

# **ALABAMA MEDICAID**

## **July 2013 Provider Manual**

### **Provider Alerts**



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**RETURN TO MAIN MENU**

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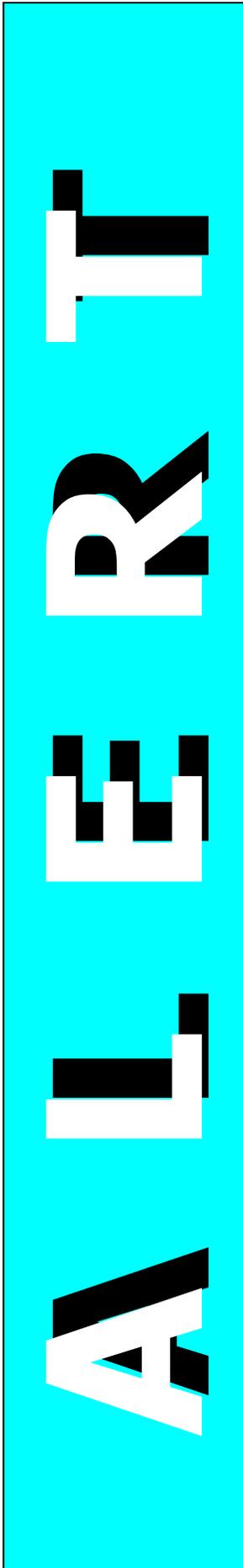
**To: ASC, Dialysis, Home Health, Hospice,  
Hospital, Nursing Home, Radiology, and RHC  
Providers**

**RE: The Change of Ownership Form**

Beginning January 1, 2009, currently enrolled providers must complete the new ***Change of Ownership Information form*** to report change of ownership information ***prior*** to making such change. This information will be used in determining how the change in ownership will be processed.

Paragraph 1.2.2 of the Provider Agreement in the Alabama Medicaid Provider Enrollment Application states "Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making such changes." Chapter 7 of the Alabama Medicaid Provider Manual will also be updated. The Change of Ownership Information form is available on the agency website at [http://www.medicaid.alabama.gov/billing/forms\\_provider\\_enrollment.aspx](http://www.medicaid.alabama.gov/billing/forms_provider_enrollment.aspx)

January 05, 2009



## To: Dental Providers

### RE: Dental Prior Authorization Process

To better serve dental providers and their patients, EDS will now receive and prepare dental prior authorization (PA) requests for Medicaid Agency review effective January 1, 2009.

To request a dental PA, providers should submit the Alabama Prior Review and Authorization Dental Request Form 343, dental x-rays, periodontal charts, and medical necessity notes to EDS. The information will be scanned and prepared by EDS staff members, then forwarded to the Alabama Medicaid Agency for review and disposition.

All correspondence related to prior authorizations should be sent to EDS at the following addresses:

EDS  
ATTN: Dental Prior Authorization Department  
PO Box 244032  
Montgomery, AL 36124

Physical address for **express delivery only**:

EDS  
ATTN: Dental Prior Authorization Department  
301 TechnaCenter Drive  
Montgomery, AL 36117

For emergency prior authorizations, please contact the Alabama Medicaid Dental Program directly at: (334) 242-5472 or via e-mail at: [dental@medicaid.alabama.gov](mailto:dental@medicaid.alabama.gov)

Please refer to Chapter 13 of the Medicaid Provider Manual for the emergency prior authorization process. The manual is available online at [http://www.medicaid.alabama.gov/billing/index\\_billing.aspx?tab=6](http://www.medicaid.alabama.gov/billing/index_billing.aspx?tab=6)

January 13, 2009

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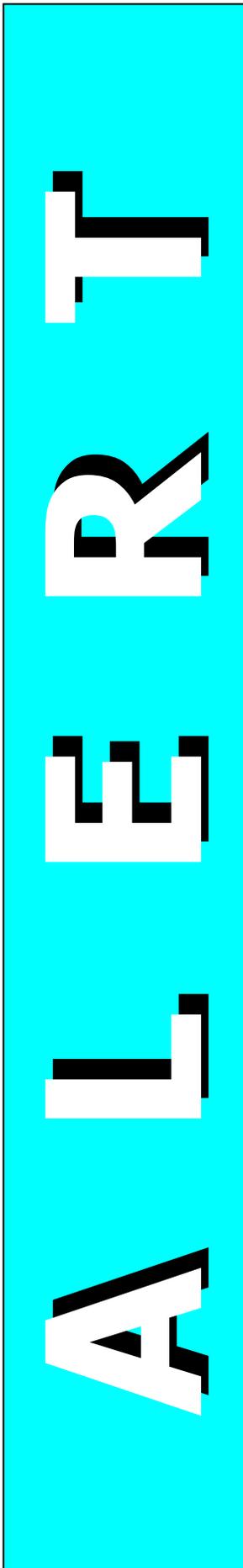
**To: Radiology Clinics, Physicians, Oral Surgeons, Nurse Practitioners, Dentists, Public Health, Hospitals, ASC, FQHC, RHC, CRS, and EPSDT Providers**

**RE: Effective Date of Radiology Prior Authorization Program**

The effective date of the Radiology Prior Authorization Program has been changed from February 2, 2009 to March 2, 2009. Medicaid will allow a grace period from March 2<sup>nd</sup> through March 31<sup>st</sup>. Providers will be required to submit prior authorizations during this grace period. Medicaid will not deny any claims for these services performed from March 2<sup>nd</sup> through March 31<sup>st</sup> due to no prior authorization. However, beginning on April 1, 2009, any claims that are submitted for these radiological services for dates of service April 1, 2009 and thereafter without prior approval will be denied. The Medicaid Contractor for this program, MedSolutions, will be sending further information soon.

Providers with questions may contact Teresa Thomas, Program Manager, Lab/X-ray services at [teresa.thomas@medicaid.alabama.gov](mailto:teresa.thomas@medicaid.alabama.gov) or by phone at (334) 242-5048.

January 16, 2009



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## To: Instate and Bordering Hospital Providers

### RE: Enrollment of Psychiatric and Rehabilitation Subparts Within a Hospital for Crossover Claims

Hospitals with psychiatric and rehabilitation subparts are now required to enroll with a separate NPI (National Provider Identifier) in order to process crossover claims.

To enroll, an application for each subpart must be submitted to EDS's Provider Enrollment Department. This step is necessary to register the separate NPIs in the Medicaid system.

To request an enrollment application, you may contact EDS' Provider Enrollment Department at 1-888-223-3630 or visit Alabama Medicaid's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) (Billing/Forms – Billing-Related/Provider Enrollment Forms/Hospital Subpart Enrollment Application) to download a copy of the Provider Enrollment Application for Providers in Alabama and bordering states.

This enrollment policy for psychiatric and rehabilitation subparts only applies to Medicare/Medicaid crossover claims. It does not apply for straight Medicaid claims.

For questions concerning this policy change, you may contact the Alabama Medicaid Agency, System Support Unit at (334)242-5627.

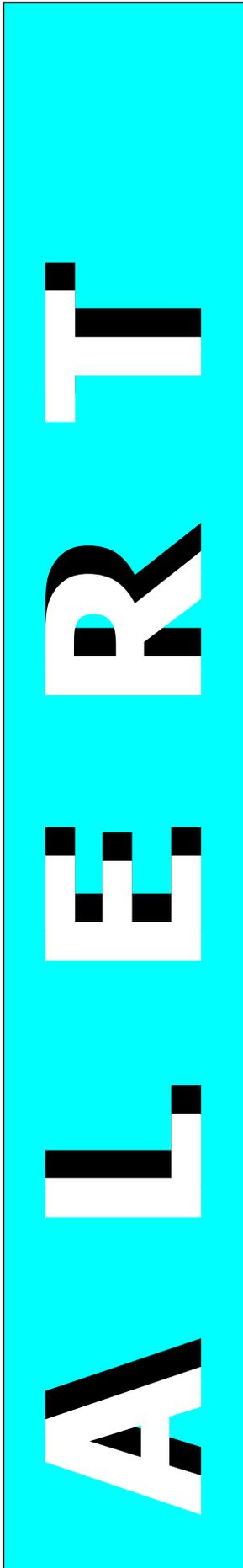
**For unpaid crossover claims that are now beyond the one-year filing limitation**, you will have until July 1, 2009 to request an administrative review. In your request, indicate these claims are for the psychiatric or rehab subparts and enclose the paper claim form.

Mail to:

System Support/Administrative Review Unit  
Alabama Medicaid Agency  
P.O. Box 5624  
Montgomery, AL 36103-5624

The time filing limitation will be overridden for those claims received on or before July 1, 2009.

March 6, 2009



**To: All Providers**

**RE: New Medical & Quality Review Services Contractor**

Effective April 1, 2009, Alabama Quality Assurance Foundation (AQAF) will perform medical and quality reviews for the Alabama Medicaid Agency. AQAF will perform prior authorizations for durable medical equipment, private duty nursing and certain medical services; long-term care reviews, including hospice pre-certification and concurrent reviews; and retrospective review of institutional admissions.

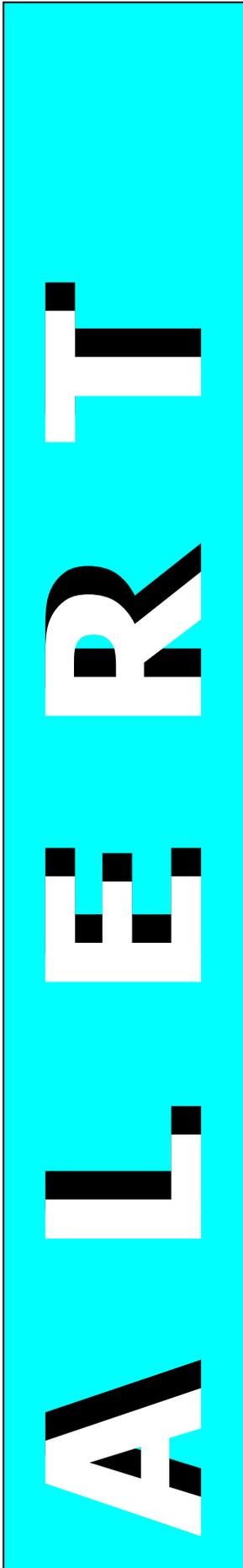
- **The current contractor (APS Healthcare), will stop accepting PA and other requests on March 27, 2009.**
- **Documents requiring immediate attention between 03/27/09 and 03/31/09 should be mailed or faxed to the Alabama Medicaid Agency at the following address or number:**

**LTC Medical & Quality Review Unit**

**Alabama Medicaid Agency  
501 Dexter Avenue, Suite 3014  
P.O. Box 5624  
Montgomery, Alabama 36103-5624  
Fax: (334) 353-4909**

**Prior Authorization (PA) Requests**

- **Effective April 1, 2009, AQAF will process all PAs except those related to:**
  - Pharmacy,
  - Dental Services,
  - Radiology Services, and
  - Augmentative Communication Devices.
- **The process for submitting PA requests will remain the same.**
  - Attachments required as part of the PA review process must be sent to EDS for scanning into the system. This allows the EDS system to link the request by PA number as well as generate a response to the provider.
  - Linking hard copy attachments with a PA request submitted electronically will delay the PA process. To expedite the attachment process, submit within 48 hours of the submission of the PA request.
- If you have questions regarding the status of a PA request that is less than 30 days from submission call the Automated Voice Response System (AVRS) Line at (800) 727-7848.
- If you need assistance with a PA that is greater than 30 days from the date of submission, contact the Provider Assistance Center at (800) 688-7989. If you are unable to resolve your problems after contacting the AVRS Line or Provider Assistance Center, you may contact AQAF at 1-205-970-1600, extension 3314.



- **Expediting turnaround time for DME Conditional Approvals**
  - To expedite the turnaround time for converting conditional approvals to an approved status, please fax delivery tickets and invoices to **APS Healthcare** at (770) 991-5429 **by 03/27/09**.
  - Effective April 1, 2009, please mail or fax to **AQAF** at the following address:

**Alabama Quality Assurance Foundation  
Two Perimeter Park South, Suite 200 West  
Birmingham, Alabama 35243-2337  
Fax: (205) 970-1614**

- Chapter 15: Submitting Prior Authorization Requests, in the Provider Electronic Solutions Manual provides additional information regarding the PA process.

### **Reviews for Institutional, Hospice, Post Extended Care Hospital (PEC), and Swing Bed providers**

- **Effective April 1, 2009**, AQAF will assume responsibility for reviewing applications for admissions for the programs listed below:
  - Hospice
  - PEC
  - Swing Beds
  - Retrospective review process for appropriateness of admissions to Nursing Homes, ICF/MR facilities and IMD facilities
- **Faxed attachments will not be accepted by AQAF with the exception of inpatient psychiatric facilities.**
- Applications for admission to Hospice, PEC, and Swing bed programs **more than 30 pages** must be mailed to AQAF to the address above.
- AQAF will request monthly retrospective reviews for Nursing Homes, ICF/MR facilities, and IMD facilities. Medical record documentation, in response to such requests, which contains **more than 30 pages**, must be mailed to AQAF to the address indicated above.
- Medical record documentation which contains **less than 30 pages**, Hospice Recipient Status Change Forms (**Form 165B**) and Long Term Care Request for Action Forms (**Form 161A**) may be faxed to AQAF at the number below:

**Fax: (205) 970-1614**

Providers with questions may contact Theresa Carlos, Associate Director of Medicaid's LTC Medical & Quality Review Unit, at [theresa.carlos@medicaid.alabama.gov](mailto:theresa.carlos@medicaid.alabama.gov) or 334-353-3711.

March 04, 2009

**To: Pharmacies, Physicians, Physician Assistants,  
Nurse Practitioners, Oral Surgeons, Optometrists,  
Dentists, FQHCs, RHCs, and Nursing Homes**

**RE: Preferred Drug List (PDL) Update**

**Two important pharmacy program updates will be effective April 1, 2009:**

1) The Alabama Medicaid Agency will no longer require prior authorization (PA) for payment of generic legend omeprazole. Preferred brands as well as OTC versions of Proton Pump Inhibitors will also continue to be available with no PA necessary.

2) The Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) recommendations as well as quarterly updates. The updates are listed below:

| <b>PDL Additions</b>   | <b>PDL Deletions*</b>   |
|--|---|
| <b>Aciphex</b> -Gastrointestinal Agents-<br>Proton-pump Inhibitors                 | <b>Caduet</b> -Cardiovascular Health/<br>HMG CoA Reductase Inhibitors/Combos      |
| <b>Patanase</b> -EENT Preparations-Antiallergic Agents                             | <b>Imitrex</b> -Pain Management/<br>Autonomic Agents-Selective Serotonin Agonists |
| <b>Treximet</b> -Pain Management/<br>Autonomic Agents-Selective Serotonin Agonists | <b>Metadate CD</b> -Behavioral Health/<br>Cerebral Stimulants-Agents for ADD/ADHD |
|  | <b>Pexeva</b> - Behavioral Health/<br>Antidepressants                             |
|  | <sup>†</sup> <b>Relenza</b> -Anti-infective Agents/<br>Neuraminidase Inhibitors   |
|  | <sup>†</sup> <b>Tamiflu</b> -Anti-infective Agents/<br>Neuraminidase Inhibitors   |

*\* denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

*<sup>†</sup>Will remain preferred throughout the defined flu season (October 1 – April 30).*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests directly to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

March 10, 2009

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**To: All Providers**

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Alabama Medicaid Agency  
501 Dexter Avenue, Suite 3014  
P.O. Box 5624  
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Fax: (334) 353-4909**

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## To: Psychologists

### RE: Minimum Qualifications for Professional Staff Working Under Supervision of Medicaid-enrolled Psychologists

Effective April 1, 2009, the only individuals recognized for reimbursement under the direct supervision of a Medicaid-enrolled psychologist are:

- A professional counselor licensed under Alabama law (i.e. LPC, ALC)
- A marriage and family therapist licensed under Alabama law
- A certified social worker licensed under Alabama law
- A licensed psychological technician
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling, behavioral specialist or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as a part of the requirements for the degree
  - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience.

Policy questions concerning this provider notice should be directed to Karen Green @ (334) 353-4945 or [karen.green@medicaid.alabama.gov](mailto:karen.green@medicaid.alabama.gov).

March 11, 2009

**To: All Pharmacy Providers**

**RE: DAW 2-Audits**

If your pharmacy has received a letter concerning Dispense as Written (DAW) 2 audit findings, the pharmacy should disregard the letter and its enclosure. The Alabama Medicaid Agency will not make any corresponding adjustments to the next provider payment based on these findings.

Although an "Appropriate Utilization of DAW Codes" article has been circulated to pharmacies through educational newsletters, as well as listed on the Agency website ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov), click on Programs/Pharmacy/Billing Resources), claims continue to be submitted utilizing inappropriate product selection codes. Please note the Agency will be updating its written policy in the April 1, 2009 provider billing manual to enforce appropriate utilization of product selection codes as defined by NCPDP standard. The use of the DAW codes will be audited on a regular basis to ensure correct billing. **As such, pharmacy claims submitted after April 1, 2009 with inappropriate product selection/DAW codes will be recouped.**

March 16, 2009

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**TO: Psychologists**

**RE: Minimum Qualifications for Professional Staff Working Under Supervision of Medicaid-enrolled Psychologists**

Effective April 1, 2009, the only individuals recognized for reimbursement under the direct supervision of a Medicaid-enrolled psychologist are:

- A professional counselor licensed under Alabama law (i.e. LPC, ALC)
- A marriage and family therapist licensed under Alabama law
- A certified social worker licensed under Alabama law
- A licensed psychological technician
- An individual possessing a master's degree or above from a university or college with an accredited program for the respective degree in psychology, social work, counseling, behavioral specialist or other areas that require equivalent clinical course work and who meets at least one of the following qualifications:
  - Has successfully completed a practicum as a part of the requirements for the degree
  - Has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience.

Policy questions concerning this provider notice should be directed to Karen Green @ (334) 353-4945 or [karen.green@medicaid.alabama.gov](mailto:karen.green@medicaid.alabama.gov).

March 20, 2009

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## **To: All Pharmacy Providers**

### **RE: Correct prescribing physician license number or NPI required on all pharmacy claims**

Pharmacies participating in the Alabama Medicaid program are required to use the prescribing physician's NPI or license number when filing a claim with the Agency. A recent review of pharmacy billing practices found that numerous pharmacies are using an incorrect prescribing physician number on claims submitted to the Agency.

Providers are reminded that any pharmacy claim with an incorrect prescribing physician number is subject to recoupment. Pharmacies with repeated violations will be subject to revocation of their Medicaid provider agreement, and referral to federal or state law enforcement personnel for criminal prosecution.

April 28, 2009

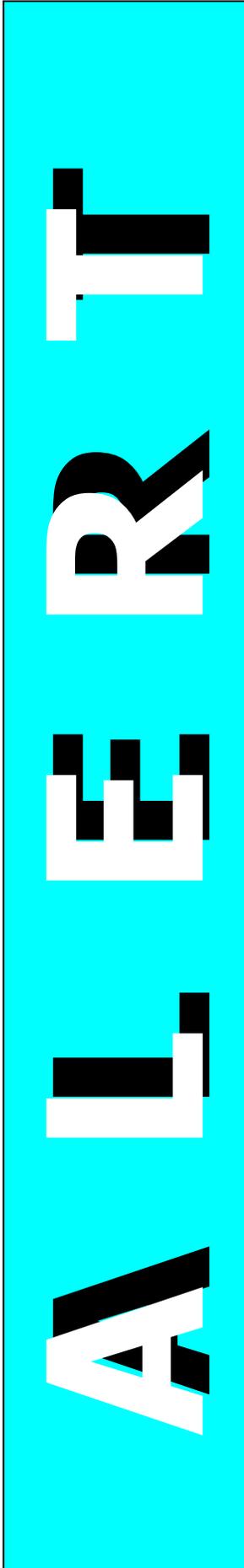
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**To: All Providers**

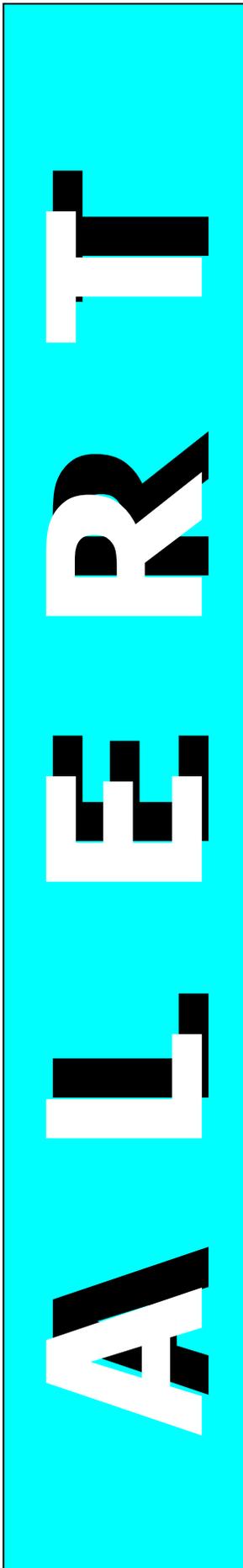
**RE: Alabama MMIS Maintenance Window**

The Alabama Medicaid claims processing system will undergo maintenance between Saturday, May 30, 2009 at 11:30 PM till Sunday, May 31, 2009 at 4 AM Central Daylight Saving Time.

The impact of this outage will be:

1. Providers will be able to submit batch transactions to the web portal. However, the response files will be delayed until the conclusion of the maintenance and the process of the submitted files can be completed.
2. Eligibility information will **not** be available by any means (interactive, AVRS, or web portal)
3. Interactive pharmacy claims processing will **not** be available.
4. MMIS user panels will **not** be responsive to queries.

May 29, 2009



**To: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Nursing Homes, and Mental Health Providers**

**RE: Preferred Drug List (PDL) Update**

**Effective July 1, 2009** the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| <b>PDL Additions</b>  | <b>PDL Deletions*</b>  |
|---|--|
| <b>Astelin</b> - EENT Preparations/Antiallergic Agents        | <b>Metrogel Vaginal</b> - Skin and Mucous Membrane Agents/Antibacterials |
| <b>Astepro</b> - EENT Preparations/Antiallergic Agents        |  |
| <b>Elidel</b> - Skin and Mucous Membrane Agents/Miscellaneous |  |
| <b>Levemir</b> - Diabetic Agents/Insulins                     |  |
| <b>Luvox CR</b> - Behavioral Health/Antidepressants           |  |
| <b>Pramox</b> - Skin and Mucous Membrane Agents/Antipruritics |  |

*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

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**To: Radiology Clinics, Physicians, Hospitals, FQHC, RHC, CRS, and EPSDT Providers**

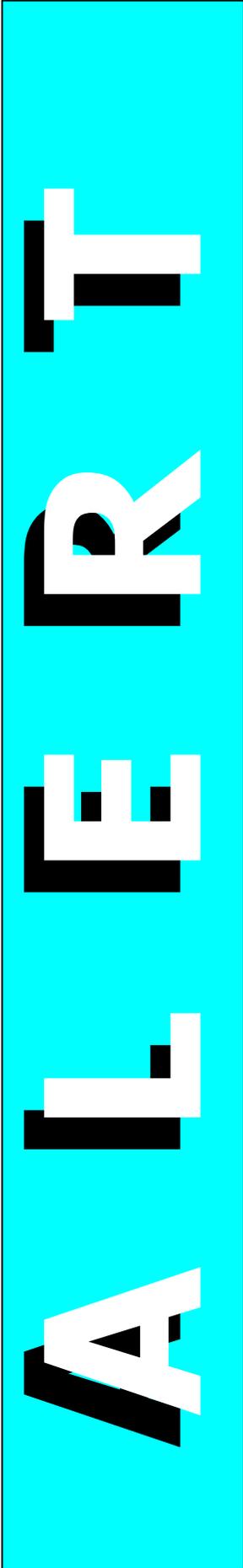
**RE: Changing Procedure Codes on Radiology Prior Authorizations for CT scans, MR scans and PET scans**

Effective June 22, 2009, providers will be allowed 30 days from the date of service to:

- change a code from “without contrast,” to a code in the same family “with contrast” or “with and without contrast” or
- change a code from “with contrast” or “with and without contrast,” to a code in the same family “without contrast” or
- add a study to radiology procedures when the Prior Authorization has already been obtained.

The ordering provider (physician’s office) or the performing provider (facility) must call Medsolutions at 1-888-693-3211 to request that a code be changed. For changing a code to a higher code (from without contrast, to with contrast, or to with and without contrast), or adding a study, Medsolutions will continue to review criteria for medical necessity before approval.

Providers with questions may contact Teresa Thomas, Program Manager, Lab/X-ray services at [teresa.thomas@medicaid.alabama.gov](mailto:teresa.thomas@medicaid.alabama.gov) or by phone at (334) 242-5048.



**To: Dental Providers**

**RE: Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)**

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3, reauthorizes the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act. CHIPRA includes many provisions aimed at improving coverage for children. Section 501 (e) of CHIPRA requires that States work with Centers for Medicare and Medicaid Services and Health Resources Services Administration **to develop a current and accurate list of all dentists and providers within each state that provide dental services to children and includes the elements as below.** This information will be posted on the Insure Kids Now website at [www.insurekidsnow.gov](http://www.insurekidsnow.gov). Please note that this is a federal requirement.

**Please assist us by completing the information below by July 8, 2009 and faxing to 334-353-5027.**

1. Provider Name: \_\_\_\_\_
2. Provider Affiliation: Private Practice \_\_\_\_ Community Health Center \_\_\_\_  
Health Department \_\_\_\_ Other \_\_\_\_
3. Provider Specialty: General Dentist \_\_\_\_ Pediatric Dentist \_\_\_\_ Oral Surgeon \_\_\_\_  
Orthodontist \_\_\_\_ Endodontist \_\_\_\_ Periodontist \_\_\_\_
4. Accepts New Patients: Yes \_\_\_\_ No \_\_\_\_
5. Can Accommodate Special Needs: Yes \_\_\_\_ No \_\_\_\_
6. NPI Number or State Medicaid Number\* \_\_\_\_\_  
*(\*This information will not be on the website)*
7. Group or Clinic Name: \_\_\_\_\_
8. Provider Physical Street Address (City, State, and Zip Code Phone and Fax Number):  
\_\_\_\_\_  
*Street Address*  
\_\_\_\_\_  
*City, State, and Zip Code*  
\_\_\_\_\_  
*Phone Number including area code*                      *FAX number including area code*
9. Optional Information: Website address: \_\_\_\_\_  
Affiliation with Managed Care Plans: \_\_\_\_\_  
Languages Spoken: \_\_\_\_\_

**If you have questions regarding this request please contact Leigh Ann Hixon at 334-353-5263 or via e-mail at [LeighAnn.Hixon@medicaid.alabama.gov](mailto:LeighAnn.Hixon@medicaid.alabama.gov)**

**If you practice at multiple locations, please complete a form for each location.**

June 30, 2009

**To: All Providers and Associations**

**RE: Synagis® Criteria for 2009-2010 Season**

The Alabama Medicaid Agency has updated its prior authorization criteria for Synagis®.

**Highlights of the updated criteria include:**

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

**Criteria**

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. The form and complete updated criteria specific to Synagis® are available on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Pharmacy Forms: 2009-2010 Synagis® Criteria and Forms.

**Educational Presentation / Web Conference**

To inform providers about changes impacting the 2009-2010 Synagis® season, the Alabama Medicaid Agency will present a statewide Web conference on August 14, 2009 at 10:00 a.m. for all Synagis® providers. A question and answer session will be held at the end of the presentation so providers may ask questions or obtain clarification as needed.

Providers may participate in the Synagis® web conference via physical attendance in the Medicaid Boardroom or join via an *iLinc* web conferencing feature. In order to join via *iLinc*, participants must register by August 10, 2009.

Providers may register by emailing their name, phone number and email address to [Earnestine.Rhodes@medicaid.alabama.gov](mailto:Earnestine.Rhodes@medicaid.alabama.gov) or by calling (334) 242-5050 and providing their name, phone number and email address during normal business hours. Participants registering via email should include SYNAGIS ILINC in the subject line of the email when responding. Participants should register early as space for the web conference is limited.

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

July 15, 2009

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**To: Physicians**

**RE: Radiology Management Program “Gold Card Changes”**

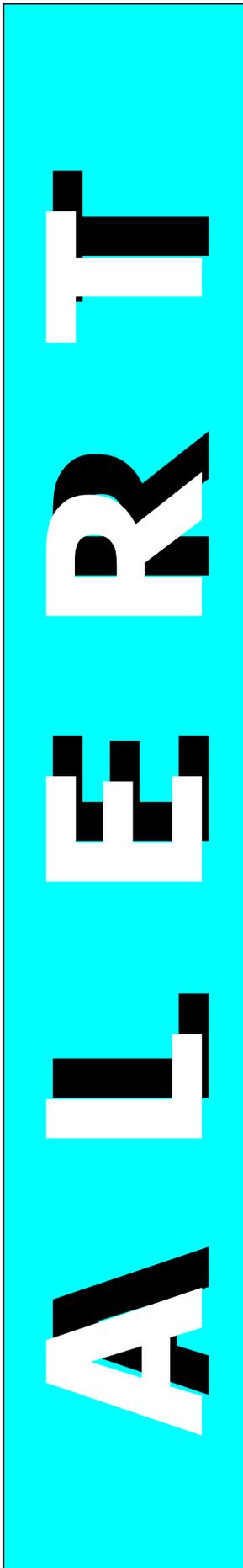
Effective October 1, 2009, changes will be made to “Gold Card” status based on Agency evaluation of prior authorization requests made between April 1 and June 30 of 2009. The following changes will be made:

- Providers who currently have “Gold Card” status, and have requested six or fewer radiology tests during the April-June quarter will continue to have “Gold Card” status.
- Providers who have requested seven or more tests during April-June quarter and would have had a denial rate of 5% or less will continue to have “Gold Card” status.
- All other providers with current “Gold Card” status will be removed from the “Gold Card” program.

The status of all providers will be re-evaluated after one year. Redetermination will be based on the preceding 12 months’ worth of data (October 1, 2009 – September 30, 2010). If the data shows that the provider has seven or more tests ordered per quarter and a 5% or less denial rate, then “Gold Card” status will be granted. Also, those providers with a gold card during those 12 months who order more than seven tests per quarter and have a denial rate above 5% will have their gold card status removed. Providers with a “Gold Card” who continue to order 6 or fewer tests per quarter will continue to have “Gold Card” status.

Providers with questions may contact Teresa Thomas, Program Manager, Lab/X-ray services at [teresa.thomas@medicaid.alabama.gov](mailto:teresa.thomas@medicaid.alabama.gov) or by phone at (334) 242-5048.

