Alabama Medicaid Management Information System Provider Manual July 2013

Alabama Medicaid Provider Manual Distribution Change

Effective January 1, 2009, the Provider Manual will be duplicated and distributed on a yearly basis.

The Provider Manual will continue to be updated quarterly and posted on the Medicaid website at www.medicaid.alabama.gov.

Alabama Medicaid Provider Number

Any reference to the nine-digit provider number should be replaced with the following:

"Prior to February 25, 2008, providers were assigned a nine-digit Alabama Medicaid provider number for each service location.

Effective February 25, 2008, newly enrolled providers are assigned a variable length Alabama Medicaid provider number for each service location. The length ranges from a six-digit to a nine-digit number. The Alabama Medicaid provider number assigned is provided on the notification letter sent to the provider along with the National Provider Identifier (NPI) number.

The Alabama Medicaid provider number assigned should be submitted as the secondary identifier when filing claims for a specific service location."

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Bookmark Usage Instructions

Bookmarks are used for easy navigation throughout the Alabama Medicaid Provider Manual. These bookmarks are located on a palette on the left side of your screen. To jump to a topic using its bookmark, click the bookmark icon or text in the palette that represents that topic.

Bookmarks can be subordinate to other bookmarks in their hierarchy; a higher level bookmark in this relationship is the parent, and a lower level bookmark is the child.

You can collapse a parent bookmark to hide all its children. When a parent bookmark is collapsed, it has a plus sign (+) next to it. If the bookmark you want to click is hidden in a collapsed parent, click the plus sign (+) next to the parent to show it.

Quarterly Revision July 2013

This table contains a listing of pages containing changes made to the *Alabama Medicaid Provider Manual.* This version replaces the entire manual.

To update your paper copy of the manual, replace the entire manual.

Changes have been tracked throughout the provider manual and noted in the margins. Additions are easily identified by underlines and deletions by a ~~strikethrough~~.

To request additional copies of the *Alabama Medicaid Provider Manual*, contact the HP Provider Assistance Center by calling 1(800) 688-7989.

You can also go to http://www.medicaid.alabama.gov to download a complete, updated, electronic version of the *Alabama Medicaid Provider Manual* from Medicaid's web site.

Find out more about the online version of the *Alabama Medicaid Provider Manual* in Chapter 1, Section 1.2, Using the Online Version of the Manual.

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1 Introduction

Thank you for your participation in the Alabama Title XIX Medicaid Program. The *Alabama Medicaid Provider Manual* has been developed to assist you in receiving reimbursement for providing medically necessary services to eligible Medicaid recipients living in the state of Alabama.

Please note this manual is not a legal description of all aspects of the Medicaid law. It is a practical guide for providers who participate in the Medicaid Program. Should there be a conflict between material in this manual and pertinent laws or *Alabama Medicaid Administrative Code* provisions governing this program, the latter are controlling.

The Alabama Medicaid Agency is the single state agency responsible for the administration of the Alabama Title XIX Medicaid program. The Alabama Medicaid Agency has contracted with HP to be the fiscal agent for the Medicaid program. Medicaid and HP developed this manual for Medicaid providers. HP is responsible for maintaining and distributing the manuals to the Alabama Medicaid provider community.

The HP Provider Relations Department is composed of field representatives who are committed to assisting Alabama Medicaid providers in the submission of claims and the resolution of claims processing concerns. If you have any comments or suggestions for improving this manual, please contact HP Provider Relations at the following address:

HP Provider Relations
P.O. Box 241685
Montgomery, AL 36124-1685
1 (800) 688-7989
e-mail: provrelations@alxix.slg.hp.com

This chapter describes how the manual is organized, how to access and use the online version of the manual, and the method for distributing and documenting changes to the manual.

1.1 How to Use this Manual

This section describes the organization of the *Alabama Medicaid Provider Manual* and provides tips for using the manual to resolve billing and eligibility-related questions.

