in the patient's medical record. Professional interpretation may be billed in addition to a hospital visit if the rounding physician also is responsible for the documentation of the final report for the procedure in the patient's medical record. The procedure code must be billed with modifier **26** (Professional Component) and modifier **CG** (Policy criteria applied) appended. Please refer to the Alabama Medicaid Provider Manual, Chapter 28, for a list of inpatient professional interpretation services that are allowed in addition to a hospital visit.

Physician(s) **may not** bill for inpatient professional interpretation(s) in addition to hospital visits if the provider reviews results in the medical record or unofficially interprets medical, laboratory, or radiology tests. Review and interpretation of such tests and results are included in the evaluation and management of the inpatient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit for most services.

## Oncotype DX™

Effective for dates of service, July 1 and thereafter, Medicaid will cover the Oncotype DX™ genetic profiling lab test if the patient meets Medicaid's prior authorization criteria. Oncotype DX™ is a genetic profiling test developed to classify the risk of recurrence among women treated for early stage breast cancer.

The use of the 21-gene RT-PCR Assay (i.e., Oncotype DX™) to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy meets Alabama Medicaid's medical criteria for coverage in women with early stage breast cancer with **ALL** of the following characteristics:

- Newly diagnosed, primary, early stage breast cancer (stage I or stage II) in a female without significant co-morbidities;
- Unilateral, non-fixed tumor;
- Hormone receptor positive (ER-positive or PR-positive);
- HER2-negative;
- Tumor size 0.6-1cm with moderate/poor differentiation or unfavorable features OR tumor size > 1cm;
- Node negative;
- Will be treated with adjuvant endocrine therapy, e.g., tamoxifen or aromatase inhibitors; AND
- When the test result will aid the patient in making the decision regarding chemotherapy (i.e., when chemotherapy is considered a therapeutic option); AND
- When ordered within 6 months following breast cancer diagnosis.

### Limitations:

- The 21-gene RT-PCR Assay Oncotype DX™ should only be ordered on a tissue specimen obtained during surgical removal of the tumor and after subsequent pathology examination of the tumor has been completed and determined to meet the above criteria (i.e., the test should not be ordered on a preliminary core biopsy).
- The test should be ordered in the context of a physician-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy. This discussion must be documented in the patient's clinical record and a copy of the progress note (signed by the ordering physician) must accompany the PA request (Form 342).
- The Oncotype DX™ test will be limited to one per lifetime, per recipient.
- Repeat tests will not be covered.
- The test will be limited to the following diagnoses: malignant neoplasm of the female breast, carcinoma in situ of breast, and personal history of malignant neoplasm, breast.

Providers must bill procedure code S3854 (gene expression profiling panel for use in the management of breast cancer).

The Oncotype DX™ will be exempt from Patient 1st and EPSDT requirements. The Form 342 **must be** completely filled out, signed by the ordering physician and indicate the name and phone number of the ordering physician. The Form 342 will suffice as the prescription for the test. The test must be performed by an enrolled independent laboratory and ordered by a physician. Please contact Toni Hopgood at [toni.hopgood@medicaid.alabama.gov](mailto:toni.hopgood@medicaid.alabama.gov) for any questions.

### Nerve Conduction Studies and Electromyography

Effective July 1, 2013 and thereafter, the following policy will apply to providers performing Nerve Conduction Studies and Electromyography: Nerve Conduction Studies (NCS) measure action potentials recorded over the nerve or from an innervated muscle. Nerve Conduction Velocity (NCV), one aspect of NCS, is measured between two sites of stimulation or between a stimulus and a recording site. It is axiomatic that neurodiagnostic studies are an extension of the history and physical examination of the patient and must be performed as part of a face-to-face encounter. Obtaining and interpreting nerve conduction velocities requires extensive interaction between the performing physician and patient and is most effective when both obtaining raw data and interpretation are performed together on a real-time basis.

Results of NCV reflect on the integrity and function of: 1) the myelin sheath {Schwann cell-derived insulation covering an axon}; and, 2) the axon {an extension of the neuronal cell body} of a nerve. Axonal damage or dysfunction generally results in loss of nerve or muscle potential amplitude, whereas demyelination leads to prolongation of conduction time.

The following are examples of appropriate clinical settings where nerve conduction studies are helpful in diagnosing:

- Focal neuropathies or compressive lesions such as carpal tunnel syndrome, ulnar neuropathies or root lesions for localization.
- Traumatic nerve lesions for diagnosis and prognosis.
- Diagnosis or confirmation of suspected generalized neuropathies, such as diabetic, uremic, metabolic, inflammatory or immune.
- Repetitive nerve stimulation in diagnosis of neuromuscular junction disorders such as myasthenia gravis and myasthenic syndromes.