September 11, 2009



**To: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Nursing Homes, and Mental Health Providers**

**RE: Preferred Drug List (PDL) Update**

**Effective October 1, 2009**, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| <b>PDL Additions</b>   | <b>PDL Deletions*</b>  |
|--|--|
| <b>Azor</b> -Cardiovascular Health/ Calcium Channel Blockers/Combos                        | <b>Augmentin XR</b> -Anti-infective Agents/ Penicillins            |
| <b>OTC pyrantel pamoate</b> (ex. <b>Pin-X, Reese</b> ) Anti-infective Agents/Anthelmintics | <b>Exelon</b> -Behavioral Health/Alzheimer's Agents                |
| <b>Prandin</b> -Diabetic Agents/Meglitinides   | <b>Paxil CR</b> -Behavioral Health/Antidepressants                 |
|  | <b>Starlix</b> -Diabetic Agents/Meglitinides                       |
|  | <b>Valtrex</b> -Anti-infective Agents/ Nucleosides and Nucleotides |

*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

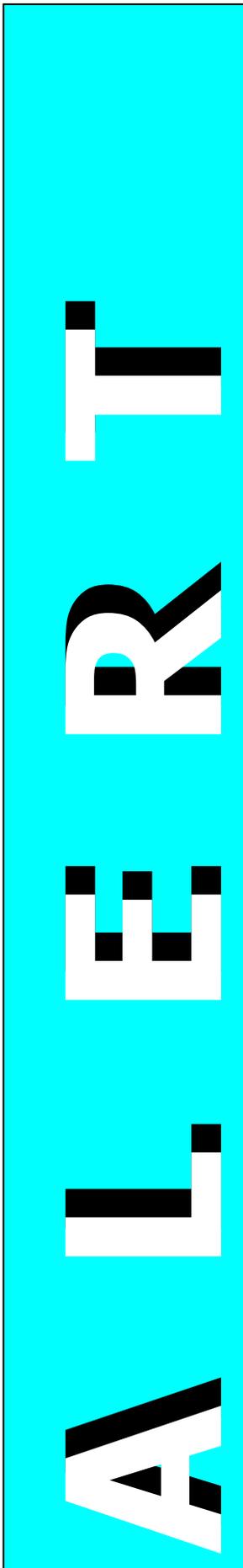
The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

September 11, 2009



**To: All In-State Hospital Providers and Maternity Care Primary Contractors**

**RE: Maternity Inpatient Hospital Claims**

Beginning with delivery dates of October 1, 2009, the Alabama Medicaid Agency will process all maternity inpatient hospital claims as fee-for-service claims and will make payment directly to the hospital provider. Deliveries prior to October 1, 2009, are the responsibility of the Maternity Care Primary Contractor.

Examples of how claims will be processed when filed to Medicaid are described below:

**If the Delivery occurs BEFORE October 1, 2009:**

**Example: Inpatient claim Dates of Service: 09/20/09 – 10/03/09; Delivery date 09/30/09**

**Inpatient Hospital Providers:**

- The inpatient hospital provider's claim will be the responsibility of the Maternity Care Primary Contractor because the delivery occurred prior to October 1, 2009.

**Maternity Care Primary Contractors:**

- The Maternity Care Primary Contractor will bill for the date of delivery (09/30/09) and will receive the full global payment amount since the delivery occurred BEFORE October 1, 2009.
- The Maternity Care Primary Contractor will be responsible for the inpatient hospital claim since the delivery occurred in September.

**If the Delivery occurs on or after October 1, 2009:**

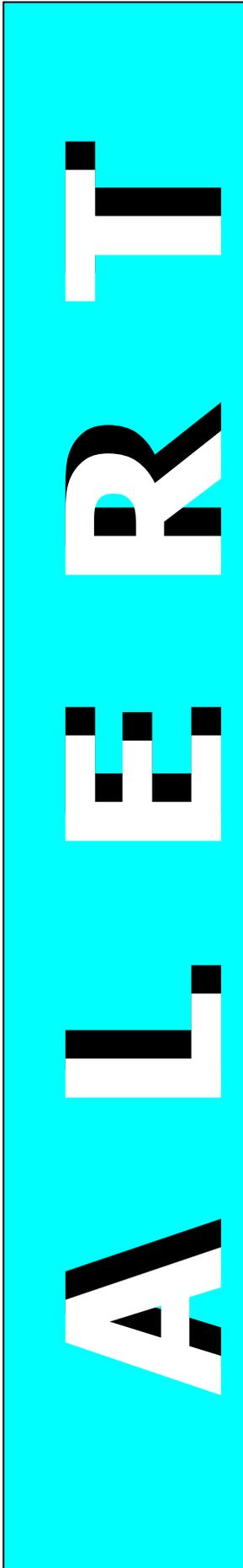
**Example: Inpatient claim Dates of Service: 09/20/09 – 10/03/09; Delivery date 10/01/09**

**Inpatient Hospital Providers:**

- The inpatient hospital provider will bill with September services on one claim and October services on another claim.
- In order for the hospital to be reimbursed for services provided in September that were medically necessary, the hospital must send a paper claim to the Alabama Medicaid Agency for an override. It is not necessary for the hospital to receive a denial or bill this claim prior to sending an override request to the Agency. If a hospital provider bills a claim for September services, it will be processed through the Medicaid claims processing system automatically as a Maternity care claim and deny. The inpatient hospital provider's claim for October services will be paid fee-for-service through the Medicaid claims processing system. (see override procedure below)

**Maternity Care Primary Contractors:**

- The Maternity Care Primary Contractor will bill for the date of delivery (10/01/09) and will receive the reduced global payment amount since the delivery occurred on or after October 1, 2009.
- The Maternity Care Primary Contractor will not be responsible for the September inpatient hospital services since the delivery occurred in October and their global payment amount was reduced.



**OVERRIDE PROCEDURE:**

The hospital must send a letter requesting an override because the delivery occurred on or after 10/1/09. The letter must include the actual date of the delivery. A completed paper (red-drop out ink) UB-04 claim form must be enclosed with the letter.

Send the written letter and claim to:

Alabama Medicaid Agency  
ATTENTION: INSTITUTIONAL SERVICES  
PO Box 5624  
Montgomery AL 36103-5624

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**To: All Providers**

**RE: Additional Information for Prior Authorization (PA)  
Reconsiderations \***

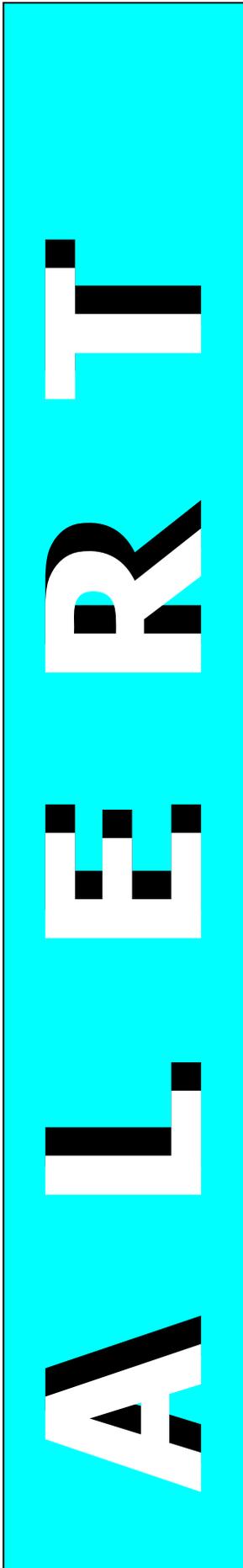
Effective immediately, the Agency's Medical & Quality Review Services Contractor, AQAF (Alabama Quality Assurance Foundation) will implement a page on their website where providers can enter a PA number to inform AQAF that additional information for a reconsideration has been submitted. As before, this information should be submitted to the fiscal agent, HP (formerly EDS), to scan into the system. Please see the instructions below.

- Type in the URL for the AQAF website:
- <http://www.aqaf.com/recon>
- Enter the PA number and press the submit button to alert AQAF that additional information has been submitted to HP (formerly EDS) for reconsideration.

This information goes into a database for AQAF staff to access.

\*AQAF does NOT review PAs for pharmacy, radiology, CTs, MRIs, Dental, or TCM

October 02, 2009



## To: All In-State Hospital Providers and Maternity Care Primary Contractors

### RE: Maternity Hospital Claims Payment Clarification

Effective for delivery dates of October 1, 2009, and thereafter, inpatient hospital maternity claims are to be sent to the Alabama Medicaid Agency's fiscal agent for processing. The fiscal agent will process inpatient hospital maternity claims as maternity encounter claims. Payment of these claims will be the responsibility of the PHPs. Outpatient hospital ultrasounds that have been historically paid by the Maternity Care Primary Contractor may now be billed to Medicaid's fiscal agent for payment. Examples of how inpatient maternity claims will be processed when filed to Medicaid are described below:

1. **If the Delivery occurs BEFORE October 1, 2009 and the claim DOES NOT span September and October -- OR,**

**If the delivery occurs BEFORE October 1, 2009 and the claim DOES span September and October:**

**For example: Inpatient claim for Dates of Service: 9/20/09 – 9/30/09; Delivery date 9/25/09**

**Or, Inpatient claim for Dates of Service: 9/20/09 – 10/02/09; Delivery date 9/30/09**

Inpatient Hospital Providers:

- The inpatient hospital provider's claim will be the responsibility of the Maternity Care Primary Contractor because the delivery occurred prior to October 1, 2009.

Maternity Care Primary Contractors:

- The Maternity Care Primary Contractor will bill Medicaid's fiscal agent for the date of delivery and will receive the full global payment amount since the delivery occurred BEFORE October 1, 2009.
- The Maternity Care Primary Contractor will be responsible for the inpatient hospital claim since the delivery occurred BEFORE October 1, 2009.

2. **If the delivery occurs on or after October 1, 2009, and the claim DOES span September and October:**

**For example: Inpatient claim for Dates of Service: 09/20/09 – 10/03/09; Delivery date 10/01/09**

Inpatient Hospital Providers:

- The inpatient hospital provider's claim will be the responsibility of the PHP because the delivery occurred on or after October 1, 2009.
- Bill all services on one claim to the Medicaid fiscal agent. Do NOT split bill September services on one claim and October services on another claim.

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Maternity Care Primary Contractors:

- The Maternity Care Primary Contractor will bill for the date of delivery (10/01/09) and will receive the reduced global payment amount since the delivery occurred on or after October 1, 2009.
- The Maternity Care Primary Contractor will NOT be responsible for the September inpatient hospital services since the delivery occurred in October and their global payment amount was reduced.

**3. If the Delivery occurs on or after October 1, 2009 and the claim does NOT span September and October :**

Inpatient Hospital Providers:

- Bill the claim to the Medicaid fiscal agent.
- The inpatient hospital provider's claim will be the responsibility of the PHPs.

Maternity Care Primary Contractors:

- The Maternity Care Primary Contractor will bill Medicaid's fiscal agent for the date of delivery and will receive the reduced global payment amount since the delivery occurred on or after October 1, 2009.
- The Maternity Care Primary Contractor will not be responsible for the inpatient hospital claim since the delivery occurred on or after October 1, 2009.

Note: There is no claim override requirement as described in a previous memo for hospital inpatient maternity care claims.

For questions, please contact Nancy Headley at 334-242-5684 or [nancy.headley@medicaid.alabama.gov](mailto:nancy.headley@medicaid.alabama.gov).

October 13, 2009

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**To: Pharmacies**

**RE: Reimbursement for Administration of Seasonal Influenza and H1N1 Vaccines**

Effective November 2, 2009, Alabama Medicaid will begin 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/programs/pharmacy\\_svcs/pharmacy\\_services.aspx](http://www.medicaid.alabama.gov/programs/pharmacy_svcs/pharmacy_services.aspx).
- Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.

October 29, 2009

**ATTENTION**

**To: All Pharmacies, Physicians, Maternity Care Primary Contractors, FQHCs, RHCs, and Health Departments**

**RE: Recipient Access to Contraceptive Products Under Plan First**

Effective November 1, 2009, the Alabama Medicaid Agency is making important changes to improve recipient access to contraceptive products covered under Medicaid's Plan First Program.

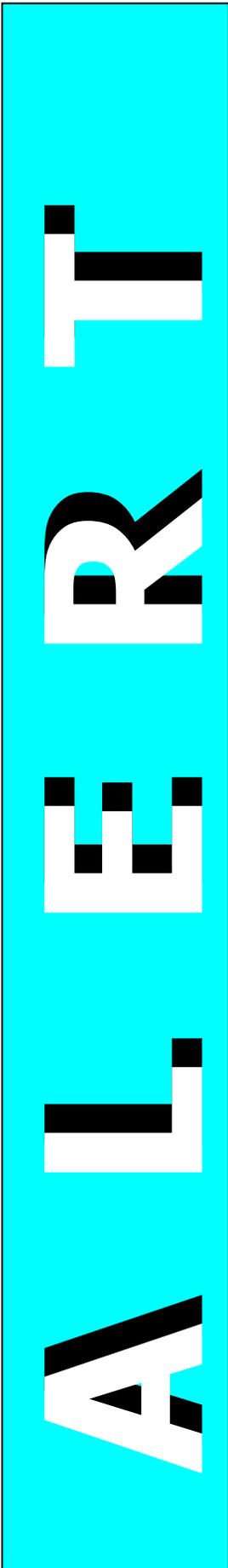
The changes:

1. Women on Plan First will have a new option of obtaining oral contraceptives, the contraceptive ring, or the contraceptive patch at a Medicaid-enrolled community/outpatient pharmacy. This is in addition to the contraceptive products already available at pharmacies, such as injectible contraceptives and diaphragms. In order to fill a prescription at a community/outpatient pharmacy, the Plan First-eligible patient must have received the prescription from a private provider. A 30-day supply is the maximum that may be dispensed at one time.
2. Women on Plan First will continue to have the option of receiving family planning services from the Alabama Department of Public Health or a Federally-qualified Health Center, along with oral contraceptives, the contraceptive ring, or the contraceptive patch. To receive contraceptive products from ADPH or an FQHC, the Plan First-eligible patient must have been seen first by the health department or FQHC. A 12-month supply of contraceptive products may be dispensed at one time.
3. The Plan First Patient Contraceptive Order Form will be discontinued.

Note: 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 post-partum period, these recipients 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 be directed to Leigh Ann Hixon, Plan First Program Manager at [leighann.hixon@medicaid.alabama.gov](mailto:leighann.hixon@medicaid.alabama.gov) or by calling 334-353-5263.

October 29, 2009



**To: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes**

**RE: Preferred Drug List (PDL) Update**

Effective January 4, 2010, the Alabama Medicaid Agency will:

1. Require prior authorization (PA for payment of the non-preferred brands in the following drug classes:
  - Eye, Ear, Nose and Throat (EENT) Preparations: Antibacterials
  - Prenatal Vitamins, and
2. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| <b>PDL Additions</b>                                       | <b>PDL Deletions*</b>  |
|--|--|
| <b>Azasite</b> -EENT Preparations/Antibacterials           | <b>Crestor</b> -Cardiovascular Health/HMG CoA Reductase Inhibitors       |
| <b>Bactroban Nasal</b> -EENT Preparations/Antibacterials   | <b>Simcor</b> -Cardiovascular Health/HMG CoA Reductase Inhibitors/Combos |
| <b>Blephamide</b> -EENT Preparations/Antibacterials        |  |
| <b>Blephamide S.O.P.</b> -EENT Preparations/Antibacterials |  |
| <b>Bleph-10</b> -EENT Preparations/Antibacterials          |  |
| <b>Neosporin</b> -EENT Preparations/Antibacterials         |  |
| <b>Poly-Pred</b> -EENT Preparations/Antibacterials         |  |
| <b>Tobrex</b> -EENT Preparations/Antibacterials            |  |
| <b>Vigamox</b> -EENT Preparations/Antibacterials           |  |

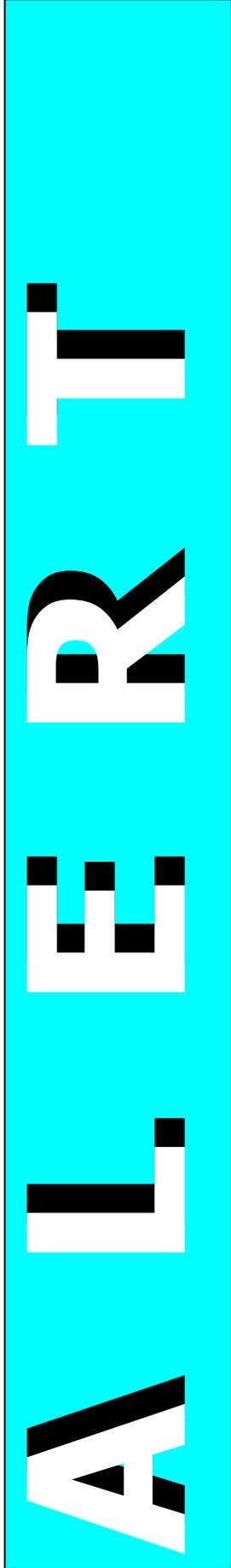
*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.



**To: All Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes**

**RE: Mandatory National Drug Codes (NDC) for ALL Physician-Administered Drugs**

In 2008, the Alabama Medicaid Agency (Medicaid) began requiring the NDC number for the top 20+ physician-administered multiple source drugs. Reference the July 2008 and April 2009 Provider Insiders.

**Effective July 1, 2010**, the NDC number will be mandatory on ALL physician-administered drugs in the following ranges: J0000 – J9999, S0000 – S9999, and Q0000 – Q9999. Physician-administered drugs include any covered outpatient drug billed either electronically or on paper CMS-1500 or UB-04 claim forms. The 11-digit NDC submitted must be the actual NDC number on the package or container from which the medicine was administered.

Medicaid will provide a **grace period from March 1, 2010, to June 30, 2010**, to allow providers sufficient time to acclimate to the change. During this grace period, Medicaid will validate the data and will set an informational denial code, but will NOT deny the claim.

This requirement applies to:

- All fee-for-service providers
- HCPCS codes in the ranges J0000 – J9999, S0000 – S9999, and Q0000 – Q9999.
- Both electronic and paper submissions

This requirement does NOT apply to:

- 340-B Providers enrolled on the HHS website
- Providers paid on a per diem, encounter or other type of rate, which includes, but may not be limited to:
  - Inpatient Hospitals
  - Nursing Facilities
  - Federally Qualified Health Centers
  - Rural Health Centers
  - Ambulatory Surgical Centers
  - Home Health Agencies
- Vaccines or other drugs in the CPT code range 01000 – 99999.

As this process is to facilitate Medicaid drug rebates from manufactures for physician-administered drugs, providers are encouraged to utilize drugs manufactured by companies who hold a federal rebate agreement. In the future, these NDCs will be the only ones Medicaid will cover for payment. A list of those drug manufactures who hold a federal rebate agreement, as well as their labeler codes (the first 5 digits of the NDC number), are listed on the Medicaid website at [http://www.medicaid.alabama.gov/programs/pharmacy\\_svcs/resources\\_providers.aspx?tab=4](http://www.medicaid.alabama.gov/programs/pharmacy_svcs/resources_providers.aspx?tab=4). Select the **Click Here** link to access the list of covered labelers (manufacturers) available from CMS.

Providers are encouraged to begin providing the NDC for all physician-administered drugs immediately; however, it is not required until July 1, 2010. Refer to the Alabama Medicaid Provider Manual for billing instructions.

Questions should be directed to the Provider Assistance Center at 1-800-688-7989 for in-state providers or (334) 215-0111 for out-of-state providers.

December 29, 2009

**To: All Renal Dialysis Providers**

**RE: Renal Dialysis Claims from Medicare**

Unresolved issues have required the Alabama Medicaid Agency to stop automatic acceptance of crossover claims from Medicare that began with the December 18, 2009 checkwrite.

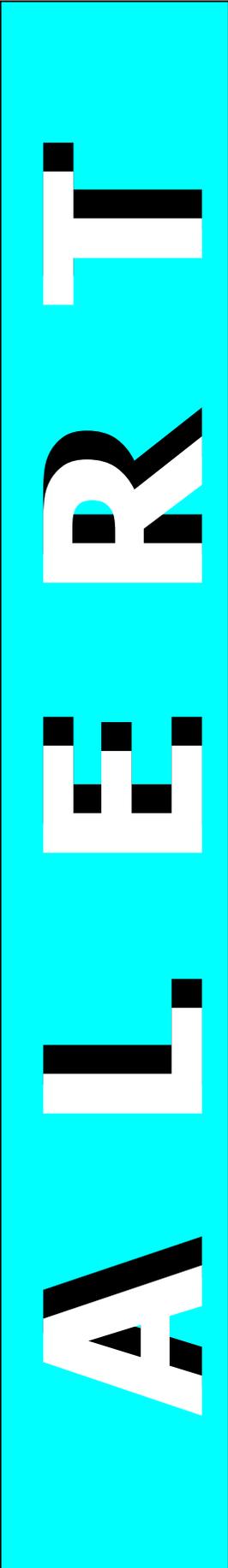
This action is effective immediately.

Providers whose claims were processed and paid incorrectly on the December 18, 2009 checkwrite, (and possibly on the January 8, 2010 checkwrite), must take action on those claims, by either adjusting or voiding and resubmitting electronically as done prior to the December 18<sup>th</sup> checkwrite.

Providers will be notified when the Alabama Medicaid Agency will begin automatically accepting renal dialysis claims from Medicare.

January 04, 2010

**ALBERT**



**To: All Physicians, Pharmacies, and Maternity Care Contactors**

**RE: Maternity Care Program Changes for Recipients**

Two important coverage changes for Alabama Medicaid maternity care patients will be implemented effective February 1, 2010. These programs include coverage of smoking cessation products and coverage of substance use screening (H0049) and a brief intervention and referral to treatment (SBIRT) for pregnant women (H0050). Details and requirements are listed below.

**Coverage of Smoking Cessation Products**

Effective February 1, 2010, smoking cessation products for pregnant females will be covered as a component of the Maternity Care Program.

1. Prior authorization through the Pharmacy Administrative Services contractor, Health Information Designs, will be required.
2. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline (1-800-784-8669).
3. Approval will be granted for up to three months at a time. Subsequent approvals are contingent upon the recipient's continued participation in counseling services through the ADPH Quitline which must be certified by the prescribing provider or Maternity Care Coordinator as a component of the prior authorization request.
4. Only one course of therapy will be approved per pregnancy.

Providers with questions regarding prior authorization for smoking cessation products may contact Health Information Designs at 1-800-748-0130.

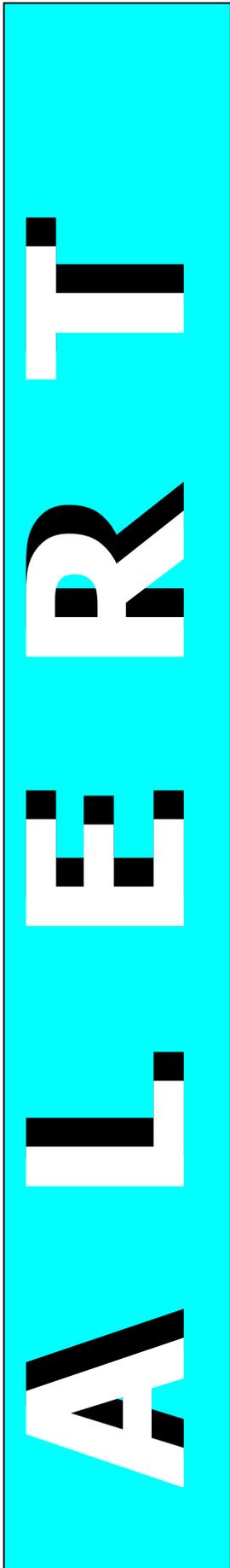
**Coverage of Screening, Brief Intervention and Referral for Treatment**

Effective February 1, 2010, Alabama Medicaid Agency will begin coverage of procedure codes H0049 screening for substance use and H0050 Brief Intervention and Referral to Treatment (SBIRT) for pregnant women in conjunction with antepartum care provided by physicians, physician employed nurse practitioners, nurse midwives, physician-employed physician assistants, and Federally Qualified Health Centers.

1. Prior to offering the service, Health care professionals must successfully complete an online tutorial which can be accessed at <http://www.mh.alabama.gov/SATR/AlabamaSBIRT/Default.aspx>.

The tutorial has been developed by Alabama Department of Mental Health Substance Abuse Service Division to prepare health care professionals to screen and refer Medicaid recipients for treatment for alcohol, tobacco, and substance abuse.

2. The Department of Mental Health Substance Abuse Division will notify the Alabama Medicaid Agency Maternity Care Program of health care professionals' successful completion of the tutorial.
3. Procedure codes H0049 and H0050 will then be billable for the health care professional who has successfully completed the online tutorial.
4. Reimbursement is as follows:  
H0049 - \$24.00 one per pregnancy  
H0050 - \$48.00 one per pregnancy
5. A diagnosis code of V222 must be billed by the provider on the claim form.



## Maternity Care Primary Contractors

The following organizations have been awarded contracts to provide Medicaid maternity services in Alabama effective January 1, 2010. All maternity services for Medicaid-eligible women who are pregnant or who become pregnant in the future must be coordinated through the appropriate organization.

### **District 1: Health Group of Alabama**

Counties: Colbert, Franklin, Lauderdale and Marion  
Phone: 1-888-500-7343

### **District 2: Health Group of Alabama**

Counties: Jackson, Lawrence, Limestone, Madison, Marshall, and Morgan  
Phone: 1-888-500-7343

### **District 3: Quality of Life**

Counties: Calhoun, Cherokee, Cleburne, Dekalb and Etowah  
Phone: 1-888-490-0131

### **District 4: Greater Alabama Health Network**

Counties: Bibb, Fayette, Lamar, Pickens and Tuscaloosa  
Phone: 1-877-553-4485

### **District 5: Alabama Maternity Inc.**

Counties: Blount, Chilton, Cullman, Jefferson, St. Clair, Shelby, Walker and Winston  
Phone: 1-877-997-8377

### **District 6: Gift of Life Foundation**

Counties: Clay, Coosa, Randolph, Talladega and Tallapoosa  
Phone: 1-877-826-2229

### **District 7: Greater Alabama Health Network**

Counties: Greene and Hale  
Phone: 1-877-553-4485

### **District 8: Tombigbee Healthcare Authority**

Counties: Choctaw, Marengo, and Sumter  
Phone: 1-888-531-6262

### **District 9: Greater Alabama Health Network**

Counties: Dallas, Perry and Wilcox  
Phone: 1-877-553-4485

### **District 10: Gift of Life**

Counties: Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery and Pike  
Phone: 1-877-826-2229

### **District 11: Maternity Services of District Eleven**

Counties: Barbour, Chambers, Lee, Macon, and Russell  
Phone: 1-877-503-2259

### **District 12: Southwest Alabama Maternity Care LLC**

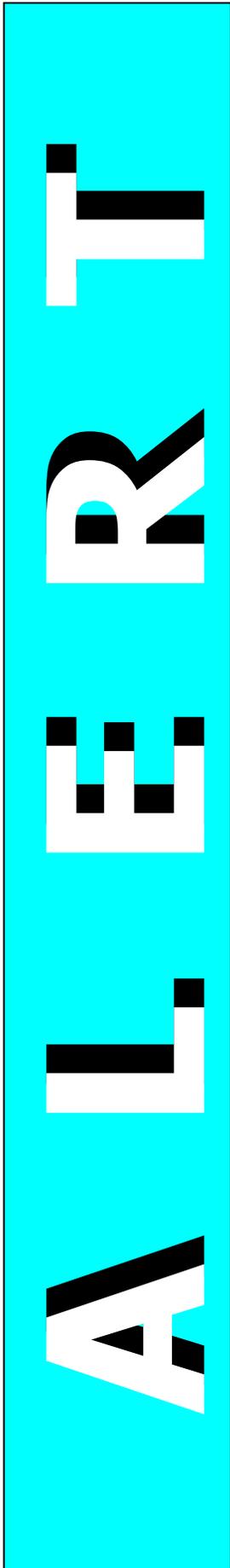
Counties: Baldwin, Clark, Conecuh, Covington, Escambia, Monroe, and Washington  
Phone: 1-877-826-2229

### **District 13: Southeast Alabama Maternity Care LLC**

Counties: Coffee, Dale, Geneva, Henry, and Houston  
Phone: 1-800-735-4998

### **District 14: University of South Alabama**

Counties: Mobile  
Phone: 1-251-415-8585



**To: Dental, Oral Surgeons, FQHCs, Health Department,  
Children Specialty Clinic Providers**

**RE: Dental Program Changes**

The following Dental Program changes will be effective **February 15, 2010**:

1. D2394 will be **non-covered for primary posterior teeth** (A, B, I, J, T, S, L, and K).
2. Resin restorations (D2391, D2392, and D2393) have been **reduced** to the same Medicaid reimbursement as amalgam restorations (D2140, D2150, and D2160).

| CDT   | OLD RATE | NEW RATE as of 02/15/10 |
|-------|----------|-------------------------|
| D2391 | \$59.00  | \$48.00                 |
| D2392 | \$77.00  | \$60.00                 |
| D2393 | \$88.00  | \$73.00                 |

3. Prefabricated Post & Core in addition to Crown (D2952) will be **reduced** to the same Medicaid reimbursement as D2954.

| CDT   | OLD RATE | NEW RATE as of 02/15/10 |
|-------|----------|-------------------------|
| D2952 | \$151.00 | \$132.00                |

4. **These codes will be non-covered:** D0350, D0470, D1510, D1515, D1520, D1525, D1550, D3110, D3120, D4355, D6212, D6240, D6242, D6750, and D6752.

5. D2750 and D2752 will be non-covered and providers may bill D2751.

6. **Changes to the Reimbursement Rates for the following codes are as follows:**

| CDT   | OLD RATE | NEW RATE as of 02/15/10 |
|-------|----------|-------------------------|
| D0240 | \$18.00  | \$15.00                 |
| D1351 | \$26.00  | \$22.00                 |
| D2951 | \$33.00  | \$28.00                 |
| D3230 | \$219.00 | \$175.00                |
| D3240 | \$248.00 | \$49.00                 |
| D3430 | \$145.00 | \$129.00                |
| D7220 | \$141.00 | \$128.00                |
| D7250 | \$96.00  | \$95.00                 |
| D7510 | \$85.00  | \$65.00                 |
| D7971 | \$78.00  | \$44.00                 |
| D9110 | \$40.00  | \$33.00                 |
| D9220 | \$224.00 | \$212.00                |
| D9230 | \$25.00  | \$22.00                 |

If you have any questions, please contact the Dental Program Manager at 334-353-5263.

January 25, 2010

## To: ALL Providers

### RE: Cost Saving Measures to be Implemented March 1, 2010

The Alabama Medicaid Agency is implementing the following cost saving measures in order to maintain a basic package of services while preserving the health care safety net for our most vulnerable citizens.

#### Changes Related to Submitting Paper Claims

Effective March 1, 2010, all claims which do not require attachments or an Administrative Review override by Medicaid must be submitted electronically.

##### **Which claims require attachments?**

The only attachment requiring paper claims submission is a third party insurance denial. All other claims must be filed electronically beginning March 1, 2010.

\*Some claims may require administrative or manual review. If you submit claims which require an administrative or manual review, these claims will continue to be filed on paper, following guidelines set forth in your specific chapter of the billing manual.

##### **Options are available for Electronic Claims Submission:**

- Medicaid's Interactive Web Portal allows claims to be submitted in an online real time environment. This service is available at no charge to providers.
- Provider Electronic Solutions (PES) software allows claims to be submitted in batch mode for processing. This service is available at no charge to providers.
- Providers can select a private software vendor for electronic claims submission. This service would involve a fee determined by the selected vendor.

**Beginning on March 1, 2010, all paper claims received by HP which do not require an attachment will be returned to the provider without being processed.**

#### Changes Related to Recipient Eligibility Inquiry via Provider Assistance Center

Effective March 1, 2010 providers must check eligibility electronically.

##### **Electronic options for verifying eligibility:**

- Medicaid's Interactive Web Portal allows providers to check eligibility in an online real time environment. This service is available at no charge to providers.
- Provider Electronic Solutions (PES) software allows eligibility verification to be submitted in batch mode. This service is available at no charge to providers.
- The Automated Voice Response System (AVRS) allows providers to check eligibility telephonically by dialing 1-800-727-7848 (in-state) or (334) 215-0111 Option 5 (out-of-state). This service is available at no charge to providers.