1.1.1 Manual Organization

The *Alabama Medicaid Provider Manual* is divided into three parts:

Part I – Provider Information

The information in Part I is intended for all health care providers who are enrolled in the Alabama Medicaid Program and who provide services to Medicaid recipients. Specifically, Part I addresses the following:

- *Introduction*, which describes the purpose and organization of the manual
- *Becoming a Medicaid Provider*, which briefly describes the enrollment process required for participation in the Alabama Medicaid program
- *Verifying Recipient Eligibility*, which describes how to determine whether a recipient is eligible to receive Medicaid benefits, and how to interpret the eligibility verification response received through the Provider Electronic Solutions software or Automated Voice Response System (AVRS)
- *Obtaining Prior Authorization,* which describes how to submit a request for services requiring prior authorization
- *Filing Claims*, which informs providers how to correctly complete a claim form for submission to Medicaid
- *Receiving Reimbursement*, which describes the Remittance Advice (RA) statement, a report that lists claim and payment activity for a provider
- *Understanding Your Rights and Responsibilities as a Provider*, which describes fair hearings, utilization review, maintaining provider records, and other information regarding provider rights and responsibilities

Part II – Alabama Medicaid Services

Part II provides enrollment, billing, and reimbursement information specific to each program type identified by the Alabama Medicaid Agency. Each chapter within Part II describes a different program.

Providers who are unaccustomed to general billing or reimbursement requirements should refer to Part I before using the information in Part II.

Part III – Appendices

Part III contains referential information important to all providers, including the following:

- Guidelines for billing EPSDT, family planning, and managed care claims
- Samples of forms used by Alabama Medicaid providers
- Lists of codes and other data useful for providers

1.1.2 Tips for Using the Manual

This section provides information that can enhance your ability to quickly locate information in the manual. To make the manual easier to read, it includes standardized section numbering and use of bold, italics, and notes. Introductions to chapters and sections allow you to quickly determine whether a particular section contains the information you seek. The manual also contains an index and a table of contents to help you locate both broad topics and specific information quickly.

Section Numbering and Page Numbering

The first page of each chapter features a large chapter number, shaded in black, at the top right margin of the page. All major headings within chapters include section numbers. The section numbers may contain up to three heading levels, all of which are documented in the table of contents.

The header for each odd-numbered page identifies the chapter number. All pages also contain the chapter title. The footer of each page contains a unique page number, including the corresponding chapter number. Each chapter begins again at page one: for instance, Chapter 1 numbers 1-1, 1-2, 1-3; Chapter 2 numbers 2-1, 2-2; and so on.

Date Field

The bottom of each page contains a date field indicating when the page went to print. The date field includes the month and year of distribution (for instance, January 2004). Changes to the provider manual are distributed as change pages. The date at the bottom of each page reflects the date the policy changed or procedural information went into effect.

Use of Bold and Italics

To help you locate important information more quickly, chapter and section headings are designated by bold and italics. As much as possible, the section headings describe the content of the sections they introduce.

Index and Table of Contents

The provider manual features a table of contents that uses three heading levels. In the online version of the manual, these headings are referred to as “bookmarks.” You can position your cursor on a bookmark and click your left mouse button to jump to the corresponding page of the manual. For more information about the online version of the manual, please refer to Section 1.2, Using the Online Version of the Manual.

The paper version of the manual also contains an index. The online version of the manual features search capability, so an index is not included.

Notes

Throughout this document, note boxes and margin notes emphasize important details, messages, or references to other sections in the manual. Because the manual will be updated periodically, note boxes and margin notes do not contain specific page references; rather, they contain section references as appropriate. This way, as pages are added to the manual, you may still refer to the same section references to access important data quickly and efficiently.

NOTE:
Note boxes display like this.