**F-wave studies** are often performed in conjunction with motor NCS; H-reflex studies involve both sensory and motor nerves and their connections with the spinal cord. The device used must be capable of recording amplitude, duration, response configuration (motor NCV) and latency and sensory nerve action potential amplitudes (sensory NCV).

**Electromyography (EMG)** is the study of intrinsic electrical properties of skeletal muscle utilizing insertion of a (frequently disposable) needle electrode into muscles of interest. EMG testing relies on both auditory and visual feedback from the electromyographer. EMG results reflect not only the integrity of the functioning connection between a nerve and its innervated muscle, but on the integrity of the muscle itself. The device used must be capable of recording motor unit recruitment, amplitude, configuration, spontaneous and insertional activity. Use for intraoperative monitoring of central nervous system tissue during the resection of benign and malignant neoplasia and during corrective surgery for scoliosis may also be needed.

The axon innervating a muscle is primarily responsible for the muscles' volitional contraction, survival and trophic functions. Prime examples of diseases characterized by abnormal EMG are disc disease with abnormal nerve compression, amyotrophic lateral sclerosis and neuropathies. Axonal and muscle involvement are most sensitively detected by EMGs, and myelin and axonal involvement are best detected by NCV.

### **Use of EMG with Botulinum Toxin Injection**

EMG may be used to optimize the anatomic location of botulinum toxin injection. It is expected there will be one study performed per anatomic location of injection, if needed. It is expected that the accompanying study to the injection be billed as a limited study (95874) unless supportive documentation is noted to show why more extensive studies are indicated.

### **Limitations**

- Sensory nerve function testing performed with various sensory discrimination and pressure-sensitive devices, including but not limited to current perception testing (e.g., Neurometer®), is not covered. Do not report such testing as nerve conduction testing using any CPT code included in this Policy.
- Nerve conduction studies and EMG will not be covered if provided in the beneficiary's home.

Providers shall consider a service to be reasonable and necessary if the provider determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the clinical trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - o Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  - o Furnished in a setting appropriate to the patient's medical needs and condition.
  - o Ordered and furnished by qualified personnel.
  - o The EMG must always be ordered, performed and interpreted by a physician trained in electrodiagnostic medicine.
  - o The NCS may be performed by a physician or a trained allied health professional working under the direct supervision of a physician trained in electrodiagnostic medicine. The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) states, "NCSs should be either (a) performed directly by physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed". One that meets, but does not exceed, the patient's medical need.
  - o At least as beneficial as an existing and available medically appropriate alternative.

## **Documentation Requirements**

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and made available to Medicaid upon request.

It is expected that the (Nerve Conduction Velocity) NCV and EMG reports will contain data from the study as well as the interpretation and diagnosis.

- In the event of a review for medical necessity, the patient's medical record must support the need for the studies performed. The number of limbs or areas tested should be the minimum needed to evaluate the patient's condition. Repeat testing should be infrequent; limitation of testing services will be determined on the basis of individual medical necessity.
- Documentation addressing the need to evaluate the patient for peripheral neuropathy must be maintained by the practitioner and available upon request.
- Documentation addressing the indications and circumstances requiring individual nerve conduction studies (without accompanying EMG) must be maintained by the practitioner, and made available upon request.
- Credentials of providers billing for needle electromyography must be made available on request. According to the AANEM American Association of Neuromuscular & Electrodiagnostic Medicine, the EMG must be performed and interpreted by a physician who received training during residency and/or in special EDX fellowships after residency. Knowledge of EDX medicine is necessary to pass the board exams given by the American Board of Physical Medicine and Rehabilitation and the American Board of Psychiatry and Neurology.
- The NCS may be performed by a physician or by a trained allied health professional under direct supervision of a physician trained in electrodiagnostic medicine; although always interpreted by a credentialed physician..
- The record must reflect the need for EMG to localize the optimal injection site for the botulinum toxin.

Medicaid would not expect to see multiple uses of EMG in the same patient at the same location for the purpose of optimizing botulinum toxin injections.

Medicaid does not expect to see nerve conduction testing accomplished with discriminatory devices that use fixed anatomic templates and computer-generated reports used as an adjunct to physical examination routinely on all patients.

**Note:** Medicaid requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record.

For any questions, contact Toni Hopgood via e-mail at [toni.hopgood@medicaid.alabama.gov](mailto:toni.hopgood@medicaid.alabama.gov).