Providers can select a private vendor for electronic eligibility verification. This service would involve a fee determined by the selected vendor. **Beginning on March 1, 2010, all eligibility requests received by HP's Provider Assistance Center for eligibility verification will be directed to this Alert and the caller will be given the option to be transferred to the Automated Voice Response System.**

## **RE: Cost Saving Measures to be Implemented March 1, 2010**

### **Changes Related to Printing and Distributing Remittance Advices (RAs)**

Effective March 1, 2010, Medicaid will no longer print and distribute paper Remittance Advices (RA's) to providers.

#### **Options available for viewing RAs**

- Medicaid's Interactive Web Portal allows providers to view RAs on-line. RAs are stored for six months on the interactive database. RAs can also be printed, saved to a personal computer, or viewed from the web portal. This service is available at no charge to providers.
- Providers can select a private vendor for electronic RA download. This service would involve a fee determined by the selected vendor.

### **Changes Related to Claim Adjustments**

Effective March 1, 2010, Medicaid will no longer accept paper adjustment request forms.

#### **Options for performing adjustments on claims:**

- Medicaid's Interactive Web Portal allows adjustments to be submitted in an online in a real time environment. This service is available at no charge to providers.
- Provider Electronic Solutions (PES) software allows providers to submit adjustments on-line in batch mode.

**Beginning on March 1, 2010, adjustment requests received on paper will be returned to the provider without being processed.**

### **Changes Related to Printing and Distributing Reports to Patient 1<sup>st</sup> Primary Care Providers and EPSDT Screening Providers.**

Effective March 1, 2010, Medicaid will discontinue printing and mailing the following reports:

- EPSDT Periodic Rescreening Report
- Patient 1<sup>st</sup> Referral Report
- Monthly PMP Enrollment Roster for Patient 1<sup>st</sup>

The reports may be accessed through Medicaid's Interactive Website. The link to the Interactive Website is: <https://www.medicaid.alabamaservices.org/ALPortal>. Once logon to the website is successful, reports may be found at the following location:

1. Trade Files
2. Download
3. Under Transaction type, select the down arrow to review all available reports.

Information may then be viewed, saved, or printed as needed in your office.

### **Electronic Access Methods Available Through HP**

#### **Accessing Medicaid's Interactive Web Portal:**

In February 2008, letters were mailed to all providers with web portal log-on ID and initial password information. If your office has never accessed the website, refer to this letter for log-on information. If you cannot locate the letter, contact the Electronic Media Claims Helpdesk to obtain an additional copy of the letter. The phone number is 1-800-456-1242 (in-state) and (334) 215-0111 Option 2 (out-of-state). E-mail: [alabamasytemsemc@hp.com](mailto:alabamasytemsemc@hp.com) (preferred method of contact is e-mail).

#### **Accessing Provider Electronic Solutions Software:**

Provider Electronic Solutions software may be downloaded from the Medicaid website at the following link: <http://www.medicaid.alabama.gov/billing/pes.aspx?tab=6>

## RE: Cost Saving Measures to be Implemented March 1, 2010

Download instructions and user manual are also available at this link. To access Provider Electronic Solutions software, providers must obtain a trading partner ID. Trading partner ID's may be requested by logging on the Interactive website at the following link:

[https://www.medicaid.alabamaservices.org/documentation/Trading\\_Partner\\_ID\\_Request\\_Form.zip](https://www.medicaid.alabamaservices.org/documentation/Trading_Partner_ID_Request_Form.zip)

### Accessing Automated Voice Response System (AVRS)?

The Automated Voice Response System can be accessed through any telephone. Instructions on how to access AVRS can be found in Appendix L of the provider manual at the following link:

[http://www.medicaid.alabama.gov/documents/Billing/5-G\\_Manuals/5G-2\\_Provider.Manual\\_Jan.2010/Jan10\\_L.pdf](http://www.medicaid.alabama.gov/documents/Billing/5-G_Manuals/5G-2_Provider.Manual_Jan.2010/Jan10_L.pdf)

### Training Information

HP will be offering training on how to use Interactive Web Portal and Provider Electronic Solutions software for the upcoming changes. The workshops will be offered on-line through HP's Virtual Room Training. Training will be provided for the following claim types:

- CMS-1500
- UB-04
- Dental
- Pharmacy

Information on classes will be posted on the Medicaid website in early February. Registration and class information will be available at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov). The training will cover the following topics:

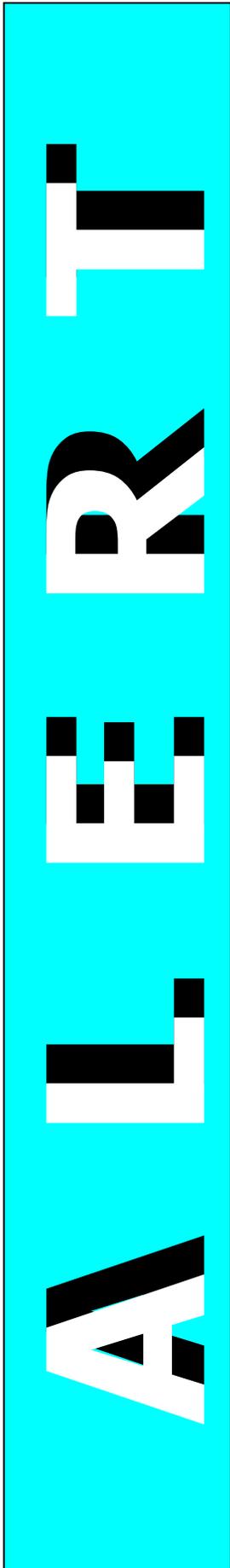
How to access the Interactive Web Portal and perform the following functions:

- Verify recipient eligibility
- Download, view, print RA's
- Download, view, print reports
- Claim submission
- Claim adjustments
- Claim voids

How to access Provider Electronic Solutions software and perform the following functions:

- Verify recipient eligibility
- Claim submission
- Claims adjustment
- Claim void

January 26, 2010



## To: In-state and Border Hospital Providers

## RE: InterQual ® and Adverse Events Policy and Billing Workshop

Medicaid will be implementing InterQual® Adult and Pediatric Medical criteria with Alabama Medicaid Local Policy and Adverse Events on all Inpatient Hospital claims for dates of service beginning June 1, 2010. Sessions for Quality Assurance staff as well as billing staff will be offered on the following dates:

- **Wednesday, February 24, 2010**, 10am-12pm Children's Hospital campus, 1600 7th Avenue South Birmingham, AL. Meeting will be held at the Bradley Lecture Center, 4<sup>th</sup> Floor of the Children's Harbor building on the campus of Children's Hospital, 6<sup>th</sup> Avenue South at 16<sup>th</sup> Street. Please park in the Park Place parking deck. (Limited seating—no more than 65). **Registration deadline for this session is Wednesday, February 17, 2010.**
- **Friday, February 26, 2010**, 1pm-3pm USA Children's and Women's Hospital Mobile, 1700 Center Street Mobile, AL. Meeting will be held in the Atlantis Room. **Registration deadline for this session is Friday, February 19, 2010.**
- **Tuesday, March 2, 2010**, 10am-12pm Alabama Hospital Association office, 500 N Eastern Blvd, Montgomery, AL. The meeting will be held in the Boardroom. (Limited seating—no more than 60) **Registration deadline for this session is Tuesday, February 23, 2010. A web conference will also be provided during this session in which registration is required. Registration deadline for the web conference is Friday, February 19, 2010. A personal link will be sent to you upon registration completion and prior to the date of the conference.**
- **Wednesday, March 3, 2010**, 1pm-3pm Decatur General Hospital, 1201 7<sup>th</sup> Street SE, Decatur, AL. Meeting will be held in the Camp Bluebird room. **Registration deadline for this session is February 23, 2010.**
- **Thursday, April 22, 2010**, 10am-12pm (Web Conference Only). A personal link will be sent to you one week prior to the date of the conference; if you have registered for this conference. **Registration deadline for this session is Monday, April 12, 2010.**

A registration form is attached. This form must be completed and faxed or e-mailed to Carolyn Thompson. Seating is limited; you may be contacted if seating is not available. For any questions, contact Carolyn Thompson via e-mail at [Carolyn.thompson@medicaid.alabama.gov](mailto:Carolyn.thompson@medicaid.alabama.gov) or by phone at 334-353-4650.

# InterQual ® and Adverse Events Policy and Billing Workshop

## Registration Form

Registration Information is required to attend any of the workshops\*\*

Check ONLY one date:

Meeting workshops:       2/24/10       2/26/10       3/2/10       3/3/10

OR

Web conference workshops:     3/2/10       4/22/10

Name and title: \_\_\_\_\_

Hospital or Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

### Contact Information

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

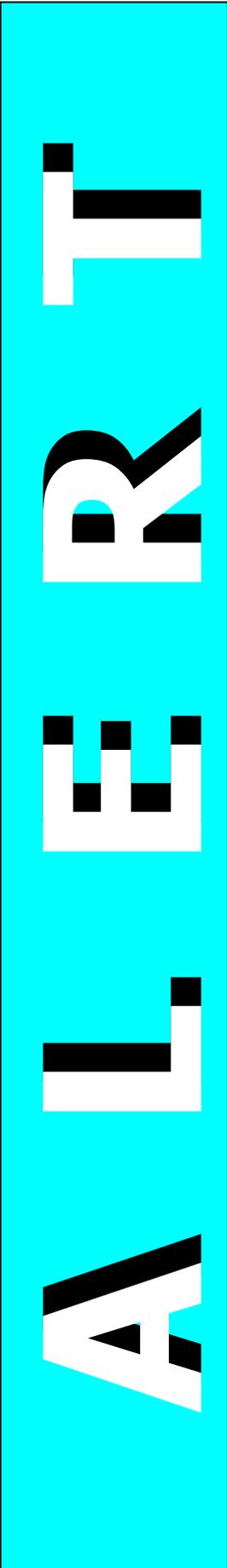
Office Contact Person: \_\_\_\_\_

Fax this registration form to: Carolyn Thompson at 334-242-0533

E-mail this registration form to: [Carolyn.thompson@medicaid.alabama.gov](mailto:Carolyn.thompson@medicaid.alabama.gov)

**\*\*Please note that there are limited spaces in each workshop. Please limit your facility to no more than two attendees per session. You may be asked to attend another session or take part in the web conference if space is not available.**

February 11, 2010



**To: Dental Providers, Oral Surgeons, FQHCs, Health Departments, and Children Specialty Clinics**

**RE: Dental Program Changes/Dental Meeting**

An open forum for Alabama Medicaid dental providers has been rescheduled for 1 p.m. on Friday, February 26, 2010, at the Alabama Medicaid Agency, 501 Dexter Avenue in Montgomery. Directions and a map are available on the Agency's web site at [http://www.medicaid.alabama.gov/contact/index\\_contact.aspx?tab=8](http://www.medicaid.alabama.gov/contact/index_contact.aspx?tab=8)

The meeting will be in the fourth floor boardroom for those who would like to attend in person and also will be available by conference call and web conference. To participate in the conference call or web conference and to receive future notices and information regarding the Medicaid Dental Program, please contact Nancy Rawlinson at (334) 353-4099 or by e-mail at [nancy.rawlinson@medicaid.alabama.gov](mailto:nancy.rawlinson@medicaid.alabama.gov)

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February 19, 2010

**To: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, and Nursing Homes**

**RE: Preferred Drug List (PDL) Update**

**Effective April 1, 2010**, the Alabama Medicaid Agency will:

1. Remove from the Preferred Drug List and no longer cover, even with prior authorization, all **Brand Benzodiazepines with the exception of Diastat**, and
2. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| <b>PDL Additions</b>   | <b>PDL Deletions*</b>                                |
|--|--|
| <b>Daytrana</b> -Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting | <b>Amerge</b> - Pain Management/Antimigraine Agents  |
|  | <b>Mycostatin</b> -Anti-infective Agents/Antifungals |
|  | <b>Relpax</b> -Pain Management/Antimigraine Agents   |

*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers are to mail or fax hard copy PA requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

March 09, 2010

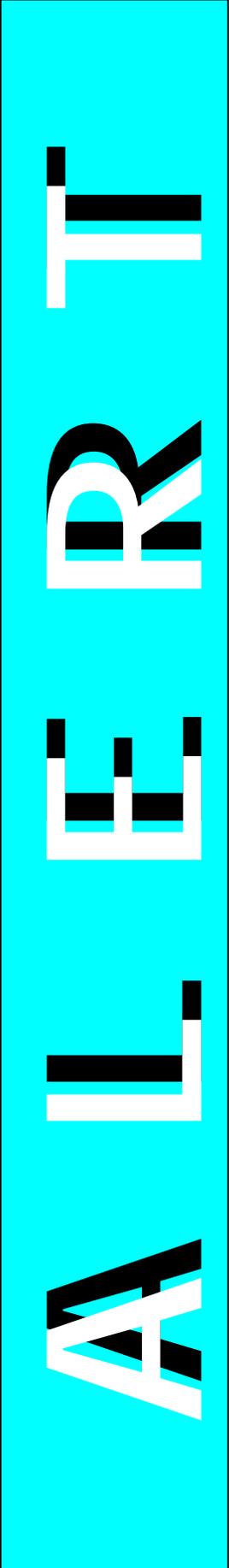
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## To: In-state and Border Hospital Providers

### RE: InterQual® and Adverse Events Policy and Billing Workshop

Medicaid will be requiring hospitals to capture non-covered days per InterQual® Adult and Pediatric Medical criteria with Alabama Medicaid Local Policy and Adverse Events on all inpatient hospital claims for dates of service beginning July 1, 2010. Sessions for Quality Assurance staff, as well as billing staff, will be offered on the following dates:

- **Monday, April 19, 2010**, 10 a.m.-12 p.m., Decatur General Hospital, 1201 7<sup>th</sup> Street SE, Decatur, AL. Meeting will be held in the Camp Bluebird room. **Registration deadline for this session is Monday, April 12, 2010.**
- **Tuesday, April 20, 2010**, 10 a.m.-12 p.m., Children's Hospital campus, 1600 7th Avenue S, Birmingham, AL. Meeting will be held at the Bradley Lecture Center, 4<sup>th</sup> Floor of the Children's Harbor building on the campus of Children's Hospital, 6<sup>th</sup> Avenue S at 16<sup>th</sup> Street. Please park in the Park Place parking deck. (Limited seating—no more than 65). **Registration deadline for this session is Tuesday, April 13, 2010.**
- **Monday, April 26, 2010**, 10 a.m.-12 p.m., USA Children's and Women's Hospital Mobile, 1700 Center Street, Mobile, AL. Meeting will be held in the Atlantis Room. **Registration deadline for this session is Monday, April 19, 2010.**
- **Tuesday, May 4, 2010**, 10 a.m.-12 p.m., Alabama Hospital Association office, 500 N Eastern Blvd, Montgomery, AL. The meeting will be held in the Boardroom. (Limited seating—no more than 60) **Registration deadline for this session is Tuesday, April 27, 2010. A web conference will also be provided during this session in which registration is required. Registration deadline for the web conference is Friday, April 16, 2010. A personal link will be sent to you upon registration completion and prior to the date of the conference.**
- **Thursday, April 22, 2010**, 10 a.m.-12 p.m. (Web Conference Only). A personal link will be sent to you one week prior to the date of the conference. This web conference will be limited to 100 recipients. **Registration deadline for this session is Monday, April 12, 2010.**

A registration form is attached to this alert. This form must be completed and faxed or e-mailed to Karen Smith. Seating is limited; you may be contacted if seating is not available. For any questions, contact Karen Smith via e-mail at [karen.watkins-smith@medicaid.alabama.gov](mailto:karen.watkins-smith@medicaid.alabama.gov) or by phone at 334-353-4945.

# InterQual ® and Adverse Events Policy and Billing Workshop

## Registration Form

Registration Information is required to attend any of the workshops\*\*

Check ONLY one date:

Meeting workshops:             4/19/10         4/20/10         4/26/10         5/4/10

OR

Web conference workshops:    4/22/10         5/4/10

Name and title: \_\_\_\_\_

Hospital or Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

### Contact Information

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

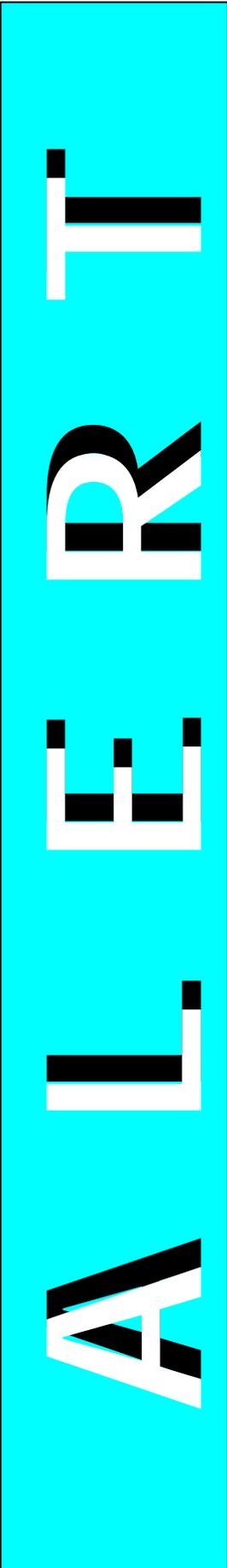
Office Contact Person: \_\_\_\_\_

Fax this registration form to: 334-353-4818

E-mail this registration form to: [karen.watkins-smith@medicaid.alabama.gov](mailto:karen.watkins-smith@medicaid.alabama.gov).

**\*\*Please note that there are limited spaces in each workshop. Please limit your facility to no more than two attendees per session. You may be asked to attend another session or take part in the web conference if space is not available.**

March 22, 2010



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**To: All Pharmacy Providers, Pharmacy Associations, and Vendors**

**RE: Usual & Customary Amount on Electronic Drug Claims**

Effective April 13, 2010, Alabama Medicaid will accept the Usual & Customary (U & C = charge to the general public) amount in Field 426-DQ on Electronic Drug claims. Currently, the Agency requires the total amount due on a drug claim in the "Gross Amount Due" Field 430-DU while the U & C amount in Field 426-DQ is not captured.

Effective April 13, 2010, the Agency will accept the U & C amount in Field 426-DQ in the "lower of" reimbursement methodology. Pharmacies should submit their U & C amounts in Field 426-DQ, and must continue to submit the 'Total Amount Due' in the Gross Amount Due field. The Alabama Medicaid Companion Guide to the NCPDP 5.1 Specifications has been updated on the Medicaid website ([www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)) to reflect this change. Questions related to electronic billing should be directed to HP at 1-800-456-1242 in state, and 1-334-215-0111 out of state.

March 31, 2010

**To: All Hospital Providers**

**RE: Third Party Release of Information Policy**

This notice is to clarify Alabama Medicaid's requirement of providers to notify the Agency's Third Party Division prior to releasing medical records. As indicated in the Alabama Administrative Code, Rule No. 560-X-20-.05(3), it is not the Agency's intention to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Division.

Providers are to ensure that all HIPAA Privacy and Security rules are met regarding an individual's "right of access to inspect and obtain a copy of protected health information about the individual" (as stated in 45 C.F.R. §164.524).

Medicaid's rule is also designed to ensure that Medicaid is informed of potential circumstances in which Medicaid may have a subrogation interest pertaining to the medical records being requested.

It does not permit providers to deny individuals access to their records. **Providers should not cite Medicaid's rule as cause for not meeting the HIPAA Privacy rule, nor should they attempt to place the responsibility for notifying the Medicaid Agency on the recipient.**

The "Request for Medical Records" form will still be available for use by providers to document that Medicaid has been notified of a medical record request on a Medicaid recipient. The form is available on the Agency's Web site at [http://www.medicaid.alabama.gov/billing/release\\_info.aspx?tab=6](http://www.medicaid.alabama.gov/billing/release_info.aspx?tab=6)

While Medicaid will continue to send a return response to the form, **a provider should not deny the release of medical information to an individual because the provider has not received a response back from Medicaid.**

To determine if Medicaid should be notified, the provider should inquire as to the purpose of the medical information and who is in need of the information. If the request meets any of the circumstances in Rule No. 560-X-20-.05(1) [attached], then the provider is not required to send Medicaid notification of the request. Otherwise, the provider should notify Medicaid of the request and provide the information to the requestor (if all other provisions have been met).

**In addition, the Alabama Medicaid Agency has contracted with Health Management Systems (HMS) to handle the processing of requests for medical records. "Request for Medical Records" forms should be faxed to HMS at 866-274-5974. Other notifications to Medicaid regarding medical record releases should be provided to HMS by phone at 877-252-8949.**

If you should have any questions regarding this notice, please contact Keith Thompson, Director, Third Party Division, at (334) 242-5248.

May 17, 2010

**Rule No. 560-X-20-.05. Release of Information - All Providers**

(1) Information pertaining to a patient's treatment (including billing statement, itemized bills, etc.) may be routinely released **ONLY UNDER THE FOLLOWING CIRCUMSTANCES AND/OR TO THE FOLLOWING AGENCIES** if Medicaid has been billed or is expected to be billed:

- (a) The Medicaid Fiscal Agent,
- (b) The Social Security Administration,
- (c) The Alabama Vocational Rehabilitation Agency,
- (d) The Alabama Medicaid Agency,

(e) Requests from insurance companies for information pertaining to a claim filed by the provider in accordance with Medicaid Regulations and for which an assignment of benefits to the provider was furnished the insurance company.

(f) Requests by insurance companies for information to process an application for insurance, to pay life insurance benefits, or to pay on a loan.

- (g) Requests from other providers for medical information needed in the treatment of patient.

(2) If information pertaining to a patient's treatment is requested by any other source, or under any other circumstance, the Alabama Medicaid Agency, Third Party Section, must be contacted **PRIOR TO RELEASE OF INFORMATION**. The only exception is when a subpoena is received during nonworking hours of the Alabama Medicaid Agency and must be responded to immediately. Should this occur, the provider may respond to the subpoena and must include with the released records a notice that the patient was covered by Medicaid. In addition, the provider must notify the Third Party Section of the subpoena as soon as possible.

(3) It is not the intention to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Section.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

**To: All Providers**

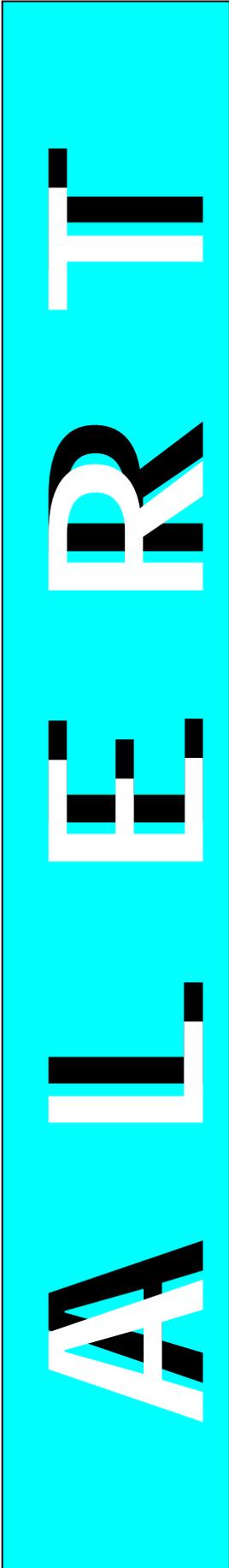
**RE: Printing of RAs**

The missing RA page issue for the May 21, 2010, check write has now been resolved. RAs can now be downloaded via the Web Portal. There will be two files listed until the erroneous file can be deleted. Please ensure the file you use contains all pages.

Please contact the Electronic Media Claims Help Desk if you have any questions at (800) 456-1242 for Alabama, Florida, Georgia, Mississippi and Tennessee and (334) 215-0111 for all other locations.

May 27, 2010

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**To: All Dental Providers**

**RE: Dental IV Sedation Certification**

To ensure the safety of Alabama Medicaid recipients, state dental providers using IV sedation must submit documentation of their certification to the Agency prior to August 1, 2010.

On August 1, 2010, Alabama Medicaid will deny procedure codes D9241 and D9220, if the provider does not submit their IV sedation certification to Medicaid.

To ensure that Medicaid enrollment files are updated prior to the August 1, 2010 start date, providers are asked to complete the form below and return it with a copy of your IV sedation certification by June 21, 2010 to:

Provider Enrollment  
HP Enterprise Services  
301 Technacenter Dr  
Montgomery, AL 36117

Please complete the following:

Provider's Name \_\_\_\_\_

Provider's NPI \_\_\_\_\_

Medicaid Numbers (please include Medicaid assigned numbers for all clinics the provider is enrolled to provide services)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTACH a copy of Certificate**

May 27, 2010

**To: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes**

**RE: PDL Update**

**Effective July 1, 2010**, the Alabama Medicaid Agency will: Require prior authorization (PA) for payment of non-preferred brands in the First Generation Antihistamine drug class, and Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| <b>PDL Additions</b>                               | <b>PDL Deletions*</b>  |
|--|--|
| <b>Besivance</b> -EENT Preparations/Antibacterials | <b>Optivar</b> -EENT Preparations/Antiallergic Agents                              |
|  | <b>Pramox</b> -Skin and Mucous Membrane Agents/Antipruritics and Local Anesthetics |

*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

June 10, 2010

**To: All In-State and Border Hospital Providers**

**RE: Adverse Events Policy**

Effective July 1, 2010, Medicaid will require hospitals to report Adverse Events. The following is approved policy that will be a part of Medicaid's Billing Manual and Administrative Code.

**Serious Preventable Events, Hospital-Acquired Conditions, and Present on Admission Indicators and Billing**

Adverse Events are the events that must be reported to Medicaid by the hospital. To be reportable, these events must meet the following criteria:

- The event must be reasonably preventable as determined by a root cause analysis or some other means.
- The event must be within the control of the hospital.
- The event must be clearly and unambiguously the result of a preventable mistake made and hospital procedures not followed, and not an event that could otherwise occur.
- The error or event must result in significant harm. The events for consideration should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 0 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and an internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability. Pursuant to these guidelines, hospitals will not seek payments for additional days directly resulting from adverse events.

Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

**Reporting Adverse Events**

Adverse events must be reported to Medicaid by encrypted emailing required information to: [AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov). Each hospital will receive a password specifically for e-mail reporting. Reportable "Adverse Events" include:

- Surgery on a wrong body part
- Wrong surgery on a patient
- Surgery on a wrong patient

Reports will require the following information: Recipient first and last name, date of birth, Medicaid number, date event occurred and event type. A sample form is on the Alabama Medicaid Agency website at [www.medicicaid.alabama.gov](http://www.medicicaid.alabama.gov) under Programs/Hospital Services although hospitals may submit their own form as long as it contains all required information.

**Reporting Hospital-Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form**

Hospitals should use the POA indicator on claims for these events. If no claim is submitted for the event or the event cannot be filed on a UB-04 claim form, then the Alabama Medicaid Agency is to be notified via encrypted e-mail at [AdverseEvents@medicaid.alabama.gov](mailto:AdverseEvents@medicaid.alabama.gov). The following information will be required: Recipient first and last name, date of birth, Medicaid number, date of event occurrence and event type. A sample form can be found on the Alabama Medicaid Agency website or a hospital may submit their own form as long as it contains all of the required information. Below are Hospital Acquired Conditions (HACs) with ICD-9 Codes that hospitals are required to report on the UB-04 claim form.

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| Selected HAC   | CC/MCC (ICD-9-CM Codes)  |
|--|--|
| Foreign Object Retained After Surgery  | 998.4 (CC) and 998.7 (CC)  |
| Air Embolism   | 999.1 (MCC)  |
| Blood Incompatibility  | 999.6 (CC)   |
| Pressure Ulcer Stages III & IV   | 707.23 (MCC) and 707.24 (MCC)  |
| Falls and Trauma:<br>-Fracture<br>-Dislocation<br>-Intracranial Injury<br>-Crushing Injury<br>-Burn<br>-Electric Shock | Codes within these ranges on the CC/MCC list:<br>800-829.1<br>830-839.9<br>850-854.1<br>925-929.9<br>949-949.5<br>991-994.9  |
| Catheter-Associated Urinary Tract Infection (UTI)  | 996.64—Also excludes the following from acting as a CC/MCC: 112.2 (CC), 590.10 (CC), 590.11 (MCC), 590.2 (MCC), 590.3 (CC), 590.80 (CC), 590.81 (CC), 595.0 (CC), 597.0 (CC), 599.0 (CC) |
| Vascular Catheter-Associated Infection   | 999.31 (CC)  |
| Manifestations of poor glycemic control  | 250.10-250.13 (MCC), 250.20-250.23 (MCC), 251.0 (CC), 249.10-249.11 (MCC), 249.20-249.21 (MCC)   |
| Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)                                  | 519.2 (MCC) and one of the following procedure codes: 36.10-36.19.   |
| Surgical Site Infection Following Certain Orthopedic Procedures  | 996.67 (CC) OR 998.59 (CC) and one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.38, 81.83, or 81.85.   |
| Surgical Site Infection Following Bariatric Surgery for Obesity  | Principal Diagnosis code-278.01 OR 998.59 (CC) and one of the following procedure codes: 44.38,44.39, or 44.95   |
| Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures                                    | 415.11 (MCC), 415.19 (MCC), or 453.40-453.42 and one of the following procedure codes: 81.51-81.52, 81.54.   |

The hospital may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis was present at time of inpatient admission.
- **N**-No. Diagnosis was not present at time of inpatient admission.
- **U**-No information in the record. Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- **1**-Unreported/Not used. Exempt from POA reporting.

If the value code '81' is indicated; then non-covered days must be present and the amount field must be greater than '0'.

It is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

A document with frequently asked questions has been posted on the Agency's website under Programs/Hospital Services. Any further questions regarding this notice should be directed to Jerri Jackson at 334-242-5630 or Karen Smith at 334-353-4945.

June 22, 2010

**To: All In-State and Border Hospital Providers**

**RE: Utilization Review Policy**

Effective for admissions on or after July 1, 2010, Medicaid will require hospitals to report dates that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy on the UB-04 claim form. The following is approved policy that will be a part of Medicaid's Billing Manual and Administrative Code.

**Utilization Review for Inpatient Hospital Admissions and Concurrent Stays**

Medicaid will utilize Alabama Medicaid Adult and Pediatric Inpatient Care Criteria (SI/IS) for utilization review, billing and reimbursement purposes.

- It is the hospital's responsibility to utilize its own physician advisor.
- The attending physician and/or resident may change an order up to 30 days after discharge, as long as the patient met criteria for inpatient or observation services.

For admissions and continued stays on or after July 1, 2010, Medicaid will 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.

Dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy must be reported on the UB-04.

- Hospital Providers are required to use Occurrence Span Code 74 to identify days not meeting InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy, and
- Must enter the occurrence span dates for the dates that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

Inpatient psychiatric and rehabilitation services in an acute care facility will be exempt from reporting dates of service that do not meet InterQual® Adult and Pediatric Medical Criteria and Alabama Medicaid Local Policy.

The Alabama Medicaid Local Policy is available on the Alabama Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under *Programs/Hospital Services*. Hospital providers are to use the 2009 criteria until the 2010 criteria have been reviewed.

A percentage of admissions and concurrent stay charts will be reviewed by the Alabama Medicaid Agency and a Quality Improvement Organization contracted by the Agency.