General Writing Style

To make the manual easier to read and understand, the manual uses a standard writing approach that includes the following:

- Introductory paragraphs for each chapter and major section heading, which briefly but clearly describe the contents of the chapter or section, enabling you to scan the first few lines of a chapter or section to determine whether it contains the information you seek
- Shorter sentences and paragraphs that employ bullet lists where necessary, enabling you to quickly locate important information
- Tables and graphs, which can convey complex information more clearly than text

1.2 Using the Online Version of the Manual

For your convenience, a copy of the billing manual is available in online format. The online and paper versions of the manual have identical content. However, the online version includes enhanced features that allow you to access information more quickly. Some of these features include:

- Point-and-click access to all sections of the manual, allowing you to quickly locate information by section title
- Update tracking features, such as an update log and online notes indicating the exact location and nature of all modifications to the provider manuals
- Powerful online search capabilities, allowing you to locate information by keywords

Refer to the Section 1.3, Manual Update Log, for a description of the update log. Refer to Section 1.2.2, Benefits of Using the Online Manual, for more information about the other features described.

The manual may be downloaded from the Alabama Medicaid Web site at no charge.

1.2.1 Downloading the Online Manual

The online version of the manual is produced using Adobe® Acrobat™. Acrobat files are in a *portable document format* (*pdf*). A *pdf* file is platform-independent, meaning it may be viewed on a personal computer (PC) running on practically any platform. You may already be familiar with this type of file: the federal government uses *pdf* files as the standard for delivering documents over the Internet. For instance, anyone who has ever downloaded a tax form from the Internet has used a *pdf* file.

NOTE:

To use the online version of the manual, you must have **all** of the following:

- A PC with minimum hardware and software requirements, as listed below
- The Acrobat Reader™, available to you at no charge through the Alabama Medicaid Web Site or other sources on the World Wide Web (WWW)
- An Online version of the *Alabama Medicaid Provider Manual*

This section describes the PC hardware and software requirements, how to download the Acrobat Reader®, and how to download the online manual.

Hardware and Software Requirements

To use the online version of the *Alabama Medicaid Provider Manual*, your computer must meet, at a minimum, the following hardware and software requirements:

- **Windows System Requirements:** i486 or Pentium® processor-based personal computer with Microsoft Windows 95, Windows 98, or Windows NT 4.0 with Service Pack 3 or later. Requires 8 MB of RAM (16 recommended) on Windows 95 or 98; 16 MB of RAM (24 recommended) on Windows NT
- **Macintosh System Requirements:** Apple Power Macintosh computer with Apple System Software version 7.1.2 or later. Requires 4.5 MB of available RAM (6.5 recommended) and 8 MB of available hard-disk space
- **OS/2® System Requirements:** i386, i486, Pentium, or Pentium Pro processor-based personal computer with IBM® OS/2 Warp or Warp Connect 3.0 or later (IBM OS/2 Warp 4.0 recommended). Fixpak 26 required for printing using OS/2 Warp 3.0 or Warp Connect 3.0. Requires 4 MB of application RAM available to Acrobat Reader, 8 MB of RAM available for system, and 5 MB of hard-disk space plus 5 MB of temporary space available during installation. Netscape Navigator 2.02E or later for viewing *pdf* files inside a Web browser

Acrobat files are also viewable on other platforms. For a complete listing of system requirements, please refer to the Adobe home page. Click on the Download Acrobat Reader icon and scroll down the page to access the System Requirements link.

Acrobat Reader

To view a *pdf* file, you must have the Acrobat Reader installed on your PC, or you must be able to access the Reader through a Local Area Network (LAN) connection.

The Acrobat Reader is distributed free of charge, and is commonly bundled, or delivered in conjunction with other software. You may already have a copy of the Reader, acquired through downloading other files from the Web. If not, you may download a free copy of the Reader, along with the *Alabama Medicaid Provider Manual*, from the Alabama Medicaid Home Page.

Online *Alabama Medicaid Provider Manual*

These instructions are written for Internet Explorer. Other browsers may require slightly different procedures. The instructions assume you know how to access the WWW and how to perform a search.

Perform the following steps from your browser to download the manual:

Step 1 Access the Alabama Medicaid home page by choosing the Open option from the File menu. The Open dialog box displays.

Step 2 Enter the following address in the text box: http://www.medicaid.alabama.gov

Step 3 Click OK. The Alabama Medicaid home page displays.

Step 4 Click on the word Providers located across the top of the home page.