### **Pevnar 13**

Medicaid currently covers Pevnar 13 through the Vaccines for Children program for children 0-5 years of age with no restrictions. Effective beginning date of service June 1, 2013, and thereafter Medicaid will cover Pevnar 13 vaccine for ages 6 years and above who are at high risk for invasive pneumococcal disease because of:

- Anatomic or functional asplenia (sickle cell disease, other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction)
- Immunocompromising conditions (HIV infection, chronic renal failure/nephrotic syndrome, congenital immunodeficiency, diseases associated with treatment with immunosuppressive drugs/radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; or solid organ transplant)
- Cochlear implant
- Cerebrospinal fluid (CSF) leaks.

**Please note:** Pevnar 13 should be ordered through the vaccines for children program for children 0-18 years of age.

If you have any further questions, contact Toni Hopgood at [toni.hopgood@medicaid.alabama.gov](mailto:toni.hopgood@medicaid.alabama.gov) or Jerri Jackson at [jerri.jackson@medicaid.alabama.gov](mailto:jerri.jackson@medicaid.alabama.gov).

### **Lead Screening Guidelines**

Lead Screening guidelines have been revised in Appendix A (EPSDT) of the Provider Manual. Please review these guidelines in this version of the Provider Insider. If you have further questions, please contact Toni Hopgood at [toni.hopgood@medicaid.alabama.gov](mailto:toni.hopgood@medicaid.alabama.gov).

## ***Attention: Nursing Home Providers Tips for an Efficient Medical Review***

- Please accurately complete the Admission and Evaluation Data (Form 161) in its entirety. This includes documenting the **Name, Medicaid Number and Date on pages 2 and 3 of the form**. If the recipient is a spend down, please check spend down on the form and give the dates of the spend down status.
- Please ensure that the Medicaid date is documented correctly on the Form 161. When the physician signs the form he/she is stating that “I certify this resident requires nursing facility care effective on the admission date appearing on this form”.
- The facility is not required to send the entire medical record, only information that supports the request for LTC.
- Initial audit requests and requests for additional information **must** be submitted timely to avoid any penalties as referenced in the Administrative Code **Rule Number Rule No. 560-X-10-. 07. Review of Medicaid Residents**.
- If unstable medical condition is the qualifying criterion (criterion G), the medical record must contain information to support the condition and the active treatment rendered within 60 days prior to admission.
- PRN Oxygen is not covered; must submit MAR showing regular usage.
- Multiple criteria under K will count as one criterion.
- When criteria K is checked on Form 161, please submit at least 1 week of nurse’s notes or ADLS flow sheets, approximately 1 week prior to the Medicaid admission date if transferring from Medicare to Medicaid. This information can also be documented on Form 161 under the section of Diagnosis and Pertinent Medical Information.
- Submit the full MDS prior to and closest to the Medicaid admission date.
- Cannot mark A and K7,  
MUST BE ONE OR THE OTHER.
- Cannot mark G and K9,  
MUST BE ONE OR THE OTHER.
- If the recipient is out in the community greater than 30 days, then the recipient will be a new admission and must meet at least two criteria.
- Transfer from out of state will require two criteria –  
Cannot use preadmission screening information from another state.



### ***Look Up Feature for Operating Performing or Referring (OPR) Providers***

***Providers may now check to see if another provider is on file with Medicaid.***

Providers should access the Medicaid Secure Website. Provider should click on the ‘Providers’ tab at the far right corner. The provider’s NPI or license number is required to perform the search. The system will display the name, location and indicate if the provider is active/inactive. If a provider has multiple locations with both active and inactive locations, the system will list the first active location match in the HP claims processing system.



### ***Important Password Requirements for Medicaid Secure Website***

**E**ffective July 23, 2013, new password requirements will be implemented for providers using the Medicaid Secure Website.

The password requirements will be as follows:

Password must be at least 8 characters in length and must contain 3 of the 4 requirements below:

- One lower case value (b)
- One upper case value (B)
- One numeric value (6)
- One Special Character  
(~!@#\$%^&\* \_+ -= `| \(){}[]:;”<>,.?/)

If your password does not currently meet the requirement, you will be required to use the new password requirements when your current password expires. Passwords must be updated every sixty days. If you have any questions, please contact the Electronic Media Helpdesk at 1-800-456-1242.