All in-state and border hospitals must submit Medical Care Evaluation (MCE) Studies (i.e. Performance Improvement Studies) and Utilization Review (UR) Plans to the contracted Quality Improvement Organization every year upon request.

A document with frequently asked questions has been posted on the Agency's website under *Programs/Hospital Services*. Questions regarding this notice should be directed to Jerri Jackson at 334-242-5630 or Karen Smith at 334-353-4945.

June 22, 2010

**To: All Psychologists**

**RE: Change in Billing for Diagnostic Testing Codes and Use of Modifiers**

Based on the support and input of Alabama's psychologists, the Alabama Medicaid Agency will make two changes to Chapter 34 of the Provider Manual, effective July 1, 2010.

1. **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.

2. **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. The modifiers are as follows:

- **U6** for a Licensed Professional Counselor (LPC) or Associate Licensed Counselor (ALC)
- **U7** for a Licensed Marriage and Family Therapist (LMFT)
- **AJ** for a Licensed Certified Social Worker (LCSW)
- **HO** for an individual with a masters degree or above, not yet licensed but has successfully completed a practicum as a part of the requirements for the degree or has six months of post master's level clinical experience supervised by a master's level or above clinician with two years of post graduate clinical experience.

If you have further questions, you may contact Karen Smith via e-mail at [karen.watkins-smith@medicaid.alabama.gov](mailto:karen.watkins-smith@medicaid.alabama.gov) or telephone at 334-353-4945.

June 28, 2010

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**TO: All Providers**

**RE: Denial 1825 – “COBA Denial-Do Not Crossover”**

**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:

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

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

July 1, 2010

**To: All Providers**

**RE: Identifying Oil-Spill Related Illnesses/Injuries for Medicaid Recipients**

In order to track and evaluate health outcomes and costs related to the BP Oil Spill, the Alabama Medicaid Agency will begin use of claims billing indicators to identify services provided to Alabama Medicaid recipients when treated for an oil-spill related illness or injury.

Effective immediately, providers are asked to use the following indicators on applicable claims submitted to Alabama Medicaid:

- Professional Claims (837P, other electronic methods, or CMS-1500) – Enter **Modifier “U9”** (Disaster-Related Service or Illness) with all appropriate procedure codes. This modifier should follow any other modifiers currently required for claims payment.
- Institutional Claims (837I, other electronic methods, or UB-04) – Enter the **Condition Code “DR”** (Disaster-Related Service or Illness) as the first condition code with all appropriate services.
- Pharmacy POS Transactions – Enter the NCPDP Field **Reason for Service Code “RE”** (Suspected Environmental Risk) with all appropriate services. This reason for service code should follow any other reason for service code required for claims payment.

Providers should begin immediately to use these indicators on claims submitted for Medicaid payment. Please contact the Provider Assistance Center at 1-800-688-7989 with any related questions.

July 12, 2010

**To: All Hospice Providers**

**RE: Concurrent Care for Children Under the Hospice Election**

Effective immediately, Medicaid will no longer require parents with children under the age of 21 receiving hospice care, to waive all rights to Medicaid services covered under Medicaid for the duration of hospice care. Based on the *Patient Protection and Affordable Care Act*, a voluntary election to receive hospice care for a child shall not constitute a waiver of any rights of the child to be provided with, or to have payments made for services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made. Children can now receive services related to the treatment of the condition for which a diagnosis of terminal illness was made.

For additional information or further clarification, please contact Samantha McLeod at (334)242-5584 or [Samantha.McLeod@medicaid.alabama.gov](mailto:Samantha.McLeod@medicaid.alabama.gov) .

July 19, 2010

**To: All Providers**

**RE: Synagis® Criteria for 2010 – 2011 Season**

The Alabama Medicaid Agency has updated its prior authorization criteria for Synagis®.

- The approval time frame for Synagis® will begin October 1, 2010 and will be effective through March 31, 2011.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2010 (for an October 1 effective date).
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

**Criteria**

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. The form and complete updated criteria specific to Synagis® are available on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs: Pharmacy Services: Prior Authorization/Overrides Criteria and Pharmacy Forms: 2010-2011 Synagis® Criteria and Forms.

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

July 30, 2010

**To: All Home Health Providers**

**RE: Home Health Certification and Re-Certification Forms**

*Effective immediately, Medicaid will no longer require providers to add information included on Medicaid's Home Health Certification/Re-Certification Forms to the Medicare Home Health Certification and Plan of Care Form.*

Currently, there are two approved forms for documenting Medicaid home health certification and re-certification admissions:

- A. *Medicaid's Home Health Certification & Re-Certification Forms (Forms 377 & 378).*
- B. *Medicare's Home Health Certification and Plan of Care Form (Form CMS-485).*

Formerly, providers using the Medicare Form CMS-485 were required to add all missing information from Medicaid Forms 377 & 378. This information includes: adding the name, address, and relationship of the caregiver, etc. and continues to include the falsification statement/paragraph.

After a thorough evaluation, the Agency found it unnecessary to add this information to the CMS-485 form. However, providers are still required to keep this essential information on file to be in compliance with Medicare and Medicaid regulations.

Please address questions or concerns to Monica Abron, at (334)-242-5642.

August 31, 2010

**To: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes Providers**

**RE: PDL Update**

**Effective October 1, 2010**, the Alabama Medicaid Agency will:

1. Require prior authorization (PA) for payment of non-preferred brands in the Genitourinary Smooth Muscle Relaxants drug class.
2. Require prior authorization (PA) for payment of generic lansoprazole and omeprazole-sodium bicarbonate. Preferred brands as well as OTC versions of Proton Pump Inhibitors will continue to be available with no PA necessary. The preferred status of the Proton Pump Inhibitors are listed below:

| Preferred Brands | Preferred Generic or OTC | Non-Preferred Brand or PA Generic       |
|------------------|--------------------------|---|
| Aciphex          |                          |   |
|                  | Prevacid OTC             |   |
|                  | Prilosec OTC             |   |
|                  | Zegerid OTC              |   |
|                  |                          | Dexilant                                |
|                  |                          | lansoprazole (generic)                  |
|                  |                          | Nexium                                  |
|                  |                          | omeprazole-sodium bicarbonate (generic) |
|                  |                          | pantoprazole (generic)                  |
|                  |                          | Prevacid*                               |
|                  | omeprazole               | Prilosec*                               |
|                  |                          | Protonix*                               |

3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions   | PDL Deletions*   |
|---|--|
| <b>Aricept ODT</b> -Behavioral Health/Alzheimer's Agents                              | <b>Azor</b> -Cardiovascular Health/Calcium Channel Blockers/Combos                   |
| <b>Oxytrol</b> -Genitourinary Agents/ Genitourinary Smooth Muscle Relaxants           | <b>Cozaar</b> -Cardiovascular Health/ Angiotensin-II Receptor Antagonists            |
| <b>Teveten</b> -Cardiovascular Health/ Angiotensin-II Receptor Antagonists            | <b>Diovan HCT</b> -Cardiovascular Health/ Angiotensin-II Receptor Antagonists/Combos |
| <b>Teveten HCT</b> -Cardiovascular Health/ Angiotensin-II Receptor Antagonists/Combos | <b>DynaCirc CR</b> -Cardiovascular Health/ Calcium Channel Blockers                  |
|   | <b>Exforge</b> -Cardiovascular Health/Calcium Channel Blockers/Combos                |
|   | <b>Hyzaar</b> -Cardiovascular Health/Angiotensin-II Receptor Antagonists/Combos      |
|   | <b>Lescol</b> -Cardiovascular Health/HMG CoA Reductase Inhibitors                    |

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| PDL Additions | PDL Deletions*   |
|---------------|--|
|               | <b>Lescol XL</b> -Cardiovascular Health/HMG CoA Reductase Inhibitors           |
|               | <b>Maxalt</b> -Pain Management/Autonomic Agents/Selective Serotonin Agonists   |
|               | <b>Niaspan</b> -Cardiovascular Health/Miscellaneous Antilipemic Agents         |
|               | <b>Norpace</b> -Cardiovascular Health/Antiarrhythmics                          |
|               | <b>Norpace CR</b> -Cardiovascular Health/Antiarrhythmics                       |
|               | <b>Treximet</b> -Pain Management/Autonomic Agents/Selective Serotonin Agonists |
|               | <b>Veramyst</b> -EENT Preparations/Intranasal Corticosteroids                  |

*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

September 02, 2010

**To: All Providers**

**RE: National Correct Coding Initiative (CCI) Edits**

The Patient Protection and Affordable Care Act (Public Law 111-148), Section 6507 requires that State Medicaid agencies implement National Correct Coding Initiatives (NCCI) edits into their claims processing systems. These edits are intended to reduce coding errors because of clerical mistakes and incorrect use of codes or their units of service. Therefore, in the coming months, the Alabama Medicaid Agency will implement the following edits:

- (1) NCCI procedure to procedure edits for practitioner\* and Ambulatory Surgical Center (ASC) claims
- (2) NCCI procedure to procedure edits for outpatient hospital (including emergency department and observation) claims
- (3) Medically Unlikely Edits (MUE) units of services for practitioner\* and ASC claims
- (4) MUE units of service for outpatient hospital (including emergency department and observation) claims
- (5) MUE units of service for DME claims

*\*Practitioners are defined as: all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act of 1965, and the Code of Federal Regulations*

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The coding principles are explained in the National Correct Coding Initiative Policy Manual for Medicare Services available on the CMS NCCI website at <http://www.cms.gov>

Educational tools are available on the CMS NCCI website at <http://www.cms.gov/nationalcorrectcodinitied>.

The Alabama Medicaid Agency will notify the providers when these NCCI edits are scheduled to be implemented.

September 08, 2010

**TO: All Pharmacy Providers, Pharmacy Associations, and Pharmacy Vendors**

**RE: Average Acquisition Cost (AAC) Reimbursement for Drug Ingredient Cost**

The Alabama Medicaid Agency will move to an Average Acquisition Cost (AAC) reimbursement for drug ingredient cost, plus a modified dispensing fee, for outpatient pharmacy claims effective September 22, 2010. Pharmacy providers will not be required to take any new or additional action when submitting claims.

Additional information can be found on the Agency AAC website at the link [http://www.medicaid.alabama.gov/programs/pharmacy\\_svcs/AAC.aspx](http://www.medicaid.alabama.gov/programs/pharmacy_svcs/AAC.aspx)

September 17, 2010



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**TO: All Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Hospitals, Renal Dialysis Facilities and Nursing Homes**

**RE: Compound Drugs for Non-Pharmacy Providers**

**In order for Medicaid to reimburse non-pharmacy providers for drugs purchased from a compounding pharmacy, these guidelines must be followed:**

- The compound drug **must not** be commercially available.
- The active ingredient of the compound drug must follow coverage policy of drugs (FDA approved, non-DESI, not obsolete, etc).
- The billed amount should represent the lesser of the actual acquisition cost for the drug or Medicaid rate on file (ASP CMS pricing) at the time of service.
- The Agency does not reimburse non-pharmacy providers for prescription compounding time or non-covered ingredients used in the compounding process. The Alabama Medicaid Agency only reimburses for the compounding time by the billing of NDC numbers through the Pharmacy Program.
- When billing the HCPCS code for a purchased compounded drug, only one NDC can be used per procedure code. Providers must use the HCPCS procedure code, billing units and corresponding covered NDC number on the claim form.

For example, if billing HCPCS code J1094 (Injection, dexamethasone acetate, 1 mg), the NDC billed should be the one that represents the drug as described in the HCPCS code definition, in this case, dexamethasone acetate. See Appendix H of the Medicaid Provider Billing Manual entitled "Calculation of Billing Units and Wastage" for information on calculating billing units.

Questions should be directed to the Provider Assistance Center at 1-800-688-7989 for in-state providers or (334) 215-0111 for out-of-state providers.

September 27, 2010



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**TO: All Instate Hospitals**

**RE: Inpatient and Outpatient Changes for Instate Hospitals for PHP Closeout**

Effective September 18, 2010, **inpatient** hospital claims will be processed and paid as fee-for-service by the Alabama Medicaid Agency's fiscal agent, HP Enterprise Services. All billing rules for inpatient claims still apply.

Effective September 18, 2010, **outpatient** hospital claims will be processed as encounters. All billing rules for outpatient claims will still apply. The remittance advice that each hospital will receive beginning with the October 8, 2010, check write will look the same except an encounter procedure code (T1015) will be added for the encounter payment.

**Outpatient Hospital Adjustments**

Instate hospitals should **HOLD** all Outpatient Hospital adjustments for fee-for-service claims paid from October 1, 2009 to September 17, 2010, until further notice. However, if the outpatient claim was paid as an encounter (T1015 detail added by Medicaid), an adjustment may be submitted. Please reference the *Claim Denial 3307* below for instructions.

**Outpatient Hospital Payments**

For the two-year period beginning October 1, 2009, and ending September 30, 2011, all outpatient claims will be paid as encounters. An audit payment or recoupment on the September 17, 2010 check write was initiated in order to adjust outpatient claims paid at the fee-for-service rate to the outpatient encounter rate that was established as a part of the hospital assessment legislation. The amount was based on claims processed by quarter for FY 2010. The quarters are as follows: October-December 2009, January-March 2010, April-June 2010 and June-August 2010.

Note: The last quarter (June-August 2010) will be adjusted to include July-September paid dates and the difference will appear either as an audit payment or recoupment on the October 22, 2010 remittance advice.

**Outpatient Hospital Encounter**

As outlined in Emergency Rule No. 560-X-7-.17-.02 ER, Outpatient Hospital Services, of the Medicaid Administrative Code, effective September 2, 2010, the following bullets describe an outpatient hospital encounter:

- Outpatient hospital encounters are generally face-to-face contacts between a patient and a health professional for medically necessary services.
- An encounter may also be classified as non-patient hospital services such as specimens and blood samples sent to the hospital for performance of tests. This may also include collection and processing of blood samples.
- Claims for ER and noncertified outpatient visits must be all inclusive. All inclusive means all charges associated with that visit such as lab and radiology services.



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- Each hospital shall continue to bill for outpatient services as it did prior to the implementation of the encounter payment methodology. This means that Medicaid should not see a huge increase or decrease in the amount of claims with the implementation of the encounter payment methodology. If a hospital provider span billed for services such as chemotherapy, radiation services, or physical therapy services prior to implementation of the encounter payment methodology, then continue to span bill these services. Periodic post-payment reviews will be conducted by Medicaid.
- One encounter rate will be paid per ICN (internal control number).

### **Outpatient Hospital NDC Requirement**

Hospital providers received an Alert dated August 3, 2010 regarding the mandatory national drug codes (NDC) for all physician administered drugs. Medicaid will require that hospitals report the NDC for all physician-administered drugs on the UB-04 claim form beginning October 1, 2010 as described in the Alert. This requirement does not apply to 340-B providers enrolled on the HHS website.

### **Outpatient Hospital Claim Denial 3307**

If you are using the web portal to resubmit a denied outpatient claim or adjust a paid outpatient claim that contains the detail T1015, you must first delete the T1015 detail line before submitting. Otherwise, your claim will receive denial code 3307.

If you have further questions contact Jerri Jackson via phone at 334-242-5630 or e-mail at [jerri.jackson@medicaid.alabama.gov](mailto:jerri.jackson@medicaid.alabama.gov).

September 27, 2010



## Attention: All Medicaid Providers

**RE: Medicaid Implementing National Correct Coding Initiatives (NCCI) Edits Effective November 9, 2010**

The Patient Protection and Affordable Care Act (Public Law 111-148), Section 6507 requires that State Medicaid agencies implement National Correct Coding Initiatives (NCCI) edits into their claims processing systems. These edits are intended to reduce coding errors because of clerical mistakes and incorrect use of codes or their units of service

While the law specifies the effective date as October 1, 2010, Alabama Medicaid will implement these edits on November 9, 2010, due to the programming and system testing required. The Alabama Medicaid Agency will **not** reprocess any claim with dates of service October 1, 2010, and thereafter, that were processed before the implementation date of November 9, 2010.

**The Alabama Medicaid Agency will implement the following edits on November 9, 2010:**

- (1) NCCI procedure to procedure edits for practitioner\* and Ambulatory Surgical Center (ASC) claims
- (2) NCCI procedure to procedure edits for outpatient hospital (including emergency department and observation) claims
- (3) Medically Unlikely Edits (MUE) units of services for practitioner\* and ASC claims
- (4) MUE units of service for outpatient hospital (including emergency department and observation) claims
- (5) MUE units of service for DME claims

\*Practitioners are defined as: all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act of 1965, and the Code of Federal Regulations

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The coding principles are explained in the National Correct Coding Initiative Policy Manual for Medicare Services available on the CMS NCCI website at <http://www.cms.gov>.

Educational tools are available on the CMS NCCI website at <http://www.cms.gov/nationalcorrectcodined>.

November 5, 2010



**TO: All Providers**

**RE: Medicaid Identification Number**

After four years of transition, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID number for claims processing, effective January 17, 2011. **Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number.**

All new Medicaid ID numbers issued after the conversion also begin with a "5". The old Medicaid ID number begins with "000". Please verify the Medicaid ID number for Medicaid recipients at the time of service. If the Medicaid ID number begins with "000", obtain the correct Medicaid ID number before submitting the claim to Medicaid for processing.

Providers with questions about the new recipient ID numbers should contact the Provider Help Desk at **1-800-688-7989**. Medicaid recipients with questions about the new ID numbers should call toll-free at **1-800-362-1504**. Other information is available at: [http://www.medicaid.alabama.gov/news/medicaid\\_id\\_numbers.aspx?tab=2](http://www.medicaid.alabama.gov/news/medicaid_id_numbers.aspx?tab=2)

November 08, 2010



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**TO: All Medicaid Providers  
All Provider Associations**

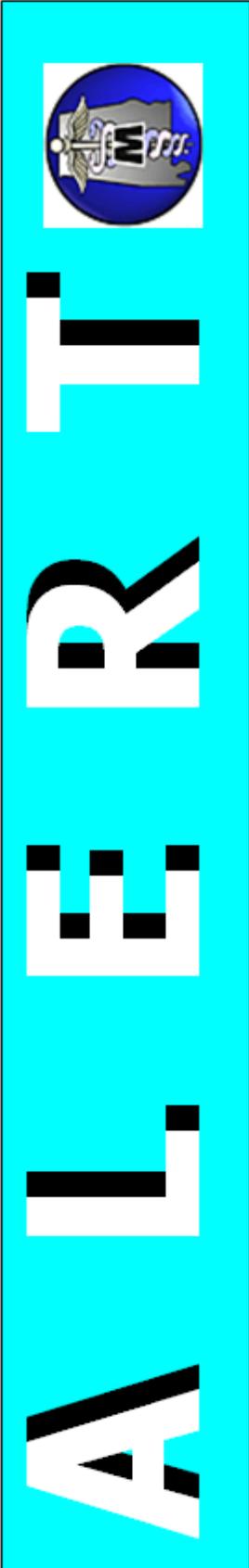
**RE: November 19, 2010 Checkwrite**

The release of Medicaid funds for the 11/19/2010 checkwrite is expected to be Wednesday, December 1, 2010.

The release of direct deposits and checks depends on the availability of funds.

Please verify direct deposit status with your bank.

November 19, 2010



**TO: All Medicaid Physicians**

**RE: Radiology Management Program “Gold Card Changes”**

Effective January 1, 2011, changes will be made to the “Gold Card” status based on Agency evaluation of prior authorization requests made between October 1, 2009 and September 30, 2010. The following changes will be made:

- Providers with “Gold Card” who maintained a 5% or less denial rate during the above timeframe will continue to have “Gold Card” status.
- Providers who currently have “Gold Card” status with low request volume will continue to have “Gold Card” status.
- Providers with high volume and high denial rate (>5%) will be removed from gold carding.
- Providers with high volume and low denial rates who will be added to the “Gold Card” program.

The status of all providers will be re-evaluated after one year. Redetermination will be based on the preceding 12 months’ worth of data.

Providers with questions may contact Carolyn Thompson, Program Manager, Lab/X-ray services at [carolyn.thompson@medicaid.alabama.gov](mailto:carolyn.thompson@medicaid.alabama.gov) or by phone at (334) 242-5048.

November 19, 2010



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**TO: All Pharmacies**

**RE: Reimbursement for Administration of Pneumococcal and Tdap Vaccines**

Effective December 1, 2010, Alabama Medicaid will begin reimbursing Medicaid-enrolled pharmacy providers for the administration, to eligible recipients age 19 and older, of pneumococcal vaccine and Tdap vaccine. Alabama Medicaid will also continue to, in addition to the administration reimbursement, reimburse pharmacies for the pneumococcal and Tdap vaccines (i.e. ingredient).

- Beginning December 1, pharmacy providers may bill the following NDC numbers on a pharmacy claim for reimbursement of vaccine administration:
  - NDC 99999-9992-11 for pneumococcal vaccine administration
  - NDC 99999-9993-11 for Tdap 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 is a maximum quantity for each administration of 1 injection per recipient within a timeframe in accordance with the CDC dosing regimen.
- A prescription from a recipient's Primary Medical Provider (PMP) is required for each Tdap and pneumococcal vaccine administration.
- To facilitate coordination of care, Pharmacy providers are required to inform (via phone, fax, e-mail, mail) each recipient's Primary Medical Provider (PMP) upon administration of the vaccine(s) for which an administration claim is submitted. 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/programs/pharmacy\\_svcs/pharmacy\\_services.aspx](http://www.medicaid.alabama.gov/programs/pharmacy_svcs/pharmacy_services.aspx).
- Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.
- A separate claim for the vaccine (i.e. ingredient) should be submitted with the appropriate NDC of the vaccine (i.e. ingredient) and will be reimbursed according to the current drug/pharmacy reimbursement policy.

December 01, 2010



**TO: All Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, and Nursing Homes Providers**

**RE: PDL Update**

Effective January 3, 2011, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions | PDL Deletions*   |
|---------------|--|
| None          | <b>Aceon</b> -Cardiovascular Health/ACE Inhibitors                             |
|               | <b>Avandamet</b> -Diabetic Agents/Thiazolidinediones                           |
|               | <b>Avandaryl</b> -Diabetic Agents/Thiazolidinediones                           |
|               | <b>Avandia</b> -Diabetic Agents/Thiazolidinediones                             |
|               | <b>Diovan</b> -Cardiovascular Health/Angiotensin-II Receptor Antagonists       |
|               | <b>Eurax</b> -Skin and Mucous Membrane Agents/Scabicides and Pediculicides     |
|               | <b>Micardis</b> -Cardiovascular Health/Angiotensin-II Receptor Antagonists     |
|               | <b>Micardis HCT</b> -Cardiovascular Health/Angiotensin-II Receptor Antagonists |
|               | <b>Teveten</b> -Cardiovascular Health/Angiotensin-II Receptor Antagonists      |
|               | <b>Teveten HCT</b> -Cardiovascular Health/Angiotensin-II Receptor Antagonists  |
|               | <b>Vigamox</b> -EENT Preparations/Antibacterials                               |

\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at <http://aldrug.rxexplorer.com/>.

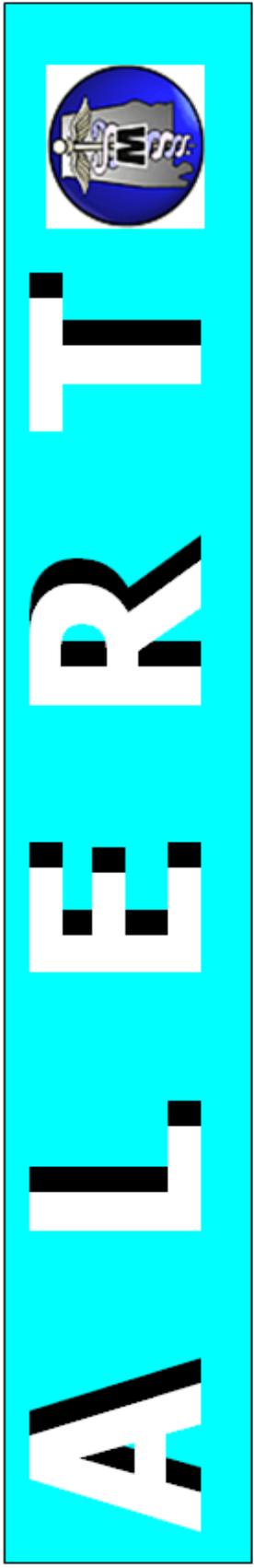
The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

December 07, 2010





## TO: All Renal Dialysis Facility Providers

### Re: Medicare Crossover Changes and Medicaid Changes

#### Medicare Crossover Changes:

Effective February 1, 2011, renal dialysis crossover claims will be received from Medicare and will be processed by Medicaid for all renal dialysis providers.

**\*Note:** Crossover claims with Dates of Service prior to January 1, 2011 that crossover from Medicare will not pay correctly. These crossover claims must be electronically submitted through the previous claim submission process to Medicaid.

**Medicare claims billed by renal dialysis providers will cross over directly from Medicare and will be processed by Medicaid. Providers are limited to the following codes on Medicare crossover claims. Future Medicare revisions may require code updates to this table:**

| Revenue Codes                        | Condition Codes   | Procedure Code                   | Description  |
|--------------------------------------|-------------------|----------------------------------|--|
| 821, 881                             | 71, 72,73, 74, 76 | 90999                            | Hemodialysis, home hemodialysis, self care training, home hemo training and ultrafiltration. |
| 831, 841, 851                        | 74                | 90945                            | Dialysis procedure other than hemodialysis   |
| 831, 841, 851                        | 73                | 90993                            | Dialysis training, patient, including helper.  |
| 634, <10,000<br>635, >or =<br>10,000 |                   | Q4081                            | Injection epogen   |
| 636                                  |                   | J0882                            | Darbopoetin alfa, injection  |
| 636                                  |                   | Appropriate Injectable Codes     | Injectable Drugs   |
| 250                                  |                   | Appropriate NDC Codes (No HCPCS) | PO Drugs   |
| 31X, 921                             |                   | Appropriate Lab Codes            | Labs   |
| 270                                  |                   | A4697, A4913 (IV)                | Supply/Admin   |
| 771                                  |                   | Appropriate vaccine HCPCS        | Vaccine  |

January 24, 2011

**Medicaid Changes:**

All Medicaid services **beginning with dates of service January 1, 2011**, and thereafter, must be billed according to the following policy. Medicaid's new requirements mirror Medicare's as closely as possible.

| Revenue Codes                     | Condition Codes | Procedure Code   | Description  |
|-----------------------------------|-----------------|------------------|--|
| 821                               | 71              | 90999            | Hemodialysis, limited to 156 units per year.   |
| 831, 841, 851                     |                 | 90945            | Dialysis procedure other than hemodialysis.  |
| 831, 841, 851                     | 73, 74          | 90993            | Dialysis training, patient, including helper. Limited to 12 per lifetime.                |
| 634, <10,000<br>635, >or = 10,000 |                 | Q4081*           | Injection epogen   |
| 636                               |                 | J0882*           | Darbopoetin alfa, injection  |
| 636                               |                 | Injectable Codes | See Alabama Medicaid Injectable Drug Listing in appendix H for covered injectable drugs. |

**\*EPO and Aranasp Monitoring Policy:**

Medicaid is requiring providers include the GS modifier, the ED modifier, or the EE modifiers in mirroring Medicare's policy, refer to Chapter 8 of the Medicare Claims Processing Manual for further definition. These modifiers will be considered 'informational only' when billed to Medicaid and no reductions in payment will be made for straight Medicaid claims. Medicaid expects the provider to adhere to the strict definitions defined below:

|    |  |
|----|--|
| GS | Dosage of EPO or Darbopoetin Alfa has been reduced and maintained in response to hematocrit or hemoglobin level.   |
| ED | The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) 3 or more consecutive billing cycles immediately prior to and including the current billing cycle    |
| EE | The hematocrit level has exceeded 39.0% (or hemoglobin level has exceeded 13.0g/dL) less than 3 consecutive billing cycles immediately prior to and including the current billing cycle. |

Providers may contact Jerri Jackson, RN, BSN, at 334-242-5630 or e-mail at [jerri.jackson@medicaid.alabama.gov](mailto:jerri.jackson@medicaid.alabama.gov) if you have any questions.

# A L E R T

March 7, 2011

## Attention: Psychologists

### RE: Upcoming Changes to Chapter 34 of the Provider Manual

During the past year, a workgroup consisting of Alabama Medicaid Agency staff and representatives from the Alabama Psychological Association has collaborated to identify changes that enable the agency to maintain a basic package of services while preserving the health care safety net for our most vulnerable citizens.

As a result of this ongoing effort, the following changes will be implemented **effective April 1, 2011**:

- **A 52 unit annual maximum limit (including any claims with a date of service beginning January 1, 2011) will be imposed for any combination of the following codes:**
  - Individual therapy codes 90804, 90806, 90810, 90812, 90816, 90818, 90823 and 90826.
  - Group therapy codes 90846, 90847, 90849 and 90853.
- **Individual and group codes listed above are subject to a limit of one (1) unit per week (effective date of service April 1, 2011 and thereafter).** However, providers may bill one individual and one group code within the same week **or** on the same date of service. Both units will count towards the the 52 unit annual maximum limit.
- To request an override to the **maximum weekly limit**, submit documentation of medical necessity **and** the exceptional circumstance (e.g. how the recipient is an imminent danger to self or others and/or is at risk for hospitalization or decompensation) along with the original CMS-1500 claim form (with the red drop out ink), related progress note(s) and cover letter to the following address:

**Mental Health Program Director  
Institutional Services  
Alabama Medicaid Agency  
P.O. Box 5624  
Montgomery, AL 36103-5624**

A sample cover letter titled "Psychologist Override Request Form" can be found at:  
[http://medicaid.alabama.gov/documents/4.0\\_Programs/4.4\\_Medical\\_Services/4.4.9\\_Mental\\_Health\\_Services/4.4.9.2\\_Clinical\\_Psychologists/4.4.9.2\\_Psychology\\_Override\\_Request\\_Template.pdf](http://medicaid.alabama.gov/documents/4.0_Programs/4.4_Medical_Services/4.4.9_Mental_Health_Services/4.4.9.2_Clinical_Psychologists/4.4.9.2_Psychology_Override_Request_Template.pdf)

#### When billing for testing, please note the following:

- The date of service billed must be the date the test was given.
- Providers may bill for testing, scoring, interpretation and report writing in 30-minute increments. However, it is only necessary to document the time spent in face-to-face service delivery.
- Billing should reflect the **total** time for face-to-face administration, scoring, interpretation and report writing.
- The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes.

Providers with questions should contact Karen Smith via phone at 334-353-4945 or by e-mail at: [karen.watkins-smith@medicaid.alabama.gov](mailto:karen.watkins-smith@medicaid.alabama.gov)

**A L E R T**

March 8, 2011

**Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes****RE: Preferred Drug List Update**

**Effective April 1, 2011**, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions  | PDL Deletions*   |
|--|--|
| <b>Dulera</b> -Respiratory/Inhaled Corticosteroids   | <b>Daytrana</b> -Behavioral Health/Cerebral Stimulants for ADD/ADHD-Long Acting                    |
| <b>Ritalin SR</b> -Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Short and Intermediate Acting | <b>Dexedrine</b> -Behavioral Health/Cerebral Stimulants for ADD/ADHD-Short and Intermediate Acting |
|  | <b>Pataday</b> -EENT Preparations/Antiallergic Agents  |
|  | <b>Patanase</b> - EENT Preparations/Antiallergic Agents  |
|  | <b>Patanol</b> - EENT Preparations/Antiallergic Agents   |

\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at <http://aldrug.rxexplorer.com/>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)**  
**Medicaid Pharmacy Administrative Services**  
**P. O. Box 3210 Auburn, AL 36832-3210**  
**Fax: 1-800-748-0116**  
**Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

March 25, 2011

## Attention: All Providers

### RE: National Correct Coding Initiatives (NCCI) Edits Appeals Process

Effective November 9, 2010, Medicaid introduced the NCCI edits into the Medicaid claims processing system. These edits were set as "informational" edits. On March 23, 2011, these edits were set to deny for any services that do not meet the NCCI edit criteria and were furnished on or after October 1, 2010.