Step 5 Click on Manuals. The Alabama Medicaid Manuals page displays. Click on the most current version.

Step 6 If your PC is not equipped with Acrobat Reader version 4.05 or higher, click on the Download Acrobat Reader Icon. The Adobe Acrobat Download page displays. Follow the instructions on the Adobe site, then return to the Alabama Medicaid Manuals page.

Step 7 If your PC is already equipped with Adobe Acrobat Reader version 4.05 or higher, you are ready to download the manual.

Step 8 Click on the appropriate Alabama Medicaid Provider Manual link.

Step 9 If the File Download dialog box displays, choose the Save the File to Disk option to save the manual to your PC. (You should save the manual to your hard drive, to CD, or to ZIP disk. The manual is too large to fit on a standard 1.44 MB 3½ diskette.)

Step 10 When the file has finished downloading, open it by double clicking on the file in Windows Explorer.

1.2.2 Benefits of Using the Online Manual

Although a paper version of the manual is familiar and easy to use, consider how the following advantages save you and your office staff time and money in the billing process.

Maintenance-free and Always at Your Fingertips

The online manual takes up no desk space. It can never be misplaced, and if it is inadvertently deleted, you can download another version. You will never need to insert new pages and throw away old ones; merely download a new version each time you are notified of changes to the manual.