### ***Proper Claim Filing for Unclassified Drugs***

**A** provider who administers a physician drug not listed should use the following J Codes:

**J3490 – Unclassified drugs**

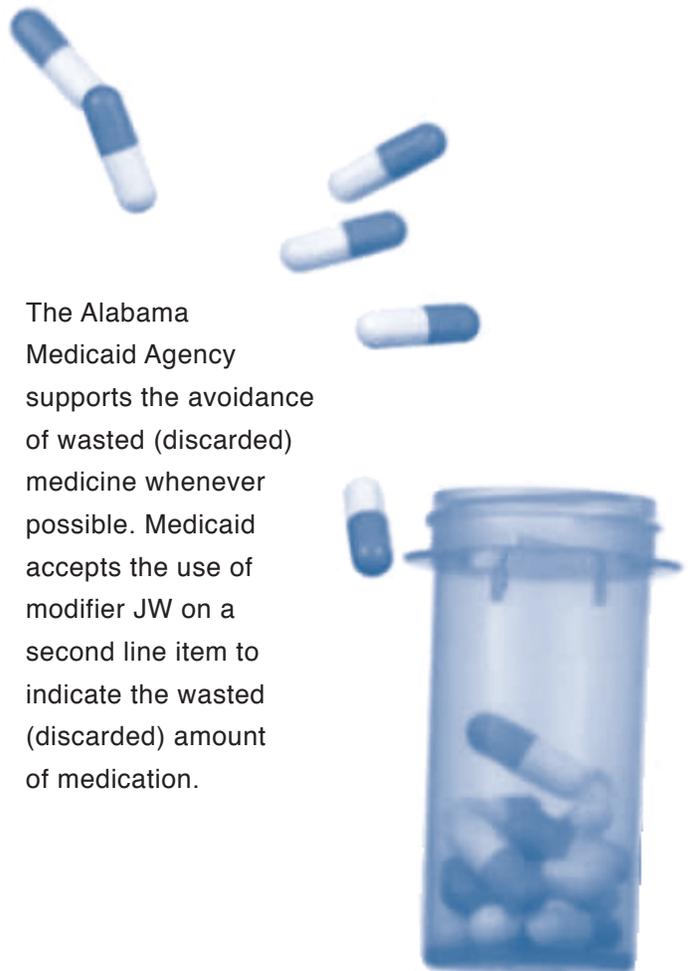
**J3590 – Unclassified biologics**

**J9999 – Not otherwise classified, antineoplastic drug**

Providers should submit an original red drop-out CMS-1500 claim with the complete name of the drug, total dosage that was administered 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:

HPES, Attn: Medical Policy  
PO Box 244032  
Montgomery, AL 36124-4032

HPES will determine the price of the drug.



The Alabama Medicaid Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicaid accepts the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication.

## Provider Assistance for:

Ambulance  
Ambulatory Surgical Centers  
CRNA  
Chiropractors  
Dental  
DME  
EPSDT (Physicians)  
ESWL  
Free Standing Radiology  
FQHC  
Hearing Services  
Waiver Services  
Home Health  
Hospice  
Hospital  
Independent Labs  
Maternity Care  
Mental Health  
Nursing Home  
Nurse Midwives  
Nurse Practitioners  
Opticians  
Optometrists  
PEC  
Personal Care Services  
Physicians  
Podiatrists  
Prenatal Clinics  
Private Duty Nursing  
Public Health Including:  
• Elderly and Disabled Waiver  
• Home and Community Based Services  
• EPSDT  
• Family Planning  
• Prenatal  
• Preventive Education Rehab Services  
• Home Bound Waiver  
• Therapy Services (OT, PT, ST)  
• Children's Specialty Clinics  
Renal Dialysis Facilities  
Rural Health Clinic  
Swing Bed

## HP PROVIDER REPRESENTATIVES



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**GAYLE SIMPSON-JONES**  
gayle.simpson-jones@hp.com  
855-523-9170 Ext. 2334582



**MELISSA GILL**  
Melissa.gill@hp.com  
855-523-9170 Ext. 2334589



**TORI TILLERY-DENNIS**  
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855-523-9170 Ext. 2334583



**Alabama  
Medicaid  
Bulletin**

Post Office Box 244032  
Montgomery, AL 36124-4032

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

**2013 State Checkwrite Schedule**

07/05/13	10/18/13	02/07/14
07/19/13	11/01/13	02/21/14
08/02/13	11/15/13	03/07/14
08/16/13	12/06/13	08/16/13
09/06/13	12/13/13	03/21/14
09/13/13	01/03/14	04/04/14
10/04/13	01/17/14	04/18/14

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.