The use of applicable modifiers will be critical in successful implementation of the NCCI procedure to procedure edits. Once a claim or line item on the claim has been denied for an NCCI procedure to procedure edit, then the claim cannot be adjusted by the provider. If a claim is denied for an NCCI Medically Unlikely Edit (MUE), the provider can resubmit the claim with the correct units as long as the units are equal to or lesser than the NCCI MUE edit allows. If the units are more than the NCCI MUE edit allows, then an appeal must be requested.

NCCI procedure to procedure edits are coding edits, and are based on coding principles. The Medicaid NCCI Coding is available on the CMS NCCI website at [http://www.cms.gov/MedicaidNCCICoding/01\\_Overview.asp#TopOfPage](http://www.cms.gov/MedicaidNCCICoding/01_Overview.asp#TopOfPage)

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "0", an appeal can **NEVER** overturn the denial. These claims are final and no appeal is applicable except for an administrative law judge who can determine that the denied column two code should be paid. These instances will be rare.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of "1" or is for an MUE, an appeal can be submitted.

All NCCI denials begin with an error code "59nn". To validate a claim denied for an NCCI error code, download the remittance advice from the web-portal which contains the Medicaid specific error codes.

Individual claim denials may be appealed at three levels. The levels, listed in order, are:

1. Redetermination Request
2. Administrative Review
3. Fair Hearing

If all appeals have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family. This denial is a provider liability.

### First Level of Appeal: Redetermination Request

The Alabama Medicaid Agency contracts with a fiscal agent (HP Enterprise Services {HPES}) to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. HPES will also be responsible for the redeterminations, which is the first level of appeals and adjudication functions.

A *redetermination* is an examination of a claim and operative notes/medical justification by HPES personnel. The provider has 60 days from the date of receipt of the initial claim determination to request a redetermination. The provider must complete the attached HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:

- Completed NCCI Redetermination Review form
- Corrected Paper Claim for the procedure codes that denied
- Operative Notes/Medical Justification

Send the request for redetermination review along with all supporting documentation to:

HP Enterprise Services  
Request for NCCI Redetermination  
PO Box 244032  
Montgomery, AL 36124-4034

HPES will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. The ICN region for the redetermination request will begin with '91'. For example: 9111082123456.

## **Second Level of Appeal: Administrative Review**

When the redetermination request results in a denial by HPES, the provider may request an *administrative review* of the claim. A written request for administrative review **must be received by the Alabama Medicaid Agency within 60 days of the date of the redetermination denial from HPES**.

To request an Administrative Review, the provider must complete the attached Alabama Medicaid Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review. The request should clearly explain why you disagree with the redetermination denial.

The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review
- Correct Paper Claim for the procedure codes that denied
- Copy of previous request for redetermination correspondence sent to HPES
- Copies of all relevant remittances advices or HPES' redetermination denial notification
- Copy of any other useful documentation

Send the request for administrative review along with all supporting documentation to:

NCCI Administrative Review  
Alabama Medicaid Agency  
Attn: System Support Unit  
501 Dexter Avenue  
P. O. Box 5624  
Montgomery, AL 36103-5624

Documentation that is submitted after the Administrative Review request has been filed may result in an extension of the time required to complete the review. Further, any documentation noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the Administrative Review decision. Documentation not submitted at the Administrative Review level may be excluded from consideration at subsequent levels of appeal unless you show good cause for submitting the documentation late.

This information will be reviewed and a written reply will be sent to the provider within 60 days.

## **Third Level of Appeal: Fair Hearing**

When the administrative review does not resolve the issue, the provider has the option to request a fair hearing. A written request must be received within 60 days of the date of the administrative review decision. The request must identify any new or supplemental documentation. Send the written request for a fair hearing to:

Alabama Medicaid Agency  
Attn: Office of General Counsel  
501 Dexter Avenue  
P. O. Box 5624  
Montgomery, AL 36103-5624

If you have further questions, contact the Provider Assistant Center at 1-800-688-7989 or (334) 215-0111.



**Request for NCCI Redetermination Review**  
**HP Enterprise Services**  
**PO Box 244032**  
**Montgomery AL 36124-4032**

**Complete ALL Fields Below - Print or Type**

|                            |                                  |                         |
|----------------------------|----------------------------------|-------------------------|
| <b>ICN #</b>               | <b>Date of Service</b>           |                         |
| <b>Recipient Name</b>      | <b>Recipient Medicaid Number</b> |                         |
| <b>Provider Name</b>       | <b>Provider NPI Number</b>       |                         |
| <b>NCCI Denial Code(s)</b> |                                  |                         |
| 1. <input type="text"/>    | 2. <input type="text"/>          | 3. <input type="text"/> |
| <b>Date of Denial</b>      |                                  |                         |

**Required Attachments (check box to indicate which attachment is being submitted with request):**  
*Corrected paper claim submitted with procedure code(s) that denied along with specific reports (see below):*

- Anesthesia report for denied procedure codes in the range: 00100 – 01999
- Operative report for denied procedure codes in the range: 10000 – 69999
- Radiology report for denied procedure codes in the range: 70000 – 79999
- Pathology or Laboratory report for denied procedure codes in the range: 80000 – 89999
- Medical report for denied procedure codes in the range: 90000 – 99605

Comments:

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**Signature of either the provider or his/her representative**

|  |
|--|
| <b>Date</b>                                  |
| <b>Address</b>                               |
| <b>City, State and Zip code</b>              |
| <b>Telephone Number, including area code</b> |
| <b>Signature</b>                             |

# Alabama Medicaid Agency

## Request For National Correct Coding Initiative (NCCI) Administrative Review

This form is to be completed only when the Redetermination Request results in a denial by the Fiscal Agent.

### Section A

Print or Type

|                   |                             |
|-------------------|-----------------------------|
| Provider's Name   | Provider Number             |
| Recipient 's Name | Recipient's Medicaid Number |
| Date of Service   | ICN                         |

I do not agree with the Redetermination denial by the Fiscal Agent Dated: \_\_\_\_\_

### Section B

My reasons are:

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### Section C

Signature of **either** the provider **or** his/her representative

|                          |                          |
|--------------------------|--------------------------|
| Provider Signature       | Representative Signature |
| Address                  | Address                  |
| City, State and ZIP Code | City, State and ZIP Code |
| Telephone Number         | Telephone Number         |
| Date                     | Date                     |

This form may be downloaded from the Alabama Medicaid Agency website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

# A L E R T

May 5, 2011

**Attention: Physicians, FQHCs, IRHCs, RHCs, Outpatient Hospitals, and Independent Radiology Providers**

**RE: Natural Disaster PA Requirements for PET, CT, MRI, and MRA**

During times of natural disasters, health care providers and patients in affected areas often must overcome challenging circumstances to furnish or obtain health care services. To assist patients and providers in areas affected by recent tornadoes, the Alabama Medicaid Agency will grant an exemption to prior authorization requests for PET scans, CT scans, MRIs and MRAs for two weeks, effective May 2, 2011. The exemption is only for recipients and requesting providers from one of the counties designated by the federal government as a disaster area.

In order for the claim to be paid, providers will need to submit a prior authorization request to MedSolutions as usual. If a provider has received a denial for a request started after May 2, 2011, please contact MedSolutions at 888-693-3211. Any other questions should be directed to Toni Hopgood at 334-353-4724 or [toni.hopgood@medicaid.alabama.gov](mailto:toni.hopgood@medicaid.alabama.gov)

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# A L E R T

May 18, 2011

## Attention: All Outpatient Hospital Providers

Effective for dates of service October 1, 2010, and thereafter, outpatient observation CPT codes 99218 through 99220 have been replaced with HCPCS Level II procedure code G0378. The policy is revised as written below:

### Outpatient Observation

Outpatient observation is a covered service billable only by a hospital provider enrolled in the Medicaid program.

Outpatient observation is the medically necessary extended outpatient care provided to a patient whose condition warrants additional observation before a decision is made about admission to the hospital or prolonged patient care. Outpatient observation is limited to 23 hours or less.

Outpatient observation is considered an outpatient visit and will be counted in the yearly outpatient visit benefit unless documented as a certified emergency by the attending physician at the time of service.

An observation unit is an area designated by the hospital in which patient beds are set aside to provide any medically necessary extended outpatient care to a patient whose condition requires additional observation. These beds may be located in various parts of the hospital depending on the type of extended care needed for the patient. The following guidelines apply:

- Patient must be admitted through the emergency room.
- A physician's order is required for admission and discharge from the observation unit.
- A physician must have personal contact with the patient at least once during the observation stay.
- A registered nurse or an employee under his/her direct supervision must monitor patients in the observation unit.
- Medical records must contain appropriate documentation of the actual time a patient is in the observation unit as well as the services provided.
- A recipient must be in the observation unit at least three hours, but no more than 23 hours.

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 – 99285).

Observation coverage is billable in hourly increments only. A recipient must receive observation services a minimum of 30 minutes before the observation charge can be billed. Observation charges are billed as follows:

- For the first three hours of observation the provider should bill a facility fee (99281 - 99285) with units of one.
- Procedure code G0378 should be used to bill the 4<sup>th</sup> through 23<sup>rd</sup> hour for the evaluation and management of a patient in outpatient observation.

Procedure Code G0378 must be billed with a facility fee (99281-99285). The facility fee is billed with units of one and covers the first three hours.

Ancillary charges (lab work, x-ray, etc.) may be billed with the facility fee and observation charge.

If the observation spans midnight and the recipient is discharged from the observation unit the following day, the provider should bill all observation charges using the date of admission to the observation unit on the claim form.

If a recipient is admitted to the hospital from outpatient observation before midnight of the day the services were rendered at the same hospital, all observation charges must be combined and billed with the inpatient charges. The provider should indicate the date of admission to the inpatient hospital as the admission date on the claim form for inpatient services.

Outpatient observation charges cannot be billed in conjunction with outpatient surgery.

Medical records will be reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria.

If there are any questions contact Jerri Jackson by telephone at 334-242-5630 or by e-mail at [jerri.jackson@medicaid.alabama.gov](mailto:jerri.jackson@medicaid.alabama.gov).

# A L E R T

May 25, 2011

**Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

**RE: Preferred Drug List Update**

Effective July 1, 2011, the Alabama Medicaid Agency will:

1. No longer reimburse for Prevacid OTC. Prilosec OTC and Zegerid OTC will continue to be covered.
2. Require prior authorization (PA) for payment of generic buprenorphine (example brand names: Butrans, Buprenex, Subutex) products.
3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions  | PDL Deletions*   |   |
|--|------------------|---|
| Daytrana Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting | <b>Aciphex</b>   | Proton-pump Inhibitors                        |
|  | <b>Astelín</b>   | EENT Preparations /Antiallergic Agents        |
|  | <b>Besivance</b> | EENT Preparations/Antibacterials              |
|  | <b>Elidel</b>    | Miscellaneous Skin and Mucous Membrane Agents |
|  | <b>Levemir</b>   | Insulins                                      |
|  | <b>Luvox CR</b>  | Antidepressants                               |
|  | <b>Protopic</b>  | Miscellaneous Skin and Mucous Membrane Agents |
|  | <b>Symbicort</b> | Respiratory/Orally Inhaled Corticosteroids    |

*\*Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at <http://aldrug.rxexplorer.com/>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)**  
**Medicaid Pharmacy Administrative Services**  
**P. O. Box 3210 Auburn, AL 36832-3210**  
**Fax: 1-800-748-0116**  
**Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

May 27, 2011

## Attention: All Providers

### RE: Medical and Quality Review Services Contractor

The Agency's current contractor, the Alabama Quality Assurance Foundation (AQAF) will stop receiving and reviewing prior authorization requests, hospice and nursing home records effective June 1, 2011. Effective June 1, 2011, the following procedures apply:

#### For Hospice, Nursing Home, PEC and Swing bed records:

Effective June 1, 2011, these records should be mailed to the Alabama Medicaid Agency:

LTC Medical and Quality Review Unit, Room 3014  
501 Dexter Avenue  
P.O. Box 5624  
Montgomery, Alabama 36103-5624

Hospice status change and LTC request for action forms should be faxed to (334) 353-4909.

For inquiries about records or forms received on or after June 1, 2011, please call:

Dodie Teel (334) 242-5149, Cheryl Cardwell (334) 242-5578, or Theresa Carlos (334) 353-3711.

**NOTE:** Due to the storms of April 27, 2011, the June retrospective audit for nursing home admissions, re-admissions and transfers will not be done. The Agency reserves the right to request these records at a later date, per Administrative Code Rule No. 560-X-1-.21. Provider Medicaid Records Inspection/Audit.

#### For Prior Authorizations:

- The process for submitting PA requests to HP remains the same. The Agency will review requests received on or after June 1, 2011.
- For inquiries about PAs received into the system on or after June 1, 2011, please call:
  - Transportation: Brenda Fincher (334) 242-5455
  - Eyecare: Kathy Hardwick (334) 353-5017
  - All other PAs: Dodie Teel (334) 242-5149, Sheila McDaniel (334) 242-2366 or Theresa Carlos (334) 353-3711.

Please allow at least 30 calendar days for all reviews above. During this transition phase, the Agency requests the cooperation of providers *to limit phone calls* to Agency staff, unless absolutely necessary, to allow staff to complete reviews timely.

The status of PA requests may be accessed using AVRS (1-800-727-7848), or the Provider Web Portal, using the link below:

<https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/65/Default.aspx>

Please use this link for instructions about using the web portal for PAs:

[http://medicaid.alabama.gov/documents/6.0\\_Providers/6.7\\_Manuals/6.7.1\\_Provider\\_Manuals\\_2011/6.7.1.2\\_April\\_2011/6.7.1.2\\_Webuser.pdf](http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2011/6.7.1.2_April_2011/6.7.1.2_Webuser.pdf)

# A L E R T

June 29, 2011

## **Attention: Independent and Provider-Based Rural Health Clinics**

### **RE: Nurse Practitioners and Federal Electronic Health Record Incentive Program**

In order to qualify for the federal Electronic Health Record Incentive program, nurse practitioners associated with Independent and Provider-based Rural Health Clinics are required to enroll as a Medicaid provider.

For more information about the federal Electronic Health Record Incentive Payment program, please go to <http://onehealthrecord.alabama.gov/providers.aspx>

For questions regarding the federal Electronic Health Record Incentive Program, please contact Kim Davis-Allen at [Kim.Davis-Allen@medicaid.alabama.gov](mailto:Kim.Davis-Allen@medicaid.alabama.gov) or (334) 242-5011.

Also, effective October 1, 2011, Independent and Provider-Based Rural Health Clinics must use the nurse practitioner's NPI number on all claims submitted for services provided by a nurse practitioner.

For questions regarding enrollment, contact HP Provider Enrollment at 1-888-223-3630.

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# A L E R T

July 1, 2011

## **Attention: Nursing Homes, ICF-MR, Hospice, PEC, Swing Bed, DME and Physicians Providers**

### **RE: Medical and Quality Review Services Contractor**

The Alabama Medicaid Agency's new medical and quality review services contractor, Qualis Health, will begin reviews of prior authorization (PA) requests, and hospice, nursing home, ICF-MR, PEC and swing bed records on July 1, 2011. **Qualis will NOT review pharmacy, dental or radiology PAs.**

Qualis will review PA requests with Julian dates of 6/16/2011 and after. For inquiries regarding PAs submitted on June 16, 2011 or later, providers may contact Qualis at (888) 213-7576. The fax number is (888) 213-8548.

### **For Hospice, Nursing Home, ICF-MR, PEC and Swing Bed Records:**

Effective July 1, 2011, these records **MUST** be mailed to HP, the Alabama Medicaid Agency's fiscal agent, along with a cover sheet, found on the website at:

[http://medicaid.alabama.gov/CONTENT/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.3\\_LTC\\_Forms.aspx](http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Forms.aspx).

The HP address is found on each cover sheet.

These records will be scanned into the system by HP so that staff from the Agency and contractor can review them electronically. Please note that the cover sheet **MUST** be used to ensure that the record is added to the correct site electronically.

ICF-MR providers should use the "LTC records" cover sheet.

For hospice records, continue to include the Form 165A, along with the HP cover sheet.

Hospice recipient status change (Form 165B) and LTC request for action (Form 161B) forms should be faxed to Qualis at (888) 213-8548 effective July 1, 2011.

### **For Prior Authorizations:**

The process for submitting PA requests to HP remains the same. The Agency will review requests received through June 15, 2011.

For inquiries about PAs received into the system through June 15, 2011, please call:

Transportation: Brenda Fincher (334) 242-5455

Eyecare: Kathy Hardwick (334) 353-5017

All other PAs: Dodie Teel (334) 242-5148, Sheila McDaniel (334) 242-2366 or Theresa Carlos (334) 353-3711.

For inquiries about PAs received on or after June 16, 2011, providers should call Qualis at (888) 213-7576.

Effective July 1, 2011, providers may enter the PA number to this webpage to notify Qualis staff when a denied PA is ready for reconsideration. <http://www.qualishealth.org/healthcare-professionals/alabama-medicaid/provider-resources>. Please submit the documents for reconsideration, along with the denial letter to HP, before submitting the PA number to Qualis.

The status of PA requests may also be accessed using:

AVRS (1-800-727-7848)

The Provider web portal, using the link

<https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/65/Default.aspx>

or the HP Provider Assistance Center at (800) 688-7989.

Please use this link for instructions about using the web portal for PAs:

[http://medicaid.alabama.gov/documents/6.0\\_Providers/6.7\\_Manuals/6.7.1\\_Provider\\_Manuals\\_2011/6.7.1.2\\_April\\_2011/6.7.1.2\\_Webuser.pdf](http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2011/6.7.1.2_April_2011/6.7.1.2_Webuser.pdf)

# A L E R T

July 29, 2011

**TO: All Optometrists, Ophthalmologists, and Opticians**

**RE: New Award for Central Source Contractor for Eyeglasses**

The Alabama Medicaid Agency awarded a new contract through an Invitation To Bid process to Steven Baker, Inc., D/B/A Korrek Optical as the Central Source Contractor for Eyeglasses. The effective date of the contract is July 1, 2011. Korrek Optical will begin accepting eyeglass orders on Tuesday, September 6, 2011. Further ordering instructions will be forwarded in the near future. Korrek Optical's Customer Service number is 1-800-624-4225.

The Alabama Medicaid Provider Manual, Chapter 15 will be updated in the October, 2011 edition to include prices and approved frames. The Manual will include changes made in the Eye Care Program regarding eyeglasses, such as previous stand-alone codes will now become add-on codes. Previously, stand-alone lens codes could not be billed with other lens. With add-on codes, the lens code and the applicable add-on code may both be billed on the same date of service. The changes will provide the Agency with improved utilization data. Eye Care providers may continue to order or fabricate eyeglasses as in the past and at the new contracted allowed amounts. Please refer to the Alabama Medicaid Provider Manual, Chapter 15 for the Eye Care Program policies.

The new contracted allowed amounts for eyeglasses will become effective August 1, 2011 and the changes are summarized in the following paragraphs. The new allowed amounts for lens, add-on codes, prior authorization codes, and frame codes are listed on the following page.

The Alabama Medicaid Agency is appreciative of your contributions and efforts as a Medicaid Eye Care Provider. If you have any questions, you may contact Mary Timmerman, RN, CPC at [mary.timmerman@medicaid.alabama.gov](mailto:mary.timmerman@medicaid.alabama.gov) or at (334) 242-5014.

**Alabama Medicaid Contracted Allowed Amounts for Eyeglasses  
Effective August 1, 2011**

(Content is referenced from July 29, 2011 Alert entitled New Award for Central Source Contractor for Eyeglasses)

| <b>Single Vision</b>    |                       | <b>Bifocal Lens</b>     |                       |
|-------------------------|-----------------------|-------------------------|-----------------------|
| <b>Lens Code Ranges</b> | <b>Price per lens</b> | <b>Lens Code Ranges</b> | <b>Price per lens</b> |
| V2100-V2101             | \$11.00               | V2200                   | \$12.00               |
| V2102                   | \$13.00               | V2201-V2202             | \$14.00               |
| V2103-V2105             | \$11.00               | V2203-V2204             | \$12.00               |
| V2106                   | \$13.00               | V2205-V2206             | \$14.00               |
| V2107-V2108             | \$11.00               | V2207                   | \$12.00               |
| V2109-V2114             | \$13.00               | V2208-V2209             | \$14.00               |
| V2115                   | \$14.00               | V2210                   | \$25.00               |
| V2118                   | \$40.00               | V2211-V2214             | \$14.00               |
| V2121                   | \$13.00               | V2215-V2218             | \$30.00               |
| V2199                   | \$15.00               | V2219                   | \$5.00                |
|                         |                       | V2220                   | \$10.00               |
|                         |                       | V2221                   | \$30.00               |
|                         |                       | V2299                   | \$14.00               |
|                         |                       |                         |                       |
| <b>Trifocal Lens</b>    |                       | <b>Other Lens</b>       |                       |
| V2300-V2314             | \$25.00               | V2410-V2700             | \$10.00               |
| V2315-V2318             | \$35.00               | V2710                   | \$30.00               |
| V2319                   | \$5.00                | V2715                   | Add-on cost \$0       |
| V2320                   | \$10.00               | V2718                   | Add-on cost \$30.00   |
| V2321                   | \$35.00               | V2745                   | Add-on cost \$0       |
| V2399                   | \$25.00               | V2784                   | Add-on cost \$0       |

**Lenses Requiring Prior Authorization from Medicaid before Ordering (per lens)**

|       |             |         |
|-------|-------------|---------|
| V2744 | Add-on cost | \$25.00 |
| V2755 | Add-on cost | \$0     |
| V2781 | Add-on cost | \$10.00 |
| V2782 | Add-on cost | \$10.00 |
| V2783 | Add-on cost | \$20.00 |

Add-on cost: This item to be billed in addition to appropriate lens code.

**Frames**

|       |        |     |
|-------|--------|-----|
| V2020 | Frames | \$0 |
|-------|--------|-----|

**Frames Requiring Prior Authorization**

|        |                      |          |
|--------|----------------------|----------|
| *V2025 | Special Order Frames | \$100.00 |
|--------|----------------------|----------|

\*This is a frame utilized for those patients requiring a special/unusual size and/or shaped frame.

# A L E R T

August 12, 2011

## Attention: All Providers

**RE: Synagis® Criteria for 2011 – 2012 Season**

The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2011-2012 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

[http://medicaid.alabama.gov/CONTENT/4.0\\_Programs/4.5.0\\_Pharmacy/4.5.14\\_Synagis.aspx](http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx)

- The approval time frame for Synagis® will begin October 1, 2011 and will be effective through March 31, 2012.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2011 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

### Criteria

Alabama Medicaid follows the 2009 updated American Academy of Pediatrics (AAP) guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

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# A L E R T

August 25, 2011

## Attention: All Providers

**RE: Pharmacy Changes for October 2011**

**Effective October 3, 2011**, the Alabama Medicaid Agency will require prior authorization (PA) of all antipsychotic medications utilizing the electronic PA process. The PA process will affect all recipients (children and adults) as well as all antipsychotics (brand and generic, first and second generation). The PA criteria for this drug class can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

Claims not approved through the electronic PA process at the pharmacy point of sale will require a manual PA form to be submitted; prescribers will receive automatic fax notification if additional medical justification is required.

**Effective October 1, 2011**, the Alabama Medicaid Agency will:

1. Limit the number of brand name prescriptions to four per month per recipient. There will not be a limit on the number of covered generic or over-the-counter prescriptions a recipient may receive. This limitation does not apply to children under the age of 21 or to recipients living in nursing facilities. In certain drug classes, allowances are allowed in the event of an adverse or allergic reaction, or failure to respond. Medicaid will also continue to allow for prescriptions to exceed the four brand limit for anti-psychotic and anti-retroviral medications; however, there will be no instance where the limit may exceed ten brand name drugs per month per recipient. Providers with questions concerning the prescription limitation should contact:

Alabama Medicaid Agency  
Pharmacy Services Division  
P.O. Box 5624  
Montgomery, Alabama 36103-5624  
(334) 242-5050

2. No longer require prior authorization (PA) for payment of generic pantoprazole (Protonix). Brand name Protonix will continue to require prior authorization.

For additional PDL and coverage information, visit our drug look-up site which can be accessed using the following link:

[http://medicaid.alabama.gov/CONTENT/4.0\\_Programs/4.5\\_Pharmacy\\_Services.aspx](http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5_Pharmacy_Services.aspx)

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)**  
**Medicaid Pharmacy Administrative Services**  
**P. O. Box 3210 Auburn, AL 36832-3210**  
**Fax: 1-800-748-0116**  
**Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

# A L E R T

September 14, 2011

## **Attention: Prosthetic, Orthotic & Pedorthic (POP) Providers**

### **RE: Newly Covered Code for the Prosthetic, Orthotic & Pedorthic Program**

Effective immediately, Medicaid has approved Procedure Code L5972 (Flexible Keel Foot) as a newly covered code for the Prosthetic, Orthotic, & Pedorthic Program.

Procedure Code L5972 must be provided by a licensed prosthetic, orthotic and/or pedorthic practitioner in the State of Alabama practicing at an accredited facility. The provider must obtain a written prescription, must keep the prescription on file, and must have supporting documentation that the device is medically necessary.

Medicaid pays for basic level prosthetic, orthotic, and pedorthic devices for ages 21-65.

For questions or concerns regarding the POP Program, please contact Felicha Fisher at (334) 353-5153.

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# A L E R T

November 1, 2011

## Attention: Nursing Home Providers

### RE: Institutional Review Record Request

Effective December 1, 2011, Qualis Health, Medicaid's medical and quality review services contractor, will begin faxing requests for medical records to conduct retrospective reviews. In the past, a certified letter requesting medical records for the review process was mailed to the facilities. The new process requires faxing the request to the facility's designated staff.

Example of faxes that might be received:

- **First Fax Notification** –Acknowledgment of Fax Receipt. Confirmation is complete after printing name and signing signature. Mail medical records to HP for record review
- **Second Fax Notification**-Acknowledgment of Fax Receipt. Confirmation is complete after printing name and signing signature. Mail medical records to HP for record review
- **Final Fax Notification**- Mail medical records to HP for record review
- **Letter of Imposition** - Mail medical records to HP for record review

The process for **mailing** medical records will remain the same.

Please mail records with the HP LTC Records coversheet to:

HP Enterprise Services

P.O. Box 244032

Montgomery, AL 36124-4032

Please contact Qualis Health at 1-888-213-7576 for questions regarding this process.

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# A L E R T

November 17, 2011

## **Attention: IUDs and Implants: Changes to Contraceptive Coverage**

**RE: To: All Pharmacies, Physicians, Maternity Care Primary Contractors, FQHCs, RHCs, and Health Departments**

The Alabama Medicaid Agency is making important changes regarding the coverage of intrauterine devices (IUDs) and implantable contraceptive devices. Effective January 1, 2012, these devices will be reimbursed only when billed on a medical claim. Pharmacies will no longer be able to bill for these devices for a specific patient and ship to the provider for insertion/implantation. Example devices include Mirena<sup>®</sup>, Paragard<sup>®</sup>, Implanon<sup>®</sup>, etc.

Questions regarding this change can be sent to [Nancy.Headley@medicaid.alabama.gov](mailto:Nancy.Headley@medicaid.alabama.gov) or by calling 334-242-5684.

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**A L E R T**

December 13, 2011

**Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.**

**RE: Preferred Drug List (PDL) Update**

**Effective January 3, 2012**, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions | PDL Deletions*     |  |
|---------------|--------------------|--|
| None          | <b>Azasite</b>     | EENT Preparations/Antibacterials             |
|               | <b>Nasacort AQ</b> | EENT Preparations/Intranasal Corticosteroids |
|               | <b>Neosporin</b>   | EENT Preparations/Antibacterials             |
|               | <b>Poly-pred</b>   | EENT Preparations/Antibacterials             |

\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

January 10, 2012

## To: Outpatient Hospitals, Physicians, and Independent Laboratories

### RE: Policy on Qualitative Drug Screening

Effective beginning dates of service January 1, 2012, and thereafter, Medicaid will adopt the following policy on qualitative drug screening:

The following drug screens will be limited to one specimen every seven days per recipient, per provider (providers within a group are considered a single provider), and may not be billed in any combination: 80100, 80101, 80102, and 80104.

Example: A test that is done on Wednesday cannot be done again until the following Wednesday.

A qualitative drug screen is used to detect the presence of a drug in the body. A blood or urine sample may be used; however urine is the best specimen for broad qualitative screening, as blood is relatively insensitive for many common drugs, including psychotropic agents, opioids, and stimulants. Detection of a drug or its metabolite(s) in urine is evidence of prior use. It does not, by itself, indicate that the drug remains in the blood.

Current methods of drug analysis include chromatography, immunoassay, chemical ("spot") tests, and spectrometry. Analysis is comparative, matching the properties or behavior of a substance with that of a valid reference compound (a laboratory must possess a valid reference agent for every substance that it identifies). Drugs or classes of drugs are commonly assayed by qualitative screen followed by confirmation with a second method.

**Note:** Medicaid will only reimburse one screen (whether the specimen is blood or urine) per recipient, per provider, per seven-day period.

**Note:** A recipient cannot be billed for panels within the specimen.

Drugs or classes of drugs that are commonly assayed by qualitative screen, followed by confirmation with a second method, include the following:

- Alcohols
- Amphetamines
- Barbiturates
- Benzodiazepines
- Cocaine and Metabolites
- Methadones
- Methaqualones
- Opiates
- Phencyclidines
- Phenothiazines
- Propoxyphenes
- Tetrahydrocannabinoids
- Tricyclic Antidepressants

# Policy on Qualitative Drug Screening

## CPT Codes

The following CPT codes are applicable for services under the qualitative drug screening policy (maximum unit limitation per recipient, per provider, per seven-day week):

- 80100-Drug screen, qualitative; multiple drug classes, each procedure-1 unit per specimen
- 80101-Single drug class, each drug class-1 unit per specimen
- 80102-Drug confirmation, each procedure-1 unit per specimen
- 80104-Drug screen, qualitative; multiple drug classes other than chromatographic method-1 unit per specimen

**Note:** Use the appropriate chemistry code (82000 – 84999) for quantitation of drugs screened, and the appropriate therapeutic drug assay code (80150 – 80299) for therapeutic drug levels.

## Drug Screening Test Frequency

Medicaid allows payment of a screening test frequency of once per every seven-day period.

## Coverage Criteria

Medicaid will cover medically necessary qualitative drug screens as follows:

1. Suspected drug overdose, **and** one or more of the following conditions:
  - Unexplained coma;
  - Unexplained altered mental status;
  - Severe or unexplained cardiovascular instability (cardiotoxicity);
  - Unexplained metabolic or respiratory acidosis;
  - Unexplained head trauma with neurological signs and symptoms; and/or,
  - Seizures with an undetermined history.
2. Beneficiary presents with clinical signs/symptoms of substance abuse.
3. High risk pregnancy **only** when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does **not** consider a qualitative drug screen as a **routine** component of assessment.
4. EPSDT services **only** when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does **not** consider a qualitative drug screen as a **routine** component of assessment.

## Exclusions

Medicaid will **not** cover qualitative drug screens for the following:

- To screen for the same drug with both a blood and a urine specimen simultaneously.
- For medicolegal purposes, including those listed under ICD-9 code V70.4. (Blood-alcohol tests, paternity testing and blood-drug tests).
- For employment purposes (i.e., as a pre-requisite for employment or as a means for continuation of employment).
- For active treatment of substance abuse, including monitoring for compliance.
- As a component of routine physical/medical examination, including those for subpopulations listed under ICD-9 code V70.5. (Armed forces personnel, Inhabitants of institutions, Occupational health examinations, Pre-employment screening, preschool children, Prisoners, Prostitutes, Refugees, School children and Students).
- As a component of medical examination for administrative purposes, including those listed under ICD-9 code V70.3. (General medical examination for: admission to old age home, adoption, camp, driving license, immigration and naturalization, insurance certification, marriage, prison, school admission and sports competition).

## Prior Approval

Prior approval will not be required for qualitative drug screens.

## Policy on Qualitative Drug Screening

### Documentation Requirements

The **ordering/referring** provider must retain documentation supporting medical necessity in the medical record. Documentation must include the medical necessity for performing the screen. All tests must be ordered in writing, and all drugs/drug classes to be screened must be indicated in the order. A copy of the lab results must be retained in the medical record.

If the **provider rendering the service** is other than the ordering/referring provider, the provider rendering the service must maintain hard copy documentation of the ordering/referring provider's order for the test and the lab results. The order must include clinical indication/medical necessity in addition to all drugs/drug classes to be screened.

Documentation must be legible and available for review upon request.

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# A L E R T

January 25, 2012

## **Attention: Medicaid Certified Nursing Facilities**

### **RE: Revision to Nursing Facility Admission Criteria**

The Alabama Medicaid Agency has updated Rule No. 560-X-10-.10 to consolidate all activities of daily living (ADLs) under one criterion for initial nursing facility admission. This means that multiple items under (k) on Form 161 will only count as one criterion.

Admission to a certified nursing facility still requires that the patient meet two or more criteria listed on Form 161 (a-k). As a result, an individual who meets one or more ADL deficits under (k) must also meet an additional criterion from the list (a-j). All applications for admission to a nursing facility must include supporting documentation.

Two exceptions are noted:

- Criterion (a) and criterion (k)-7 are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k)-7 may not be used as the second qualifying criterion.
- Criterion (g) and criterion (k)-9 are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), criterion (k)-9 may not be used as the second qualifying criterion.

Form 161 is available on the Alabama Medicaid Agency website, or you can click the link below:

[http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.3\\_LTC\\_Services/5.4.3\\_LTC\\_Admission\\_&\\_Evaluation\\_Data\\_Form161\\_Revised\\_1-30-12.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC_Admission_&_Evaluation_Data_Form161_Revised_1-30-12.pdf).

Questions regarding this ALERT should be directed to the LTC Provider/Recipient Services Unit at (334) 353-4754.

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# A L E R T

January 31, 2012

## Attention: All Providers and Vendors

### RE: Updated Alabama interChange System Vendor Interface Specifications Document

The Alabama interChange System Vendor Interface Specifications Document intended for Software Vendors to use when developing applications to interact with the Alabama Medicaid Interactive Website has been updated.

The major change made to this process is the addition of a required field that must be submitted within the XML request in support of the dual processing of 4010 and 5010 transactions:

- **cde\_industry** – Identifies the HIPAA version. Please see Appendix A within the document for the value that must be submitted for both 4010 and 5010 transactions.

We are requesting Providers and Vendors send an email to [alabamaictesting@hp.com](mailto:alabamaictesting@hp.com) by February 15<sup>th</sup> and provide the following information if you are a trading partner that utilizes this submission method.

1. Trading Partner Name and ID.
2. Software Used.
3. Time it will take to make this change and have it ready for testing.

The document has been posted to the Alabama Medicaid website at the following link:  
[http://medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.3\\_Companion\\_Guides.aspx](http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.3_Companion_Guides.aspx)

#### Vendor Interface Specifications Document

The interChange Vendor Interface Specifications document is intended for vendors to use when developing applications to interact with the Alabama State Medicaid System. Processes to upload and download HIPAA-compliant transaction batches via a secure Internet website are described and sample code is provided within the document.

- [Alabama InterChange System Vendor Interface Specifications Version 1.0-5010 - Updated 12/12/11](#)
- [Alabama InterChange System Vendor Interface Specifications Version 2.0-4010 - Updated 12/24/08](#)

Questions regarding this provider notice should be directed to the EMC helpdesk:

Monday – Friday  
7:00 a.m. – 8:00 p.m. CST  
Saturday  
9:00 a.m. – 5:00 p.m. CST  
(800) 456-1242

# A L E R T

February 3, 2012

## Attention: All Providers Except Pharmacy

### RE: 5010 Implementation Issues

**Detail DOS (Date of Service) on Outpatient claims** – deny for edit 264, From DTL DOS missing. The situation under which this information is to be billed changed for 5010. Any claim denied for error 264 should be resubmitted. Medicaid has set error 264 as informational meaning the edit will continue to post, but the claim will pay instead of deny.

**Medicare paid amount** - In 5010, the Medicare allowed amount will no longer be submitted on the 837I or 837P X12 crossover claims. Instead, this amount will be calculated as a sum of the Medicare paid amount and all applicable claim adjustment amounts (coinsurance, copayment, deductible, blood deductible, psychiatric, and late filing). We are addressing an issue related to how this amount is being calculated. Once it has been corrected, providers will be notified and you may resubmit your crossover claims.

**2310C – Service Facility Location** - 837P X12 files are currently rejecting for a HIPAA compliance error when the 2310C, Service Facility Location NM1 or REF information is not submitted. This compliance edit has been inactivated until a final determination can be made as to when this information is required for claim adjudication. If the service facility information is not submitted, but is needed to accurately adjudicate the claim, the claim will deny. Any files rejected for this error can now be resubmitted.

**Medicare Crossover Claims (COBC – Medicare’s clearing house)** - Effective Monday, March 12, 2012, the Medicare clearing house will begin transmission of 5010-formatted claims to Alabama Medicaid. There will be a “payment floor clearing” or transition period from March 12, 2012 to March 26, 2012. For details of this transition period see the *MNL Matters® Number SE1137 Revised* on the CMS website at <http://www.cms.gov/MLN MattersArticles/Downloads/SE1137.pdf>.

As a result, Medicaid providers should be aware of the following:

- 1) 4010 claims submitted before March 12, 2012, will come to Alabama Medicaid as 4010 claims with no conversion by COBC.
- 2) Due to the conversion performed by COBC, all situational data fields will be removed which may cause the claim to deny. If you get a denial for your claim during this time, which you feel is in error, resubmit the original claim directly to Medicaid via PES or Web Portal. **This applies to 4010 claims submitted on or after March 12, 2012, and to 5010 claims submitted before March 12, 2012.**

Examples of errors that may occur:

- NDCs missing for procedure codes that require them for processing –deny for edit 4277, NDC requires procedure code
  - Taxonomy missing – deny for edits 1945/1946, Multiple SVC locations for billing provider.
- 3) **5010 claims submitted on or after March 12, 2012, will come to Alabama Medicaid as 5010 claims with no conversion by COBC.**

# A L E R T

February 6, 2012

## **ATTENTION: Hospice Providers**

### **RE: Face-to-Face Communication Requirement for the Hospice Program**

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180<sup>th</sup> day recertification and every recertification thereafter, and to attest that the encounter occurred. This new face-to-face encounter requirement became effective for Medicare on January 1, 2011.

The Alabama Medicaid Agency will not require the ***Face-to-Face Communication*** for Medicaid hospice recipients. However, if a face-to-face visit has been performed for a Medicaid-only hospice recipient, Alabama Medicaid highly recommends that any documentation pertaining to the face-to-face visit be submitted to the Agency or its designee with the complete medical record. Submission of this information may provide important supporting documentation to validate the terminal status of the Medicaid hospice recipient and may also expedite review of the hospice record.

Therefore, although not a requirement, hospice providers are strongly encouraged to submit face-to-face documentation, if available.

For questions or concerns regarding the ***Face-to-Face Communication*** for the Hospice Program, please contact Felicha Fisher at (334) 353-5153.

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# A L E R T

February 14, 2012

## **Attention: Family Planning Providers (Physicians, FQHC, IRHC, PBRHC)**

### **RE: Implantable Contraceptive Capsules**

Effective December 31, 2011, two CPT® codes (11975 and 11977) for reporting removal and insertion of implantable contraceptive capsules (e.g., Implanon, Nexplanon) were deleted.

As a result, Medicaid providers should use the following codes:

**1 To bill insertion of a non-biodegradable drug delivery implant for contraception, use:**

- 11981 – Insertion, non-biodegradable drug delivery implant
- This replaces deleted code 11975: Insertion, implantable contraceptive capsules

**2 To bill removal of implantable contraceptive capsules with subsequent insertion of non-biodegradable drug delivery implant, use:**

- 11976 – Removal, implantable contraceptive capsules
- 11981 – Insertion, non-biodegradable drug delivery implant
- These codes replace deleted code 11977: Removal with reinsertion, implantable contraceptive capsules

If a provider is enrolled with the Alabama Medicaid Plan First program, the – FP modifier must be appended to family planning service claims.

Refer to Medicaid Provider Manual Appendix C: Family Planning for additional details; the CPT code changes will be reflected in the April quarterly update.

For questions, contact Laura Hamilton, Associate Director, Maternity Care and Plan First at (334) 353-5539 or [laura.hamilton@medicaid.alabama.gov](mailto:laura.hamilton@medicaid.alabama.gov)

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# A L E R T

February 22, 2012

**Attention: Outpatient Hospitals, Physicians, and Independent Radiology Providers**

**RE: Retroactive Eligibility Prior Authorizations**

Effective immediately, all claims with radiology procedure codes requiring prior authorization and with a date of service rendered during the recipient's retroactive eligibility period may now be filed electronically. These claims do not need manual override by Medicaid. If you have any questions or concerns, please contact Toni Hopgood, Program Manager, Lab/Radiology via phone at 334-353-4724 or via e-mail at [toni.hopgood@medicaid.alabama.gov](mailto:toni.hopgood@medicaid.alabama.gov).

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# A L E R T

March 1, 2012

## **Attention: Nursing Home Providers**

**RE: Estate Recovery Reviews**

Health Management Systems (HMS) has been contracted by Alabama Medicaid to perform estate recovery services. These services are for the recovery of medical assistance payments from the estates of certain deceased Medicaid recipients and/or their spouses who previously received nursing home care paid for by Medicaid. Nursing home providers may soon be receiving letters or a questionnaire from HMS requesting information in order to recover the costs of Medicaid services, when it is appropriate. HMS is working as an authorized agent for the Alabama Medicaid Agency and security agreements are in place for a provider to be able to release recipient and sponsor information to HMS.

Providers are asked to complete requests from HMS within two weeks of receipt of the notice. Questionnaires must be completely filled out with all requested documentation and faxed to (855) 809-3983 or mailed to HMS, The Alabama Medicaid Estate Recovery Contractor, P. O. Box 166709, Irving, TX 75016-6709. Any questions about any letter or questionnaire should be referred to HMS at (855) 543-8395. Any questions that need to be directed to the Agency regarding the estate recovery services being performed by HMS can be directed to Keith Thompson at (334) 242-5248.

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# A L E R T

March 1, 2012

## Attention: All Medicaid Dental Providers

**RE: Dental Service Code Changes**

**Effective:** January 1, 2012, the following changes were made to the Dental Program:

1. Non-emergency oral examinations (D0150, D0120) are limited to two per calendar year whether it is a comprehensive oral examination and one periodic oral examination or two periodic oral examinations in a 12-month period.
2. For procedure D1351, teeth to be sealed must be free of caries and restorations. The surface sealed must be noted on the dental claim form. Reimbursement for restorations placed on a previously sealed surface by the same provider within a 12-month period will be reduced by the amount of the reimbursement for the sealant.
3. For procedure codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394, the reimbursement is based on the total number of unique surfaces restored, not to exceed the total number of surfaces characteristic of that tooth, and no surface shall be billed twice. Reimbursement is not based on the total number of restorations placed. For example, if a buccal, occlusal and lingual resin restoration was placed on a posterior tooth, the correct billing code would be BOL D2393 and not D2391 times three.
4. D2792, D2752, D2751 and D2750 pay only one code per tooth per lifetime.

This information is also available on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs/Medical Services/Dental

Questions about these changes should be directed to Leigh Ann Hixon, [leighann.hixon@medicaid.alabama.gov](mailto:leighann.hixon@medicaid.alabama.gov), or by telephone at (334) 353-3031.

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# A L E R T

March 6, 2012

## Attention: DME Providers

**RE: DME Paper Claims Changes**

Effective February 1, 2012:

K0739 (Repair) procedure code's allowable units have been increased to 12. However, providers must continue to submit justification when billing more than four units. Please include all units over four on the PA request with justification for repairs. The request will be reviewed by Qualis Health. The PA letter will state the total units approved in the analyst's remarks section.

Effective March 1, 2012:

1. Disaster claims (fire and theft) should be submitted electronically to HP for processing. Provider must file these claims with the appropriate procedure code and **Modifier CR**. The provider must keep all documentation (fire report, theft report, etc) in the recipient's file. These claims will be monitored by Alabama Medicaid on a quarterly basis.
  2. DME diabetic testing supplies claims billed for recipients with Gestational Diabetes must contain a diagnosis code in the range of 64880-64884. Units will be increased for procedure code A4259 to two (2) per calendar month and for A4253 to four (4) per calendar month. These claims will be processed electronically by HP. All documentation must be kept in the recipient's file and will be monitored by Alabama Medicaid on a quarterly basis.
-

# A L E R T

March 8, 2012

## Attention: All Providers

### RE: Program of All-Inclusive Care for the Elderly (PACE)

Alabama Medicaid Agency has initiated a new program called the Program of All-Inclusive Care for the Elderly (PACE). The PACE program operates as a capitated managed care benefit that features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with the needs of the participant.

Enrolled participants must receive all of their services through the PACE Organization. PACE services include but are not limited to the following: Primary Care (including doctor and nursing services); Hospital Care; Medical Specialty Services; Prescription Drugs; Dentistry; Nursing Home Care; Personal Care; Physical Therapy; Adult Day Care; Nutritional Counseling; Laboratory/X-ray Services; Social Services; and Transportation.

The program is currently limited to participants in Mobile and Baldwin counties although programs in other locations are expected later this year.

Providers serving Medicaid recipients in these counties need to be aware that PACE participants must receive all services from PACE program-contracted providers. **Claims submitted by non-contract providers will not be paid.**

PACE participants' Medicaid cards have a sticker identifying their affiliation with the program as well as a unique PACE program identification card. PACE participation is also reported through the Agency's AVRS eligibility verification system.

Individuals enrolling in the PACE program must meet each of the following criteria:

- meet the nursing home level of care
- are able to live safely in the community at the time of enrollment
- be 55 years of age and older
- live in a designated PACE service area, currently Mobile and Baldwin counties

PACE participants may be Medicaid-only, Medicare-only, Medicaid and Medicare (dually eligible), or private pay.

For questions or concerns regarding the PACE program, please contact Linda Lackey at (334) 242-5644, or Jan Sticka at (334) 353-4151 or go to the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs/Long Term Care.

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**A L E R T**

March 8, 2012

**Attention: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

**RE: Preferred Drug List Update**

**Effective April 2, 2012**, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions      |   |
|--------------------|---|
| <b>PegIntron</b>   | Anti-infective Agents/Interferons   |
| PDL Deletions*     |   |
| <b>Avalide</b>     | Cardiovascular Health/Angiotensin II Receptor Antagonists                               |
| <b>Avapro</b>      | Cardiovascular Health/Angiotensin II Receptor Antagonists                               |
| <b>Benicar</b>     | Cardiovascular Health/Angiotensin II Receptor Antagonists                               |
| <b>Benicar HCT</b> | Cardiovascular Health/Angiotensin II Receptor Antagonists                               |
| <b>Cleocin</b>     | Anti-infective Agents/Miscellaneous Antibacterials                                      |
| <b>Focalin</b>     | Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Short and Intermediate Acting |
| <b>Pegasys</b>     | Anti-infective Agents/Interferons   |

\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at

<https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116 / Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

March 15, 2012

## Attention: All Providers

### RE: Information regarding Provider Electronic Solutions Software (PES) Version 3.0

PES version 3.0 must be in place before March 31<sup>st</sup> to submit 5010 and NCPDP 1.2 transactions.

Users have two options: 1) An upgrade from PES version 2.16 to PES version 3.0 (desired), or 2) A full install of PES version 3.0.

#### 1) Upgrade information:

Prior to upgrading to PES version 3.0:

- Users must be using PES version 2.16
  - If not, you must upgrade to PES version 2.16 or do a full install
- Users must submit all "R" status transactions (these cannot be submitted once version 3.0 is in place).

Once PES version 3.0 upgrade has completed, list information will remain unchanged, but users will not be able to change, copy, resubmit, or restore archived transactions that were entered in PES version 2.16 of the Provider Electronic Solutions Software.

All transactions converted from PES version 2.16 to version 3.0 will be flagged with a new status based on the status the transaction was in at the time of the upgrade. No further action can be taken on X12 4010 or NCPDP 1.1 transactions. The following new status codes will be used:

| Status | Description   |
|--------|---|
| U      | All transactions previously in an 'I' status at the time the upgrade is performed will have the status changed to 'U'. U = 4010 Unfinished/Incomplete             |
| B      | All transactions previously in an 'A' status at the time the upgrade is performed will have the status changed to 'B'. B = 4010 Backup record/Archive             |
| C      | All transactions previously in an 'R' status at the time the upgrade is performed will have the status changed to 'C'. C = 4010 Completed not yet Submitted/Ready |
| S      | All transactions previously in an 'F' status at the time the upgrade is performed will have the status changed to 'S'. S = 4010 Successfully Submitted/Finalized  |

#### 2) Full Install information:

Prior to full installation to PES version 3.0:

- Users may be new to PES or using any previous version of PES
- Current PES users:
  - Lists will not be retained. It is recommended that users print their lists prior to installation so that their lists can be manually created in PES version 3.0.
  - Users must submit all "R" status transactions (these cannot be submitted once version 3.0 is in place).

# A L E R T

The Provider Electronic Solutions User Guide will be available Monday, March 19, 2012 on the Alabama Medicaid Website (<http://www.medicaid.alabama.gov>) by navigating to "Providers" and click on "Manuals" **OR** available now from the Alabama Medicaid Provider Portal (<https://www.medicaid.alabamaservices.org/alportal>) by navigating to "Information" and click on "AL Links".

Full Install and Upgrade files for the Provider Electronic Solutions Software will be available Monday, March 19, 2012 on the Alabama Medicaid Website (<http://www.medicaid.alabama.gov>) by navigating to "Providers" and click on "Provider Electronic Solutions Software" **OR** available now from the Alabama Medicaid Provider Portal (<https://www.medicaid.alabamaservices.org/alportal>) and navigate to "Information" and click on "AL Links".

For additional support or questions contact the EMC Helpdesk at 1-800-456-1242, or Provider Representative Linda Hanks at 1-855-523-9170, extension 2334580 or [linda.hanks@hp.com](mailto:linda.hanks@hp.com).

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# A L E R T

March 20, 2012

## **Attention: All Providers**

### **RE: Payment Delay – March 16, 2012 Checkwrite**

The total amount of funds for the March 16, 2012 checkwrite will not be released on schedule.

Due to state cash flow issues (unrelated to state proration declared on Friday, March 16), the funds for Hospitals, Ambulatory Surgical Centers, Provider Based Rural Health Clinics, Independent Rural Health Clinics, Renal Dialysis Clinics and Maternity Care providers will be released on March 26, 2012.

A payment date for all other providers has not been established. As soon as funds are available, Medicaid will notify providers via the ALERT process and/or provider associations as well as on the Agency's website at: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

Please verify direct deposit status with your bank.

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# A L E R T

March 26, 2012

**Attention: SNF, ICF-MR and Waivers Providers**

**RE: New Long Term Care Admission Notification Software Version 2.4**

New Version 2.04 will be available for download beginning on April 1, 2012. Version 2.04 *must* be installed on or before April 23, 2012 to submit Long Term Care transactions.

Version 2.03 will not be accepted after April 24, 2012.

**Users have two options:**

- 1) An upgrade from version 2.03 to version 2.04 (desired), or
- 2) A full install of version 2.04.

**Option 1) Upgrade information:**

- Prior to upgrading to version 2.4,
  - Users must be using version 2.03
  - If not, you must upgrade to version 2.03 or do a full install
  - Users must submit all “R” status transactions (these cannot be submitted once version 2.04 is in place).
- Important: Once the version 2.04 upgrade has completed, list information will remain unchanged, but users will not be able to change, copy, resubmit, or restore archived transactions that were entered in version 2.03 of the Long Term Care Admission Notification Software.

**Option 2) Full Install information:**

- These users may be new to the Long Term Care Admission Notification software or using any previous version of the software
- Prior to full installation to version 2.04:
  - Current software users are strongly encouraged to print their lists prior to installation so that their lists can be manually created in version 2.04. **Lists will not be retained**
  - Users must submit all “R” status transactions (these cannot be submitted once version 2.04 is in place).

The Long Term Care Admission Notification User Guide can be found on the Alabama Medicaid Website (<http://www.medicaid.alabama.gov>) by navigating to “Providers” and click on “Manuals” **OR** from the Alabama Medicaid Provider Portal (<https://www.medicaid.alabamaservices.org/alportal>) by navigating to “Information” and click on “AL Links”.

# A L E R T

**March 26, 2012**

**-2-**

**Long Term Care Software Version 2.4**

Full Install and Upgrade files for the Long Term Care Admission Notification Software are available from the Alabama Medicaid Provider Portal (<https://www.medicaid.alabamaservices.org/alportal>) and navigate to "Information" and click on "AL Links".

Important notes about the new Version 2.04:

- The Long Term Care Admission Notification Software will now accept 6, 7, 8, 9 or 10 alpha numeric characters in the Provider and Performing Provider fields.
- When submission reason is "7" (death/discharge/termination/revoke), it will prompt a new drop-down box with the following options:
  - H - Recipient discharged home
  - D - Recipient died
  - T - Recipient was terminated from the program
- The Long Term Care Admission Notification software will no longer accept Medicaid numbers beginning with prefix '000'. If a user enters the old number, an error message will occur and the current Medicaid ID number will be required to save the file.
- For additional support or questions contact the EMC Helpdesk at-1-800-456-1242 or the following provider representatives:
  - Aleetra Adair 1-855-523-9170 extension 2334587
  - Remona Riley 1-855-523-9170 extension 2334532
  - Araceli Wright 1-855-523-9170 extension 2334560
  - Shamekia Pena 1-855-523-9170 extension 2334588

**THIS ALERT SUPERSEDES ANY PREVIOUS ALERT REGARDING LONG TERM CARE ADMISSION NOTIFICATION SOFTWARE VERSION 2.04.**

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# A L E R T

March 27, 2012

## Attention: Physicians

### RE: EPSDT Changes/Clarification

The Alabama Medicaid Agency has made changes to the sample referral form posted on the Alabama Medicaid website describing the “required fields.” Please see the updated version attached.

Signatures accepted on referral forms: The following has been added to the April 2012 edition of Appendix A of the Alabama Medicaid Provider Manual:

#### Signature Requirement for Referrals: Effective May 16, 2012:

For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted.** For electronic referrals, provider certification is made via standardized electronic signature protocol.

Additionally, effective April 1, 2012, for services that require physicians’ orders, all orders must be written according to practice guidelines and state/federal law and must include the date and signature of the provider, the service(s) ordered and the recipient’s name. **The Patient 1<sup>st</sup>/EPSDT referral form may be considered the physician’s order as long as these guidelines are met.** See the appropriate chapter of the April 2012 edition of the Alabama Medicaid Provider Manual for additional details regarding specific requirements for each program area.



# A L E R T

2/23/12

## Instructions for Completing The Alabama Medicaid Agency Referral Form (Form 362)

**TODAY'S DATE:** Date form completed

**REFERRAL DATE:** Date referral becomes effective

**RECIPIENT INFORMATION:**

Patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name

**PRIMARY PHYSICIAN:\*** Provide all PMP information. For hard copy referrals, the printed, typed, or stamped name of the primary care physicians with an original signature of the physician or designee is required. Stamped or copied signatures will not be accepted. For electronic referrals provider certification is made via standardized electronic signature protocol.

**SCREENING PROVIDER:\*** Screening provider (if different from primary physician) must complete and sign if the referral is the result of an EPSDT screening.

**\*NPI INFORMATION:** Provide NPI number. For billing purposes indicate Medicaid Provider number, if available.

**TYPE OF REFERRAL:**

- ♦ Patient 1st - Referral to consultant for Patient 1st recipient only (See \*Chapter 39 for Claim Filing Instructions).
- ♦ EPSDT - Referral resulting from an EPSDT screening of a child not in the Patient 1st program - indicate screening date (See \*Appendix A for Claim Filing Instructions).
- ♦ Case Management/Care Coordination - Referral for case management services through Patient 1st Care Coordinators (See \*Chapter 39 for Claim Filing Instructions).
- ♦ Lock-In - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy (See \*Chapter 3 -3.3.2 for Claim Filing Instructions).
- ♦ Patient 1st/EPSDT - Referral is a result of an EPSDT screening of a child who is in the Patient 1st program - indicate screening date (See \*Appendix A for Claim Filing Instructions).
- ♦ Other - For recipients who are not in Patient 1st program.

**LENGTH OF REFERRAL:** Indicate the number of visits/length of time for which the referral is valid.

Note: Must be completed for the referral to be valid.

**REFERRAL VALID FOR:**

- ♦ Evaluation Only - Consultant will evaluate and provide findings to Primary Physician (PMP).
- ♦ Evaluation and Treatment - Consultant can evaluate and treat for diagnosis listed on the referral.
- ♦ Referral by Consultant to Other Provider For Identified Condition (Cascading Referral) - After evaluation, consultant may, using Primary Physician's (PMP) provider number, refer recipient to another specialist as indicated for the condition identified on the referral form.
- ♦ Referral by Consultant To Other Provider For Additional Conditions Diagnosed By Consultant (Cascading Referral) - Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the Primary Physician (PMP).
- ♦ Treatment Only - Consultant will treat for diagnosis listed on referral.
- ♦ Hospital Care (Outpatient) - Consultant may provide care in an outpatient setting.
- ♦ Performance of Interperiodic Screening (if necessary) - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.

**REASON FOR REFERRAL BY PRIMARY PHYSICIAN (PMP):**

Indicate the reason/condition the recipient is being referred.

**OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PRIMARY PHYSICIAN:**

Indicate any condition present at the time of initial exam by PMP.

**CONSULTANT INFORMATION:** Consultant's name, address and telephone number.

**PLEASE SUBMIT FINDINGS TO PRIMARY PHYSICIAN BY:** The Primary Physician (PMP) should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

\*The Alabama Medicaid Provider Manual is available on the Alabama Medicaid website| at [http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.7\\_Manuals.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx)

# A L E R T

March 29, 2012

## Attention: All Providers

RE: Total System Outage

WHEN: March 31, 2012

TIME: 12:00 AM to 5:00 AM

Alabama Medicaid will be installing system updates to **discontinue** accepting X12 4010 and NCPDP 5.1 transactions on March 31, 2012, from 12:00 AM to 5:00 AM.

Medicaid will reject any claims during this downtime. See ALERT dated March 12, 2012, for further details.

After system updates have been finalized, only X12 5010 and NCPDP D.0 transactions will be processed.

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# A L E R T

April 03, 2012

**TO: Physicians**

**RE: Guidelines For Billing Prolonged Services In The Office Or Other  
Outpatient Setting**

Procedure Codes 99354 and 99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health professional on a given date providing prolonged service, even if the time spent on that date is not continuous.

Requirement for Physician Presence: Only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) beyond the typical/average time of the office visit code billed may be counted to determine whether prolonged services can be billed; and to determine the prolonged service codes that are allowable.

Documentation: Documentation is required to be in the medical record about the duration and content of the **medically necessary** evaluation and management service and prolonged services that are billed. The physician must appropriately and sufficiently document in the medical record that he/she personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. Time must be documented clearly in medical record to indicate the beginning of service time and the end of service time to justify these codes being billed in addition to the office visit.

## **Prolonged Services Associated With E & M Services Based On Counseling And/Or Coordination Of Care (Time-Based)**

When an E & M service is dominated by counseling and/or coordination of care (the counseling and /or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician and the patient in the office, the E & M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E & M code) and should not be "rounded to the next higher level". For E & M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.

## **Effective July 1, 2011 Procedure Codes 99354 and 99355 (Note above paragraph before billing prolonged service codes):**

- May be billed only in conjunction with procedure codes 99201-99215, 99241-99245, 99324-99337, 99341-99350, and only if the EP modifier is not billed. (Effective April 1, 2012, procedure code 99211 is excluded from this list and may not be billed with prolonged service codes).
- May not be billed alone.

**Refer to CPT guidelines for correct reporting of prolonged physician services with direct patient contact in office/outpatient setting.**

# A L E R T

**Example of a BILLABLE Prolonged Service:**

A physician performed a visit that met the definition of an office visit CPT code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills CPT code 99213 and *one* unit of code 99354

**Example Of A Non Billable Prolonged Service:**

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

For more examples, you may refer to <https://www.cms.gov/MLN MattersArticles/downloads/MM5972.pdf>

# A L E R T

May 7, 2012

## **Changes to Intrauterine Devices (IUD) and Implantable Contraceptive Coverage**

### **ATTENTION: Family Planning Providers (Federally Qualified Health Centers and Rural Health Centers)**

The Alabama Medicaid Agency is making changes to how FQHC's and RHC's are reimbursed for Intrauterine Devices and Implantable Contraceptives. Effective May 1, 2012, Mirena®, Paragard®, and Implanon® will be reimbursed in addition to the encounter rate. FQHCs and RHCs may submit a medical claim using the following procedure codes:

Mirena - J7302

Paragard - J7300

Implanon - J3707

For questions regarding this change, please contact Laura Hamilton, Associate Director of Maternity Care and Plan First Programs at (334) 353-5539 or [Laura.Hamilton@medicaid.alabama.gov](mailto:Laura.Hamilton@medicaid.alabama.gov).

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# A L E R T

To: All Providers

Subject: Payment Adjustment for Provider Preventable Conditions

CMS has recently approved an Alabama Medicaid State Plan change effective October 1, 2011. Federal regulations mandate that all providers must report Provider Preventable Conditions (PPCs) to Medicaid.

Provider Preventable Conditions are defined into two separate categories:

1. Healthcare Acquired Conditions, which include Hospital Acquired Conditions (HACs). Examples of HACs include but are not limited to foreign object retained after surgery, blood incompatibility, and development of pressure ulcer stages III and IV.
2. Other Provider Preventable Conditions (OPPCs). Examples of OPPCs include but are not limited to surgery on a wrong body part or site, wrong surgery on a patient, or surgery on the wrong patient.

Inpatient Psychiatric Hospitals (freestanding psychiatric hospitals and residential treatment facilities) must now use the UB-04 claim form to report HACs, as has already been required of inpatient hospitals.

It is the responsibility of the **provider** to identify and report any PPC and **not seek payment** from Medicaid for any additional expenses incurred as a result of the PPC. Provider payments may be disallowed or reduced based on a post-payment review of the medical record.

The PPC reporting policy is located on the Alabama Medicaid website at [www.medicaid.alabama.gov/CONTENT/4.0\\_Programs/4.4.0\\_Medical\\_Services/4.4.6.6\\_Adverse\\_Events\\_Reporting.aspx](http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.6.6_Adverse_Events_Reporting.aspx)

If you have any questions, please contact Patricia Williamson via e-mail at [patricia.williamson@medicaid.alabama.gov](mailto:patricia.williamson@medicaid.alabama.gov) or phone at 334-353-4142.

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# A L E R T

May 18, 2012

**To: All Providers**

**SUBJECT: General Fund Proration**

As a result of General Fund proration declared on March 16, 2012, the Alabama Medicaid Agency has been directed to identify and implement cuts to its overall budget. After program impact analysis and multiple provider meetings and communications, the Agency will implement these cuts in three ways:

- Reduction of payments to certain provider groups by 10 percent
  - Physicians
  - Dentists
  - Physician Lab & X-ray
  - Durable Medical Equipment
  - Independent Lab & X-ray
  - Other licensed practitioners
  - Maternity primary contractors (Effective for dates of service on or after May 14, 2012)
- Reduction in services to adults (benefits to children remain unchanged)
  - Change coverage of routine eye exams and work-up for refractive error to once every three years (now one eye exam every two years)
  - End coverage of eyeglasses as a benefit (now one pair every two years)
  - Limit drugs to one brand-name drug per month; generics and covered OTCs remain unlimited. Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers. (In addition to children, LTC recipients are excluded from this reduction.)
- Reduction in cough/cold covered drugs for all recipients: Legend generic cough/cold drugs will no longer be covered (legend brand drugs are currently non-covered). Certain OTC drugs will remain covered.

Except as specified otherwise above, these reductions will be effective for dates of service on or after June 1, 2012.

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# A L E R T

**May 23, 2012**

**Attention: All Providers**

**RE: 05/18/12 Checkwrite Release**

Due to the holiday on Monday, May 28, 2012, Medicaid will release the payments for the May 18, 2012 checkwrite on Friday, May 25, 2012.

Please verify direct deposit status with your bank.

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**A L E R T**

May 30, 2012

**Attention:** Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

**Effective July 2, 2012**, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions       |   |
|---------------------|---|
| <b>Pegasys</b>      | Anti-infective Agents/Interferons                                     |
| PDL Deletions*      |   |
| <b>Concerta</b>     | Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting |
| <b>Daytrana</b>     | Behavioral Health/Cerebral Stimulants/Agents for ADD/ADHD-Long Acting |
| <b>Foradil</b>      | Respiratory/ Beta-Adrenergic Agonists                                 |
| <b>Ventolin HFA</b> | Respiratory/ Beta-Adrenergic Agonists                                 |

*\* Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

May 31, 2012

**TO: All Providers**

**RE: New Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers**

Federal law now 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.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who 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\\_For\\_ms.aspx](http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_For_ms.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.**

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

Medicaid will allow a grace period until September 30, 2012 for OPR providers to become enrolled. On October 1, 2012, 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.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the October 1, 2012 deadline.

Providers should contact one of the following HPES Provider Representatives with any questions:

- Araceli Wright 1-855-523-9170 extension 2334560
  - Remona Riley 1-855-523-9170 extension 2334532
  - Shamekia Pena 1-855-523-9170 extension 2334588
  - Aleetra Adair 1-855-523-9170 extension 2334587
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# A L E R T

June 01, 2012

**TO: All Providers**

**RE: Patient 1<sup>st</sup> Referral Change**

Effective June 1, 2012 the Alabama Medicaid Agency will change Patient 1<sup>st</sup> Referral requirements to allow PMPs to see patients who are in the process of transferring to their panel without a referral. Once the PMP change becomes official, claims for the previous 60 days from the new PMP will be paid. When a recipient wishes to change their PMP, the change can be made directly by the recipient or made by the new PMP. In the past, the new PMP would have to obtain a referral from the old PMP in order to see the recipient prior to the official change date. PMP changes typically take 15 to 45 days. For example, if a PMP change is requested on June 18 it would become official on August 1. The new PMP will be able to treat the recipient, and claims for dates of service 60 days prior to August 1 will be paid on or after the effective date. These claims will deny prior to the change becoming official.

The new policy will allow the new PMP to both provide services and make referrals. Claims for referrals will also not pay until the PMP change is official. If the change does not become official the claims will not pay without a referral. This could happen if a subsequent change in PMP request is made before the original change is made active. This change does not alter the process or rules for the old PMP. Claims from the old PMP will be paid as normal. The old PMP should no longer be requested to provide referrals for a recipient transferring to other PMPs. Medicaid will monitor PMP changes to ensure that this policy change is not misapplied.

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# A L E R T

June 21, 2012

**TO: All Pharmacy Providers**

**RE: Dispense as Written (DAW) Code of 9 for brand Adderall XR**

**Effective July 2, 2012**, Alabama Medicaid will begin allowing the use of a Dispense as Written (DAW) Code of 9 for brand Adderall XR. Generic versions of the drug will be non-preferred and will require prior authorization. Additional drugs may be added to the DAW 9 list at a future time.

A DAW Code of 9 indicates the following:

**Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed.**

This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but Alabama Medicaid requests the brand product be dispensed. This situation can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. A DAW of 9 will result in a claim paying the brand Average Acquisition Cost (AAC).

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

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# A L E R T

June 26, 2012

**TO: All Provider Associations**

**RE: Alabama MMIS Maintenance Window**

This is notification of an extended maintenance window for the Alabama Medicaid system. The impact of this outage will be as follows until the conclusion of the maintenance:

1. Remittance Advices will be unavailable for download via the Alabama Medicaid Web Portal
2. Managed Care reports will be unavailable for download via the Alabama Medicaid Web Portal

**WHEN:**

Friday, June 29, 2012, beginning at 8:00 AM Central Daylight Saving Time to

Monday, July 2, 2012, ending at 7:00 AM Central Daylight Saving Time.

All other web portal functionality will continue to be available during this extended maintenance window.

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# A L E R T

July 19, 2012

**Attention:** Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

**Re:** Four (4) Brand-Name Limit

Effective for drugs dispensed on or after **August 1, 2012**, the Alabama Medicaid Agency will reinstate the four (4) brand-name drug limit per month.

The one brand-name drug limit will remain in effect for June 1, 2012 through July 31, 2012.

Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers.

Children (recipients under 21) and nursing facility recipients are excluded from the four brand-name limit.

Generics and covered over the counters remain unlimited.

Policy questions concerning this ALERT should be directed to the Pharmacy Program at (334) 242-5050.

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# A L E R T

August 13, 2012

**Attention: Family Planning Providers  
(Physicians, FQHCs, IRHCs, PBRHCs)**

**SUBJECT: Smoking Cessation Products Covered for Plan First  
Smoking Cessation Products and Preconception Care: Satellite Conference on  
September 11, 2012**

Effective for dates of service October 1, 2012, and thereafter, selected smoking cessation products will be covered for Medicaid recipients on the Plan First program. Products to be covered include nicotine patches, nicotine gum, nicotine lozenges, bupropion tablets, and varenicline tablets.

1. Prior authorization through the Pharmacy Administrative Services contractor, Health Information Designs, will be required. Providers with questions regarding prior authorization for smoking cessation products may contact Health Information Designs at 1-800-748-0130.
2. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline (1-800-784-8669).
3. Approval will be granted for up to three months at a time.
4. Only one course of therapy will be approved per year.
5. For additional details, refer to the Alabama Medicaid Provider Manual Appendix C: Family Planning.

The Alabama Public Health Training Network is providing a two-hour satellite conference and live webcast called *Preconception Care: Tobacco Cessation* on September 11, 2012, from 2:00-4:00 PM. The speakers are Clemice Hurst, R.Ph., Clinical Pharmacist, Alabama Medicaid Agency and Annie Vosel, BSN, RN, Bureau of Family Health Services, Alabama Department of Public Health. Continuing education for nurses and social workers is pending. To access and register for the live training, go to <http://adph.org/ALPHTN>. For those unable to view the program during the scheduled air time, it may be accessed at <http://adph.org/ALPHTN> by clicking "On Demand".

For questions, contact Nancy Headley, Director, Managed Care at (334) 242-5684 or [nancy.headley@medicaid.alabama.gov](mailto:nancy.headley@medicaid.alabama.gov).

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# A L E R T

August 22, 2012

**Attention: Medicaid Certified Nursing Facilities**

**RE: Coverage for Ventilator-Dependent and Qualified Tracheostomy Care Residents**

Effective January 16, 2012, the Alabama Medicaid Agency will pay nursing facilities a supplemental fee-for-service payment in addition to the daily nursing facility rate for care provided to ventilator-dependent residents and/or qualified tracheostomy residents who are eligible for Medicaid benefits. The nursing facility must meet specific provider requirements and the ventilator-dependent/tracheostomy care resident must meet specific medical criteria established by the Alabama Medical Agency.

Information regarding the required documentation for the nursing facility and the resident is included in Alabama Medicaid Administrative Code Chapter 63. Nursing facilities must mail all documentation for the facility and resident to HP with a correctly completed Long Term Care Records coversheet. The coversheet is located on the Medicaid website at:

[http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.3\\_LTC\\_Services/5.4.3\\_LTC%20Records%20Coversheet\\_6-11.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC%20Records%20Coversheet_6-11.pdf)

The records should be mailed to the following address:

**HP ENTERPRISES SERVICES  
P. O. BOX 224032  
MONTGOMERY, AL 36124-4032**

An incorrectly completed coversheet will result in the record being returned to the provider. Please write, "VENT/TRACH" on the coversheet. To facilitate review of the record, please send an e-mail to [theresa.carlos@medicaid.alabama.gov](mailto:theresa.carlos@medicaid.alabama.gov) with ONLY the Medicaid ID, stating, "The record is ready for review." Do not send any PHI in the e-mail.

Questions regarding this ALERT should be directed to the Long Term Care Provider/Recipient Services Unit at (334) 353-4754.

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# A L E R T

**TO: All Providers**

**RE: Synagis® Criteria for 2012 – 2013 Season**

- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2012-2013 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link:

[http://medicaid.alabama.gov/CONTENT/4.0\\_Programs/4.5.0\\_Pharmacy/4.5.14\\_Synagis.aspx](http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx)

- The approval time frame for Synagis® will begin October 1, 2012 and will be effective through March 31, 2013.
- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive up to a max of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) **directly** to Health Information Designs and completed forms may be accepted beginning September 1, 2012 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

## Criteria

Alabama Medicaid follows the 2012 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.

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# A L E R T

Effective October 1, 2012, the Alabama Medicaid Agency will:

1. Require prior authorization (PA) for payment of generic escitalopram and zafirlukast. Preferred brands will continue to be available with no PA necessary.
2. Allow the use of a Dispense as Written (DAW) Code of 9 for brand Lexapro and Accolate. Generic versions of the drug will be non-preferred and will require prior authorization. DAW Code of 9 indicates the following: Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed. This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but Alabama Medicaid requests the brand product be dispensed.
3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions                |   |
|------------------------------|---|
| <b>Intuniv</b>               | Behavioral Health/Cerebral Stimulants Agents for ADD ADHD-Long Acting |
| <b>Pristiq</b>               | Behavioral Health/Antidepressants                                     |
| <b>Pulmicort Flexhaler</b>   | Respiratory/Orally Inhaled Corticosteroids                            |
| PDL Deletions*               |   |
| <b>Diastat<sup>‡</sup></b>   | Behavioral Health/Anxiolytics, Sedatives, Hypnotics: Benzodiazepines  |
| <b>Maxalt MLT</b>            | Pain Management/Selective Serotonin Agonists                          |
| <b>Singulair<sup>‡</sup></b> | Respiratory/Leukotriene Modifiers                                     |

\* Denotes that these brands/generics will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA).

<sup>‡</sup>Covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

# A L E R T

**To: Outpatient Hospitals**

Subject: 340-B and OP Hospital Clinic Billing

**Hospitals designated as 340-B entities**

Effective for claims submitted on October 1, 2012, and after, hospitals designated as 340-B entities may bill 'total charges' on the UB-04 claim form when billing for outpatient pharmacy charges.

**Hospital-Based 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. Only one visit per day will be allowed.

If you have any questions, please contact Jerri Jackson via e-mail at [jerri.jackson@medicaid.alabama.gov](mailto:jerri.jackson@medicaid.alabama.gov) or phone at 334-242-5630.

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# A L E R T

UPDATED September 25, 2012

Effective October 1, 2012, the Alabama Medicaid Agency will:

1. Require prior authorization (PA) for payment of zafirlukast. Preferred brands will continue to be available with no PA necessary.
2. Allow the use of a Dispense as Written (DAW) Code of 9 for brand Accolate. Generic versions of the drug will be non-preferred and will require prior authorization. DAW Code of 9 indicates the following: Substitution Allowed By Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product To Be Dispensed. This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but Alabama Medicaid requests the brand product be dispensed.
3. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions                |   |
|------------------------------|---|
| <b>Intuniv</b>               | Behavioral Health/Cerebral Stimulants Agents for ADD ADHD-Long Acting |
| <b>Pulmicort Flexhaler</b>   | Respiratory/Orally Inhaled Corticosteroids                            |
| PDL Deletions*               |   |
| <b>Diastat<sup>‡</sup></b>   | Behavioral Health/Anxiolytics, Sedatives, Hypnotics: Benzodiazepines  |
| <b>Maxalt MLT</b>            | Pain Management/Selective Serotonin Agonists                          |
| <b>Singulair<sup>‡</sup></b> | Respiratory/Leukotriene Modifiers                                     |

\* Denotes that these brands/generics will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA).

<sup>‡</sup>Covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

# A L E R T

October 2, 2012

**To: All Providers**

**Subject: Reversal of Proration Cuts**

The Alabama Medicaid Agency today announced that payment reductions implemented earlier this year due to proration of the General Fund budget will be reversed no later than November 1, 2012. The reversals were made possible following the passage of a state Constitutional Amendment on September 18 which enabled Medicaid's 2013 Fiscal Year Budget to receive additional monies through the state's General Fund.

Effective for dates of service October 1, 2012 and thereafter, the change will reverse the 10 percent payment reduction for physicians, dentists, Physician Lab and X-ray providers, Independent Lab and X-ray providers, and other licensed practitioners (e.g. psychologists, podiatrists, chiropractors, therapists, audiologists/hearing aid, nurse practitioners, CRNAs).

Effective for dates of service November 1, 2012 and thereafter, the change will reverse the 10 percent payment reduction for durable medical equipment and supply providers. In addition to the payment changes, the Agency will also reinstate the coverage of eyeglasses for adults (one pair every two years) and will reinstate the coverage of routine eye exams and work up for refractive error from once every three years to once every two years. The delay for durable medical equipment, supplies and eyeglasses is due to federal requirements for public notice of the change.

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# A L E R T

October 16, 2012

To: Providers Submitting Claims with Third Party (TPL) Primary

SUBJECT: Changes to the Third Party Liability (TPL) Billing for Alabama Medicaid

Effective October 23, 2012, HP will begin capturing Third Party Liability patient responsibility amounts at both header and detail levels. **Changes will be made to all claim types except Pharmacy.**

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 Payor).

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. System changes will be implemented at a later date for the payment methodology of other claim types.

A new TPL attachment form has been created for TPL denials. This form will be required with the CMS 1500 form when third party denies a claim. The forms are available free of charge and may be ordered by calling the Provider Assistance Center at 1-800-688-7989.

Updates are being made to Provider Electronic Solutions (PES) software; however, currently we do not have a date for the next upgrade to accommodate the changes. Providers may use Medicaid's Interactive Web Portal until the upgrade is released.

Vendors should reference the Vendor Specifications for requirements on segments/loops to accommodate the changes.

The next section outlines changes that have been made to the Interactive Medicaid Web Portal to accommodate the changes. See screen shots and descriptions for each claim type affected by this change.

## **Dental Claims:**

Providers no longer have an option to enter the Total TPL Paid Amount in the Billing Information panel. The TPL Paid Amount should now be entered in the TPL panel. New fields have also been added to the TPL panel to allow providers to submit amounts applied to deductible, coinsurance, and copay per other insurance.

By selecting the add button in the TPL panel, providers can add up to 10 TPL carriers per claim.

# A L E R T

\*\*\* No rows found \*\*\*

TPL

Select row above to update -or- click Add button below.

Policy Number

Plan Name

Relationship to Insured

Carrier Code  [ Search ]

Carrier Name

Payer Respons. Code

Paid Date

Paid Amt

Deductible Amt

CoInsurance Amt

CoPay Amt

Policy Holder

Last Name

First Name, MI

Date of Birth

delete add

### Institutional Claims:

The Payer panel has been removed from the web portal. The TPL Paid Amount should be entered in the TPL panel. New fields have also been added to the TPL panel to allow providers to submit amounts applied to deductible, coinsurance, and copay per other insurance.

By selecting the add button in the TPL panel, providers can add up to 10 TPL carriers per claim.

Click the link below to activate the corresponding panel:  
[Condition Procedure Occurrence](#)

\*\*\* No rows found \*\*\*

TPL

Select row above to update -or- click Add button below.

Policy Number

Plan Name

Relationship to Insured

Carrier Code  [ Search ]

Carrier Name

Payer Respons. Code

Paid Date

Paid Amt

Deductible Amt

CoInsurance Amt

CoPay Amt

Policy Holder

Last Name

First Name, MI

Date of Birth

delete add

# A L E R T

**Professional Claims:**

TPL will be captured at the header and the detail.

Providers no longer have an option to enter the Total TPL Paid Amount in the Billing Information panel. The TPL Paid Amount should now be entered in the TPL panel. New fields have also been added to the TPL panel to allow providers to submit amounts applied to deductible, coinsurance, and copay per other insurance.

By clicking the add button in the TPL panel, providers can add up to 10 TPL carriers per claim.

The Third Party Payments panel has been created. Providers need to enter TPL paid, TPL Co-Pay, TPL Coinsurance, and TPL deductible amounts on each detail respectively per carrier.

By clicking the add button in the Third Party Payments panel, providers can submit multiple payments per detail line item, to specify each carrier's payment.

The Totals submitted at the header for each carrier, should balance the Totals submitted at the detail per carrier.

# A L E R T

November 26, 2012

To: DME Providers, Prosthetics & Orthotics (P&O) Providers, Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, and Nursing Homes.

SUBJECT: Durable Medical Equipment (DME) Program Changes

The Alabama Medicaid Agency's Durable Medical Equipment Program will make changes to:

- Reimbursement for CPAP
- Humidifier Reimbursement
- External Breast Prostheses Prior Authorization
- Home Medical Equipment (HME) License
- Wheelchairs Coverage Limit Change

Detailed information about each change is below. Also below is a reminder regarding the procedure for manually priced DME items' Prior Authorization (PA) Requests.

## **CPAP Reimbursement**

Effective January 1, 2013, the CPAP (E0601) will be a capped rental to purchase item. The equipment can be rented for up to three months. After three months, if the recipient continues to meet criteria and must continue on the CPAP, the CPAP machine will transition to a purchase, with the total rental payments during the first three months and a subsequent one month payment equaling the purchase rate. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient.

The monthly payment will include delivery, in-service for the caregiver, maintenance, repair and supplies. Alabama Medicaid will not reimburse separately for procedure codes A7030, A7034, A7037 and A7038 during the CPAP's four month capped rental period. Recertification is required after the initial three months. If the CPAP is determined not be medically necessary (i.e., the criteria are no longer met), the device will be returned to the supplier. NOTE: Do not use the RR modifier for initial PAs submitted on or after 1/1/13.

## **If a recipient already has CPAP and/or humidifier devices via continuous rental on January 1, 2013:**

For recipients with nine or more months of continuous rental for the devices (CPAP and/or humidifier), provider should submit a claim for needed supplies only. The device(s) is considered to have been purchased and Alabama Medicaid will no longer pay for continuous rental of the device. The device is considered to be owned by the recipient. Existing prior authorizations (PAs) will no longer be valid. Requests for Medicaid's authorization of a replacement CPAP device will be accepted for review every eight years. A request for replacement of the device submitted within less than eight years which is due to a natural disaster, or an occurrence beyond the recipient's control, and not the result of misuse, neglect or malicious acts by the user may be considered for approval and payment.

For recipients with four to eight months of continuous rental, the current PA will be capped and the provider will be paid the remaining amount equal to a cumulative total of \$800.42. If the cumulative amount has been reached, no additional claims will be paid. For these PAs, the provider will continue to include the RR modifier.

For recipients with three months rental, and the device continues to meet criteria on or after 1/1/13, the 4<sup>th</sup> month will cap the rental. If criteria are not met, then the device will be returned to the supplier.

**Humidifier Reimbursement**

Effective January 1, 2013, Alabama Medicaid will no longer reimburse procedure codes E0561 or E0562 separately when E0601 is requested at the same time. Procedure codes E0561 and E0562 can only be billed separately if requested for BiPAP (E0470, E0471, or E0472) only.

Therefore, providers are to ensure that recipients, who have current prior authorizations (PAs) for both devices, have both the CPAP and humidifier prior to January 1, 2013. These items will be considered as purchased and owned by the recipient. Therefore, after January 1, 2013, Alabama Medicaid will only reimburse the provider for needed supplies for these recipients.

**External Breast Prostheses Prior Authorization**

Effective January 1, 2013, prior authorization (PA) will no longer be required for external breast prostheses covered by Alabama Medicaid’s Durable Medical Equipment Program. This change applies to procedure codes L8000, L8015, L8020, L8030, L8035 and L8039 submitted with one of the following breast cancer diagnosis codes: 174.0 through 174.9, 198.81 and 233.0.

**Home Medical Equipment (HME) License**

Effective January 1, 2013, applicable DME providers will need to provide verification of Home Medical Equipment (HME) license during the annual on-site provider re-enrollment visits. (All other required licenses/certifications continue to apply; See Chapter 14 of the Provider Manual for provider enrollment requirements listing.) The chart below is provided to assist you with determining the required licenses/certification you must have. If you have any additional questions regarding HME licenses, please contact the Alabama Board of Home Medical Equipment Services Providers.

| <b><u>Type of Operation</u></b>   | <b><u>License/Certification Required</u></b>  |
|---|---|
| Prosthetic, Orthotic & Pedorthic (POP) Services Only (custom fabricated devices only) | Alabama Board of Prosthetists and Orthotists Accredited Facility Certification  |
| POP and Mastectomy in the same facility (custom fabricated devices only)              | Alabama Board of Prosthetists and Orthotists Accredited Facility Certification  |
| POP and HME (DME)   | Alabama Board of Prosthetists and Orthotists Accredited Facility Certification <b>and</b> Alabama Board of Home Medical Equipment (HME) license |
| HME (DME) and Mastectomy  | Alabama Board of Prosthetists and Orthotists Accredited Facility Certification <b>and</b> Alabama Board of Home Medical Equipment (HME) license |
| Mastectomy Only (Boutique)  | Alabama Board of Prosthetists and Orthotists Accredited Facility Certification  |

|               |  |
|---------------|--|
|               | <b>and</b> Alabama Board of Home Medical Equipment (HME) license |
| HME(DME) Only | Alabama Board of Home Medical Equipment (HME)                    |

**Wheelchairs Coverage Limit Change**

Effective January 1, 2013, all wheelchairs will be limited to one per recipient every seven years based on medical necessity. It was previously limited to one per recipient every five years.

**PA Requests for manually priced DME items**

When submitting PA requests for manually priced items, providers should only submit MSRPs (Manufacturer's Suggested Retail Price), procedure codes and item prices. All price calculations will be completed by Alabama Medicaid's PA contractor.

***REMINDER: Beginning January 1, 2013, if a Medicaid service requires an ordering, prescribing, or referring provider and the ordering, prescribing, referring provider does not have a current enrollment record with Alabama Medicaid, the claim will be denied. See the July and October 2012 Provider Insider articles for more details.***

# A L E R T

December 11, 2012

**TO: All Providers**

**RE: Claims for Non-Enrolled OPR Providers to Deny Effective January 1, 2013**

Federal law now requires any ordering, referring or prescribing providers to enroll with Medicaid, even if they do not accept Medicaid, to help prevent and detect fraud and abuse. **Alabama Medicaid will comply with this law effective January 1, 2013, by denying all claims that require a referral, order or prescription from a physician or other licensed health care professional unless that physician or provider has a current enrollment record on file.** To address this requirement, a new category of enrollment was created: ordering, prescribing, referring (OPR) provider; provider type 97.

Medicaid's claims processing system will monitor whether the ordering, prescribing, or referring provider is enrolled in Medicaid. Claims will deny if the ordering, prescribing, or referring provider is not enrolled.

Medicaid has been sending informational EOBs for medical claims since May 2012 informing the billing provider of the status of the ordering, referring, prescribing, physician or licensed health care provider. Medicaid has been sending informational EOBs on pharmacy claims since December 2012.

## Action Required

Providers already enrolled as active Medicaid participating providers do not need to enroll again as an OPR provider.

Providers **not** enrolled as active participating Medicaid providers must enroll as OPR providers. NOTE: For providers who choose to enroll as OPR providers, it is important to remember that an OPR provider cannot submit claims to Medicaid for payment of services rendered. If the provider wishes to be able to submit claims for payment, enrollment as another participating provider type will be required.

## Questions & Answers

Q: Why is Medicaid requiring these providers to become enrolled?

A: Medicaid is complying with Federal Medicaid Regulations 42 CFR 455.410(b) which provides that Medicaid must require all ordering or referring physicians or other professionals providing services be enrolled as providers, and 42 CFR 455.440 which provides that Medicaid must require all claims for the payment of items and services that were ordered, referred, prescribed to contain the National Provider Identifier (NPI) of the physician or other professional who ordered, referred, or prescribe such items or services.

Q: How does the ordering, referring, or prescribing provider enroll as a Medicaid provider?

A: The OPR Enrollment application can be found on the Medicaid Provider enrollment web page at: [http://medicaid.alabama.gov/CONTENT/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.6\\_Provider\\_Enrollment\\_Forms.aspx](http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx).

# A L E R T

December 11, 2012

RE: Claims for Non-Enrolled OPR Providers to Deny Effective January 1, 2013

Q: Our hospital is a teaching hospital so how do we report a “resident physician”?

A: Interns and non-licensed residents must use the NPI of the teaching, admitting, or supervising physician on the claim for reimbursement. If the resident has a medical license, then the resident must be enrolled with Medicaid and the NPI of the resident must be used on the claim for reimbursement.

Q: How does this affect hospital emergency room physicians?

A: Hospital emergency room physicians are required to enroll. They are not exempt from the requirement.

Q: How will these impact Alabama Medicaid recipients that cross state lines?

A: If services are furnished to an Alabama Medicaid recipient in another state, the out of state providers are required to enroll with Medicaid in order to receive reimbursement. Likewise, if the out of state provider writes a prescription, orders a service, or refers the patient, then the out of state provider must be enrolled with Medicaid.

Q: What if the provider is enrolled with another state’s Medicaid? Will the provider need to enroll in all states in which he or she provides service?

A: Enrollment in another state’s Medicaid program does not exempt a provider from enrolling with Alabama Medicaid. Providers are required to enroll in each state where they will provide services or where their order/referral/prescription will be provided.

Q: What if the ordering, prescribing, referring provider is with another State. For example, we receive prescriptions from out-of-state providers?

A: The out-of-state ordering, prescribing, referring provider must be enrolled with Alabama Medicaid.

Q: If Alabama Medicaid is secondary to a commercial insurance, would the claim be accepted without an enrolled ordering, prescribing, or referring provider requirement?

A: No, the enrollment requirement also applies if Medicaid is being billed as the secondary to a commercial insurance.

Q: Do Medicare crossover claims require the ordering, prescribing, or referring provider to be enrolled?

A: No, for claims that crossover directly from Medicare to Medicaid. These claims are identified with as region 30 - COBA crossover claims. When Medicare implements their edits, then Medicaid will require the region 30 claims to comply. All other Medicare/Medicaid related claims will require the provider be enrolled.

Q: How do we know the NPI of the physician or licensed health care provider who wrote the prescription or order?

A: Any prescribing physician or licensed health care provider must include his or her NPI on any prescription/order he or she writes, to allow the provider filling the prescription/order to submit their claim.

# A L E R T

December 11, 2012

RE: Claims for Non-Enrolled OPR Providers to Deny Effective January 1, 2013

Q: I have the provider's NPI, but how can I tell if he or she is enrolled with Alabama Medicaid?

A: For pharmacies filling a prescription for medication, simply bill the claim with the NPI of the prescriber. If the prescriber is not enrolled with Medicaid, you will receive a claim rejection that informs you of the prescriber's status.

For all other providers, the Medicaid Agency is enhancing the Provider web portal to add functionality to look this information up. This functionality should be available early 2013. Until it is available, you may call the Provider Assistance Center at 1-800-688-7989.

Providers of services that are ordered or prescribed (such as a laboratory or radiology facility, a pharmacy, or a medical supply company) will always need the NPI of an ordering or prescribing practitioner in order to submit their claims for payment to the Medicaid program.

NOTE: If you render services or provide medical supplies in response to a provider's order, prescription, or referral, this requirement may affect your reimbursement.

Medicaid cannot pay for any health care service requiring a referral, order, or prescription from a physician or other licensed health care professional unless the ordering, referring, or prescribing provider has a current enrollment record on file in Medicaid's system.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the December 31, 2012 deadline.

cc: Provider Associations

**A L E R T**

December 14, 2012

TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes.

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

1. No longer cover benzodiazepines and barbiturates for Medicare Part D recipients. *However, these products will remain covered for non dual-eligible recipients.* Barbiturates (when used in the treatment of epilepsy, cancer, or a chronic mental disorder) and benzodiazepines will no longer be optional coverage classes for Medicare Part D.
2. Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates. The updates are listed below:

| PDL Additions                      |  |
|------------------------------------|--|
| None                               |  |
| PDL Deletions*                     |  |
| <b>DermaSmoothe FS<sup>‡</sup></b> | Skin and Mucous Membrane Agents/Anti-inflammatory Agents |

\* Denotes that these brands/generics will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA).

<sup>‡</sup>Covered generic equivalents (unless otherwise specified) will remain preferred.

For additional PDL and coverage information, visit our drug look-up site at

<https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210 Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

December 20, 2012

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.

**PSYCHIATRIC SERVICES 2012 TO 2013 CROSSWALK**

**For Psychology Providers**

| 2012   |              |             | 2013                               |          |   |
|--|--------------|-------------|------------------------------------|----------|---|
| Service  | CPT Code     | 2013 Status | Service                            | CPT Code | Report with interactive complexity (+90785) |
| <b>Diagnostic</b>                              |              |             |                                    |          |   |
| 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    |   |
| <b>Psychotherapy</b>                           |              |             |                                    |          |   |
| 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    |   |

\*\*\*Code 90792 will not be a covered service for psychologists\*\*\*

**For Rehabilitation Option Providers**

| 2012                 |          |             | 2013                               |          |   |
|----------------------|----------|-------------|------------------------------------|----------|---|
| Service              | CPT Code | 2013 Status | Service                            | CPT Code | Report with interactive complexity (+90785) |
| <b>Diagnostic</b>    |          |             |                                    |          |   |
| Diagnostic Interview | 90801    | DELETED     | Diagnostic evaluation (no medical) | 90791    | When appropriate                            |

|                                       |       |         |                                    |       |                  |
|---------------------------------------|-------|---------|------------------------------------|-------|------------------|
| Examination                           |       |         | Diagnostic evaluation with medical | 90792 |                  |
| Individual psychotherapy<br>20-30 min | 90804 | DELETED | Psychotherapy<br>30 (16-37*) min   | 90832 | When appropriate |
|                                       |       |         | 45 (38-52*) min                    | 90834 |                  |
|                                       |       |         | 60 (53+*) min                      | 90837 |                  |

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

\* = Per CPT Time Rule

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

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.

# A L E R T

February 11, 2013

**TO: Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, FQHCs, PBRHCs IRHCs, Health Departments, Hospitals, and Provider Associations**

**RE: Coding Changes for Injection, Medroxyprogesterone Acetate**

Effective December 31, 2012, CPT<sup>®</sup> procedure codes J1051 and J1055 for billing medroxyprogesterone acetate injections were deleted. Effective for dates of service January 1, 2013, CPT<sup>®</sup> procedure code **J1050**, Injection, medroxyprogesterone acetate, **1 mg**, must be used with a required modifier for all claims. **J1050** replaces the following codes:

**J1051** – Injection, medroxyprogesterone acetate, 50 mg\*

**J1055** - Injection, medroxyprogesterone acetate for contraceptive use, 150 mg\*

**\*NOTE: J1051 and J1055 will continue to be used for dates of service prior to January 1, 2013.**

### **Billing Instructions:**

Procedure code **J1050** will require the use of a modifier in order for Medicaid to identify when the injection is for contraceptive use versus non-contraceptive use.

**1. For contraceptive use:**

**J1050** with modifier **FP** and include a contraceptive management diagnosis code

**2. For non-contraceptive use :**

**J1050** with modifier **U1**

### **Restrictions:**

**J1050-FP** will be limited to female recipients 10 to 55 years of age

**J1050-FP** is limited to no less than 104 mg and no more than 150 mg per injection

**J1050-FP** injection will be allowed once every 70 days

**J1050-FP** must use a contraceptive management diagnosis code

**J1050-U1** is covered for recipients of all ages

**J1050-U1** is limited to 1000 mg per injection

**J1050-U1** does not have a limitation other than the maximum units allowed per injection

**J1050-U1** cannot use a contraceptive management diagnosis code

### **Reimbursement Amount:**

The reimbursement rate for **J1050** is **\$0.20 per unit (1mg)**.

Since the code description is based on 1mg, providers should bill the applicable units based on the 1mg.

Examples:

- A medroxyprogesterone acetate injection was given for 150 mg for contraceptive use. The provider would bill J1050-FP for 150 units and use a contraceptive management diagnosis code.
- A medroxyprogesterone acetate injection was given for 500 mg for non-contraceptive use. The provider would bill J1050-U1 for 500 units.

**Claims for J1050 billed without a modifier will be denied for the modifier requirement.**

For questions, contact Sylisa Lee-Jackson at (334) 353-4599 or [sylisa.lee-jackson@medicaid.alabama.gov](mailto:sylisa.lee-jackson@medicaid.alabama.gov) or call the Provider Assistance Center at 800-688-7989.

# A L E R T

**February 13, 2013**

**TO: All Medicaid Eye Care Providers**

**RE: Program Changes for Eye Exams and Eyeglasses**

Due to budget constraints, the Alabama Medicaid Agency will implement changes to the Eye Care Program benefit limits which will be effective **March 1, 2013**:

- Limit adults age 21 years and older to one routine eye exam every three years (now once every two years)
- Limit adults age 21 years and older to one pair of eyeglasses every three years (now one pair every two years)

The changes will only be for services provided to adults. There will be no changes for children.

This information is also available on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) under Programs/Medical Services/Ancillary Services/Eye Care Services.

Questions about these changes should be directed to Jacquelyn King, [Jacquelyn.king@medicaid.alabama.gov](mailto:Jacquelyn.king@medicaid.alabama.gov), or by telephone at (334) 353-5407.

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# A L E R T

March 5, 2013

TO: All Physician Providers (provider type 31)

RE: Primary Care Physician Rate Increase ("Bump")

A major provision of the Affordable Care Act (ACA) requires Alabama Medicaid reimburse certain **primary care physicians** at parity with Medicare for services provided between January 1, 2013 and December 31, 2014.

## COVERED SERVICES:

Services eligible for an enhanced payment fall into two categories:

- Primary care services
- Vaccine administration service under the VFC program

Primary care services subject to the enhanced payment are Current Procedural Terminology (CPT) Evaluation and Management procedure codes 99201 to 99499.

Vaccine administration services under the VFC program 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, 90718\*, 90721, 90723, 90732, 90733, 90734, 90744, and 90748. The Alabama Medicaid Agency requires the VFC administration codes to be billed using the specific product code (vaccine codes). \*CPT deleted 90718 effective 12/31/2012; however, this code would still be used in calculating the 60% threshold for CY 2012.

## ELIGIBLE PROVIDERS:

Under the federal regulations, the physicians qualify for the enhanced rate if:

- They have a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA) and they actually practice in these areas.
- They are **not** board certified but are practicing in the fields of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, **and** 60% of their paid Medicaid procedures billed are for evaluation and management codes 99201 through 99499 and VFC administration services.
- **NOTE: To calculate your percentage, divide the total volume of E&M code and vaccine administration codes paid by Medicaid by the total volume of all codes paid by Medicaid. This calculation must be done for each eligible physician individually and not as a group practice. Although urinalyses, EKGs, and antibiotic administrations, are commonly provided by primary care physicians, CMS did not include them as primary care services in the numerator when calculating the 60% threshold for the enhanced primary care fee eligibility. Therefore, paid billed codes for ancillary services such as labs, x-rays, injections will cause the percentage threshold to be less.**

# A L E R T

**SELF-ATTESTATION:**

Eligible providers must complete the Alabama Medicaid Certification and Attestation for Primary Care Rate Increase Form and submit to HP Enterprise Services (Medicaid's fiscal agent) for each service location. A copy of the board certification must be submitted with each completed attestation form. If a copy of the board certification is not available, a copy of the website verification is acceptable. The self-attestation form is available for download at:

[http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.6\\_Provider\\_Enrollment/Fillable\\_Forms/5.4.6\\_Ala\\_Med\\_Cert\\_Attest\\_Primary\\_Care\\_Rate\\_Increase\\_2-1-13.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment/Fillable_Forms/5.4.6_Ala_Med_Cert_Attest_Primary_Care_Rate_Increase_2-1-13.pdf)

Qualifying physicians who submit their self-attestation to **HPES by March 29, 2013**, will be paid the enhanced reimbursement **retroactive to January 1, 2013**.

Qualifying physicians who submit their self-attestation to HPES **on or after April 1, 2013**, will be paid the enhanced reimbursement **for dates of service beginning with the date the attestation** is entered into the system by HPES.

Qualification for the payment increase will end the earliest of either December 31, 2014, or the expiration date of the board certification. Therefore, physicians whose board certifications expire during the CY 2013 or 2014 must reattest for the program. Services provided during any lapses in time between board-certification expiration and reattestation will not be eligible for the rate increase.

If the board certification is rescinded by the certifying board, the provider must notify HPES within 10 days. Qualification for the payment increase will end on the date the certification was rescinded by the certifying board.

At the end of each year, the Alabama Medicaid Agency must review a statistically valid sample of physicians who received the higher payments to verify that they met the requirements. Services retroactively found ineligible for the enhanced payment will be subject to recoupment.

**NON-PHYSICIAN PRACTITIONERS:**

Covered services provided by non-physician practitioners are eligible for enhanced payment when 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.

Eligible non-physician practitioners include:

- Physician Assistants
- Nurse Practitioners

# A L E R T

**GROUP PROVIDERS:**

Eligibility for enhanced reimbursement is based on **EACH** individual physician meeting the eligibility criteria.

**EXCLUDED PROVIDERS:**

Physicians are not eligible for enhanced rates when delivering services under one of the following:

- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Health Departments (ADPH)

Physician specialist certified in areas other than the three specified in the ACA are **not** eligible for the increased payments even if they otherwise meet the 60% procedure code threshold. Physicians in these categories (for example: ER doctors and OB/GYN) should **NOT** attest.

CMS rules implementing the ACA specifically exclude independently practicing nurse practitioners from the enhanced payment.

**RATE METHODOLOGY:**

The Alabama Medicaid Agency will reimburse the lesser of the following:

- The provider's submitted charge
- The enhanced fee schedule rate

**FEE SCHEDULES:**

The enhanced rate is determined by comparing the 2013 Medicare Rate established by CMS to the 2009 Alabama Medicaid rate. The higher rate will establish the rate of payment for that code. A separate fee schedule of the enhanced rates will be made available in the near future under the Provider information heading on the Alabama Medicaid Agency website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

The enhanced reimbursement rate for the VFC administration service (for each of the codes listed above under covered services) is **\$19.79**.

**WHEN WILL PROVIDERS SEE THE ENHANCED PAYMENTS:**

Federal regulations were not issued to the states in time to implement the pay increase on January 1, 2013. For a limited period of time after January 1, 2013, claims will be paid at the regular Medicaid rates. CMS will not allow enhanced payments to be made until the State Plan Amendment (SPA) is approved and attestation forms are received and processed by HPES.

To ensure that payments can be made to qualifying physicians as soon as possible, the Alabama Medicaid Agency has taken the following steps:

- 1) Submitted the Tribal Letter Notification,
- 2) Published the Public Notice Letter,
- 3) Submitted the required SPA to CMS in January, the earliest states could submit a SPA,
- 4) Submitted the Change Order for system changes (Medicaid and HPES are working together to make the computer system changes needed to process the payments)

# A L E R T

- 5) Developed a process for the self-attestation, and
- 6) Mailed a letter to all physicians who are currently enrolled with a primary care specialty or subspecialty designation.

Medicaid cannot make enhanced payments until all three of the following criteria are met:

- The Centers for Medicare and Medicaid Services (CMS) approves the State Plan Amendment (SPA).
- Medicaid implements the required system changes needed to process claims at the higher payment rate.
- Eligible physicians return the self-attestation form (along with a copy of the board certification/ website verification if applicable).
- They complete a self-attestation form to meeting the requirements above.

**Once all these requirements are in place, eligible services with dates of services starting January 1, 2013, will be retroactively adjusted for enhanced payments.**

The Alabama Medicaid Agency is working as quickly as possible to finalize a primary rate increase and will keep providers informed of the process and timeline.

# A L E R T

May 16, 2013

**TO:** Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers, Nursing Homes, Hospitals, and Provider Associations

**RE: DEA Edits Effective Date Extended to July 8, 2013**

The effective date for implementing the DEA Edits has been extended from May 13, 2013, to **July 8, 2013**.

Effective July 8, 2013, Alabama Medicaid will DENY any claim for a controlled drug written by a prescriber who does not have their Drug Enforcement Administration (DEA) number registered with the Department of Justice (DOJ) and on file at Medicaid. These edits are designed to prevent controlled substances from being filled when the prescription is written by an unauthorized prescriber. The following edits have been in place since November 2012 and are currently displaying as informational on the provider's remittance advice:

| <u>Edit</u> | <u>Description</u>                               |
|-------------|--|
| 1038        | DEA NOT ON FILE FOR PRESCRIBER                   |
| 1039        | PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED |
| 1040        | PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE     |

## 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. **Medicaid deadline for submission: June 21, 2013.**

To confirm if your DEA number is appropriately registered with the DOJ, and to ensure your correct address/contact information is registered with the DOJ, you may go to the DEA website at:

<https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp>

Prescribers of controlled substances are mandated to re-register their DEA license every three years.

To ensure your DEA is on file at Medicaid, fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate. Medicaid will apply the DEA to all service locations based on the provider's NPI and license number. **The DEA information should be received by Provider Enrollment prior to June 21, 2013.** This deadline will allow Provider Enrollment time to enter the information in the provider's file before the July 8, 2013, implementation date.

**Pharmacies** – If you are receiving the informational edits, contact the provider who ordered the prescription and advise them to fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate.

## Why is Medicaid implementing these changes?

In September 2009, the Government Accountability Office (GAO) issued the report "Medicaid Fraud and Abuse Related to Controlled Substances Identified in Selected States" which highlighted fraudulent, improper, or abusive actions in prescribing and dispensing of controlled substances. One of the report's primary recommendations was that states should use the Drug Enforcement Administration (DEA) Controlled Substance Registration file as part of their Medicaid claims processing efforts to prevent paying for controlled substances ordered by unauthorized prescribers.

**Prescribers: Please take a moment to validate your DEA number information.** Medicaid encourages all providers to be proactive and ensure the DEA number of the prescribing provider is registered with the Department of Justice (DOJ) and on file at Medicaid prior to June 21, 2013.

*NOTE: The claims which are currently paying and posting one of the informational edits above, will deny effective July 8, 2013.*

# A L E R T

**Update: Dental Prior Authorization and Use of Dental Mailbox**

May 17, 2013

**TO: All Dental Providers**

**SUBJECT: Dental Prior Authorization (PA) Requests:**

**Effective: June 15, 2013**

All Dental PA requests must be submitted on a Prior Review and Authorization Dental Request Form (Form 343). All sections of the form must be completed. If the form is not completed in its entirety or if the PA request is submitted on any other form, the request will be denied.

The form and the required documents should be forwarded to HPES, P.O. Box 244032, Montgomery, AL 36124-4032 or faxed to HPES at 1-334-215-4272.

For Emergency PA requests, contact HPES at 1-334-215-4144.

**Documents Required with PA Requests:**

- Radiographs are required with PA requests for procedure codes D7240 and D7241. A report by tooth number of actual unusual surgical complication(s) is also required for procedure code D7241.
- Radiographs and medical documentation (clinical notes) are required with PA requests for D3410 and D3430.
- Radiographs are required with PA requests for CDT codes D1515, D1510, and D4355.
- Complete periodontal charting, posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs are required with PA requests for D4341 and D4910.
- Medical documentation (clinical notes) is required with PA requests for CDT codes: D7970, D9420, D9610, and D9612.
- Radiographs, operative notes, and a completed ADA Dental claim form indicating procedures performed in the hospital setting are required with PA requests for hospital updates.

# A L E R T

**If required documents are not received with the PA request, the PA will be denied.**

**Use of Dental Mailbox:**

In order to comply with HIPAA regulations, providers using the Dental Mailbox to submit x-rays or other documents must do so by encrypted e-mail. To obtain an encrypted e-mail password, please contact HPES at 334-215-4144 or Medicaid's Dental Program at 1-334-242-5472.

# A L E R T

May 23, 2013

**TO: All Providers**

**RE: Co-Payment Changes for Medicaid Services**

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):

| Services with Co-payments  | Co-payment Amounts                     | Based on Medicaid's Allowed Amount for the Services  |
|--|--|--|
| Office Visits ( <i>including visits to physicians, optometrists, nurse practitioners</i> ) | \$1.30 to \$3.90 per office visit code | \$50.01 or more - \$3.90<br>\$25.01 - \$50.00 - \$2.60<br>\$10.01 - \$25.00 - \$1.30                             |
| Federally Qualified Health Centers (FQHC)  | \$3.90 per encounter                   |  |
| Rural Health Clinic (RHC)  | \$3.90 per encounter                   |  |
| Inpatient Hospital   | \$50.00 per admission                  |  |
| Outpatient Hospital  | \$3.90 per visit                       |  |
| Ambulatory Surgical Centers  | \$3.90 per visit                       |  |
| Durable Medical Equipment  | \$1.30 to \$3.90 per item              | \$50.01 or more - \$3.90<br>\$25.01 - \$50.00 - \$2.60<br>\$10.01 - \$25.00 - \$1.30                             |
| Medical Supplies and Appliances  | \$0.65 to \$3.90 per item              | \$50.01 or more - \$3.90<br>\$25.01 - \$50.00 - \$2.60<br>\$10.01 - \$25.00 - \$1.30<br>\$10.00 or less - \$0.65 |
| Prescription Drugs   | \$0.65 to \$3.90 per prescription      | \$50.01 or more - \$3.90<br>\$25.01 - \$50.00 - \$2.60<br>\$10.01 - \$25.00 - \$1.30<br>\$10.00 or less - \$0.65 |

Co-payment does **not** apply to services provided to/for:

- Pregnant women
- Nursing facility residents
- Recipients less than 18 years of age
- Native American Indians with an active user letter from Indian Health Services (IHS)
- Emergencies
- 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.***

# A L E R T

June 1, 2013

**TO: All Maternity Care Primary Contractors**

**RE: Reimbursement Changes**

Due to budget constraints, the Alabama Medicaid Agency will implement up to a 5 percent reduction in payment of global fee for deliveries to Medicaid Maternity Care Program Primary Contractors effective July 1, 2013. No Contractor reimbursement will be reduced beyond the current lowest bid for the Maternity Care Program. This reduction will be effective for dates of deliveries July 1, 2013 to September 30, 2014.

For questions regarding this change, please contact Sylisa Lee-Jackson, Associate Director of the Maternity Care and Family Planning/Plan First Programs at (334) 353-4599 or [Sylisa.lee-jackson@medicaid.alabama.gov](mailto:Sylisa.lee-jackson@medicaid.alabama.gov).

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# A L E R T

June 7, 2013

**TO: Pharmacies, Physicians, Physician Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes**

**RE: Pharmacy/Preferred Drug Program Updates**

**Effective July 1, 2013**, the Alabama Medicaid Agency will:

**1. Make changes to its current policy regarding compound prescriptions and reimbursement for bulk products (i.e., powders) used in compounded prescriptions.**

The changes are outlined below:

- Bulk products will no longer be covered for adults age 21 and older (some exceptions may apply). Selected medically necessary bulk products will remain covered for children.
- Claims for bulk powders must be submitted as a compound claim.
- Compounding time will no longer be reimbursed by Alabama Medicaid.
- The maximum payable amount for a compounded product will be \$200 per claim. Overrides for medical necessity may be approved. Requests for overrides should be submitted to Health Information Designs, Inc. (HID).

For information regarding compound claims and bulk powders, see section 27.2.5 of the Alabama Medicaid Provider Manual at

[http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.7\\_Manuals/6.7.7\\_Provider\\_Manuals\\_2013/6.7.7\\_Provider\\_Manuals\\_2013.aspx](http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7_Provider_Manuals_2013.aspx)

- 2. No longer require prior authorization (PA) for payment of generic lansoprazole.** Brand name Prevacid will continue to require prior authorization (PA).
- 3. Require prior authorization for payment of generic azelastine nasal spray.** Brand name Astelin will be preferred and available with no PA necessary.
- Use Dispense as Written (DAW) Code of 9 for brand Astelin. Generic versions of the drug will be non-preferred and will require prior authorization. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.

**A L E R T**

4. **Update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee's recommendations as well as quarterly updates.** The updates are listed below:

| <b>PDL Additions</b>    |                                       |
|-------------------------|---------------------------------------|
| <b>Astelin</b>          | EENT Preparations/Antiallergic Agents |
| <b>PDL Deletions</b>    |                                       |
| <b>Astepro</b>          | EENT Preparations/Antiallergic Agents |
| <b>Maxair Autohaler</b> | Respiratory/Beta-Adrenergic Agents    |
| <b>Pegasys</b>          | Anti-infective Agents/Interferons     |

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

**Health Information Designs (HID)  
Medicaid Pharmacy Administrative Services  
P. O. Box 3210  
Auburn, AL 36832-3210  
Fax: 1-800-748-0116  
Phone: 1-800-748-0130**

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.

# A L E R T

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**A L E R T**

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For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

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Medicaid Pharmacy Administrative Services  
P. O. Box 3210  
Auburn, AL 36832-3210  
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Phone: 1-800-748-0130**

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# **ALABAMA MEDICAID**

## **July 2013 Provider Manual**

### **Payment Delay Alerts**



Click on Bookmarks to the left to view Alerts

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**Attention: All Provider Associations**

**March 5, 2004 - Checkwrite Release for Nursing Home and Maternity Care Providers**

**March 19, 2004 - Checkwrite for All Providers**

**Medicaid funds for the nursing home and maternity care providers for the March 5, 2004 checkwrite will be released on April 6, 2004. Please verify direct deposit status with your bank. As of April 6, 2004, all funds for the March 5, 2004 checkwrite will be released.**

**As funds for the March 19, 2004 checkwrite are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at *[www.medicaid.state.al.us](http://www.medicaid.state.al.us)*.**

April 2, 2004

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## **Attention: All Provider Associations**

March 19, 2004 - Checkwrite for Nursing Homes and Maternity Care Providers

Funds for the nursing home and maternity care providers for the March 19, 2004 checkwrite will be released on April 8, 2004. Please verify direct deposit status with your bank.

As funds for other providers are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

April 7, 2004

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## **Attention: All Provider Associations**

March 19, 2004 - Checkwrite Release

April 09, 2004 - Checkwrite Release for Pharmacy Providers

Medicaid funds for the remainder of the March 19, 2004 checkwrite will be released on April 15, 2004. All funds from the March 19, 2004 checkwrite will now be released. Please verify direct deposit status with your bank.

Medicaid funds for the Pharmacy providers for the April 09, 2004 checkwrite will be released on April 15, 2004. As funds for other providers are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at *[www.medicaid.state.al.us](http://www.medicaid.state.al.us)*.

April 13, 2004

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**Attention: All Provider Associations**

**April 9, 2004 - Checkwrite Release for Non-Institutional and Nursing Home Providers**

**Medicaid funds for the Non-institutional and nursing home providers for the April 9, 2004 checkwrite will be released on April 22, 2004. Please verify direct deposit status with your bank.**

**As funds for hospitals and maternity care providers are released, Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).**

April 20, 2004

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**Attention: All Provider Associations**

May 7, 2004, Release of Funds

Medicaid funds for the May 7, 2004, checkwrite will be released on time (May 13, 2004).

Please verify direct deposit status with your bank.

May 11, 2004

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**Attention: All Provider Associations**

May 21, 2004, Release of Funds

Medicaid funds for the May 21, 2004, checkwrite will be released on time (May 27, 2004).

Please verify direct deposit status with your bank.

May 24, 2004

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**Attention: All Provider Associations**

ATTENTION: All Provider Associations

June 4, 2004, Release of Funds

Medicaid funds for the June 4, 2004, checkwrite will be released on time (midnight June 10, 2004).

Please verify direct deposit status with your bank.

June 8, 2004

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## **Attention: All Provider Associations**

The total Medicaid funds for the June 18, 2004 checkwrite will not be released on schedule. The funds for the Pharmacy and Maternity Care providers will be released on June 24, 2004.

Funds for all other providers will not be released. Medicaid's website will be updated with the actual release date. The Alabama Medicaid website may be accessed at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

Please verify direct deposit status with your bank.

June 22, 2004

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**Attention: All Provider Associations**

**June 18, 2004 - Release of Funds**

Medicaid funds for the remainder of the June 18, 2004 checkwrite will be released on July 7, 2004. All funds from the June 18, 2004 checkwrite will now be released. Please verify direct deposit status with your bank.

July 6, 2004

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**Attention: All Provider Associations**

**July 9, 2004 - Release of Funds**

Medicaid funds for the July 9, 2004 checkwrite will be released on time (July 15, 2004). Please verify direct deposit status with your bank.

July 12, 2004

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**Attention: All Provider Associations**

**July 23, 2004 - Release of Funds**

Medicaid funds for the July 23, 2004 checkwrite will be released on time (July 29, 2004). Please verify direct deposit status with your bank.

July 26, 2004

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**Attention: All Provider Associations**

**August 6, 2004 - Release of Funds**

Medicaid funds for the August 6, 2004 checkwrite will be released on time, August 12, 2004. Please verify direct deposit status with your bank.

August 9, 2004

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**Attention: All Provider Associations**

**August 20, 2004 - Release of Funds**

Medicaid funds for the August 20, 2004 checkwrite will be released on time, August 26, 2004. Please verify direct deposit status with your bank.

August 24, 2004

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## **Attention: All Provider Associations**

September 3, 2004, Release of Funds

The total Medicaid funds for the September 3, 2004 checkwrite will not be released on schedule. Funds for all providers, EXCEPT Hospitals and Nursing Homes, will be released on Friday, September 10, 2004.

Funds for the Hospital and Nursing Home Providers will not be released. Medicaid's website will be updated with the actual release date. The Alabama Medicaid website may be accessed at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

Please verify direct deposit status with your bank.

September 9, 2004

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**Attention: All Provider Associations**

September 3, 2004, Release of Funds--Hospitals and Nursing Home Providers

Medicaid funds for the September 3, 2004, checkwrite for Hospitals and Nursing Homes will be released on Monday, September 13, 2004.

Please verify direct deposit status with your bank.

September 10, 2004

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## **Attention: All Provider Associations**

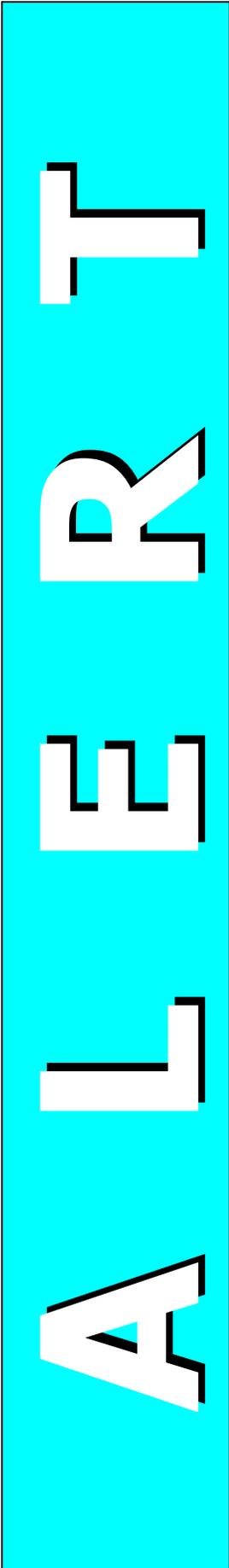
September 10, 2004, Release of Funds

The total Medicaid funds for the September 10, 2004 checkwrite will not be released on schedule. Funds for all providers, EXCEPT Pharmacies and Nursing Homes, will be released on Thursday, September 16, 2004.

Funds for the Pharmacies and Nursing Home Providers will not be released. Medicaid's website will be updated with the actual release date. The Alabama Medicaid website may be accessed at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

Please verify direct deposit status with your bank.

September 14, 2004



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## **Attention: All Provider Associations**

### **January 28, 2005: EDS Medicaid System Downtime**

EDS will be performing maintenance on its translator software from approximately 2 pm - 5 pm CT on Sunday January 30, 2005. The translator software is one of the first stages in the claims submission (837), eligibility verification (270) via X.25 line, batch web eligibility verification (270), batch web claim status (276) and web prior authorization (278) processes on the EDS system. What this means is that none of these transactions will be processed during the maintenance window. Please be advised that if any of these transactions are submitted via the web for batch processing during this timeframe they will not be processed until the translator maintenance is completed. Interactive eligibility (270) and interactive claim status (276) submitted via X.25 mode will be down during this time.

This will not impact eligibility verification via AVRS, web interactive eligibility (270), web claim status (276) or interactive pharmacy claim submission. If you have questions please call the ECS helpdesk at 1-800-456-1242.

January 28, 2005

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**Attention: Alabama Hospital Association**

03/18/05 - Checkwrite Release for Hospital Providers

Medicaid funds for the hospital providers for the 03/18/05 checkwrite will NOT be released on time. Medicaid's web site will be updated with the actual release date. Medicaid's web site may be accessed at [www.medicaid.state.al.us](http://www.medicaid.state.al.us).

March 23, 2005

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**Attention: Alabama Hospital Association**

**03/18/05 - Checkwrite Release for Hospitals**

**Medicaid funds for the hospital providers for the 03/18/05 checkwrite will be released on 03/29/05.**

March 28, 2005

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**To: Provider Associations**

Monthly Case Management Payments Delayed

Due to a systems problem, the Monthly Case Management payments were not processed on the May 11, 2007 financial cycle. The problem will be corrected and payments will be processed on the May 25, 2007 financial cycle.

May 15, 2007

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**To: Nursing Home Providers**

**RE: Payment Delay**

The payments scheduled for the September 5 and September 12, 2008 **checkwrites** have been delayed. The process to release the payments for the September checkwrites will begin October 1, and the payments should be accessible on October 3, 2008.

Additional questions concerning the delayed payments should be directed to the Medicaid office at 334-242-5600, or to the Nursing Home Association at 334-271-6214.

September 11, 2008

# A L E R T

April 5, 2011

**Attention: All Providers**

**RE: Extended Maintenance Window for the Alabama Medicaid System**

**Time Frame:** Beginning April 9, 2011 at 10:00 PM Central until April 10, 2011 at 10:00 AM Central.

**Impact:** All Alabama MMIS services will be unavailable.

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# A L E R T

November 8, 2011

**ATTENTION: ALL PROVIDERS, VENDORS, AND PROVIDER ASSOCIATIONS**

**RE: TOTAL SYSTEM OUTAGE EXPECTED**

**WHEN: FRIDAY, NOVEMBER 11, 2011 BEGINNING AT 9:00 P.M. CENTRAL TIME  
TO  
MONDAY, NOVEMBER 14, 2011 AT 6:00 A.M. CENTRAL TIME**

Alabama Medicaid will install updates to support 5010 and NCPDP D.0 transactions over the Veterans Day weekend as part of overall system upgrades.

Due to this upgrade, the system will not be available between 9:00 p.m., Friday, November 11, 2011 and at least 6:00 a.m., Monday, November 14, 2011. During this time, there will be no claims and eligibility processing or system access by any method. Submissions will not be available via batch, interactive, PES or web portal, and AVRS will be down.

The electronic media claims (EMC) helpdesk telephone line will provide updates throughout the weekend at 1-800-456-1242. The message will be updated as soon as the system is available.

Once complete, the following will be available:

- Transactions can be submitted as x12 4010 or x12 5010 / NCPDP 5.1, or NCPDP D.0.
- PES will support one version depending on your PES release. PES 2.16 will support 4010 until PES 3.0 is released. PES 3.0 will support 5010 transactions. You will be notified when PES 3.0 is released.
- Web portal direct data entry will reflect changes for x12 5010 and NCPDP D.0.
- AVRS will be operational.
- Remittance advice (835) will be available in both x12 4010 and x12 5010.
- Other responses will be returned in the same version as received.

Medicaid will continue to accept both x12 4010 and x12 5010 and both NCPDP 5.1 and NCPDP D.0 through December 2011.

Beginning January 1, 2012, only x12 5010 and NCPDP D.0 will be processed.

For updated information, please continue to visit the Medicaid website:

[http://www.medicaid.alabama.gov/content/6.0\\_providers/6.5\\_hipaa\\_5010.aspx](http://www.medicaid.alabama.gov/content/6.0_providers/6.5_hipaa_5010.aspx)

Thank you for your patience as we transition to 5010 and NCPDP D.0.

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# A L E R T

November 22, 2011

**Attention: All Providers**

**RE: 11/18/11 Checkwrite Release**

The payments scheduled for the November 18, 2011 **checkwrite** will be released on Wednesday, November 30, 2011.

As always, the release of payments depends on the availability of funds.

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# A L E R T

January 12, 2012

**Attention: All Providers**

**RE: 01/06/12 Checkwrite Release**

Due to the holiday on Monday, January 16, 2012, Medicaid will release the payments for the January 6, 2012 checkwrite on Friday, January 13, 2012.

Please verify direct deposit status with your bank.

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