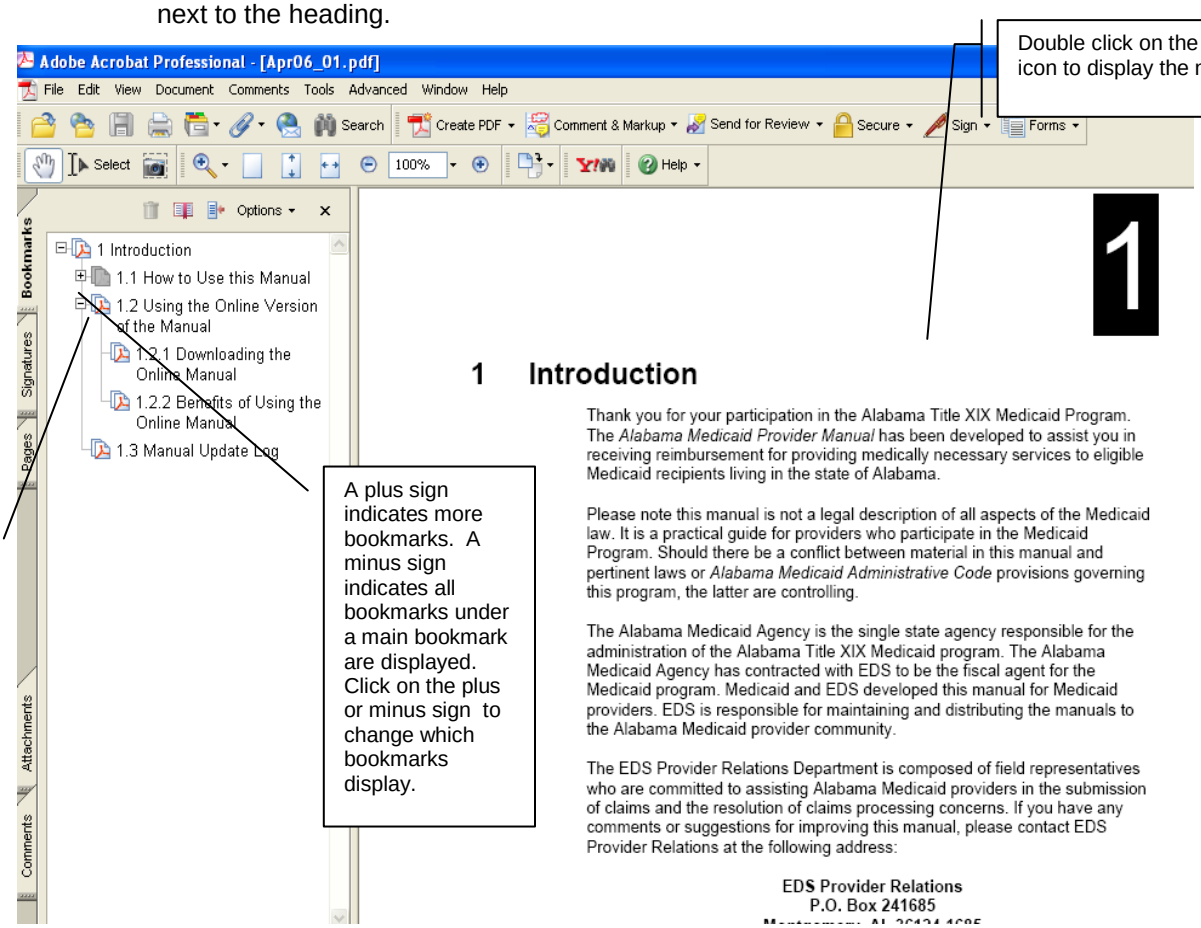
Customized Display Options

Although you cannot alter the contents of the online manual, you can modify how the manual displays online. Acrobat enables you to increase or reduce the font size, which can be helpful if you have vision problems. You may also customize other view options as available through the Acrobat Reader. The help feature resident in Acrobat Reader will guide you through using the Reader and customizing views.

Search and Browse Capabilities

The online manual features an online form of a table of contents that allows you point and click access to all the manual's sections. Acrobat calls each entry in this table of contents a bookmark. To view the bookmarks, select the Bookmark icon, the second icon from the left, on the Acrobat toolbar.

The bookmarks in the manual correspond to the section headings. Primary headings, such as the names of chapters, display as the first level of bookmarks. If a primary heading has secondary headings, a plus sign displays next to the heading.



Double click on the note icon to display the note.

Click on a bookmark to go directly to a particular page in the document.

A plus sign indicates more bookmarks. A minus sign indicates all bookmarks under a main bookmark are displayed. Click on the plus or minus sign to change which bookmarks display.

Simply click on the plus sign to view all headings beneath that heading level. To jump to a particular section of the manual, click on the corresponding bookmark.

You can also access the powerful online search capabilities of Acrobat to quickly locate information by entering a keyword in the Find dialog box. Acrobat searches the entire manual and displays the first occurrence of the word. You can then search again to find the next occurrence.

Access the help functionality in the Acrobat Reader for further instructions on using Acrobat.

1.3 Manual Update Log

Periodically, HP will make updates to this manual and mail updated pages to you. HP also provides an updated Acrobat copy of the manual on the Alabama Medicaid home page (http://www.medicaid.alabama.gov).

The following Manual Update Log describes the updates and document pages that were added, modified, or deleted as a result of the updates. HP sends a copy of this log with each paper copy of updated pages. The online copy of the manual also includes the manual update log, although the changed pages will already have been updated. Acrobat notes display on all individual page changes, or the beginning of each chapter or section replacement, in the online version of the manual. Please refer to Section 1.2.2, Benefits of Using the Online Manual, for more information about Acrobat's notes feature.

Affected Chapter	***Changes made on pages***
Chapter 1 Introduction	1-11, 1-12

NOTE:

Providers who maintain a paper copy of the manual should add or replace pages as updates occur. Providers who maintain the online version of the manual should download another copy. All providers will be notified by mail each time the manual is updated.

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2

2 Becoming a Medicaid Provider

HP is responsible for enrolling providers in the Medicaid program and for maintaining provider information in the Alabama Medicaid Management Information System (AMMIS, usually referred to as the 'system' in this manual). Based on enrollment criteria defined by Medicaid, HP receives and reviews all applications. Each application is approved, returned, or denied within ten business days of receipt.

Most readers of this manual will be current Alabama Medicaid providers who have already completed the enrollment process; however, this chapter briefly discusses how to, access the enrollment portal , where to send supporting documentation, and how to track the progress of an application. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for a description of how to notify HP of changes to provider enrollment information.

Only physicians who are fully licensed and possess a current license to practice medicine may enroll to become an Alabama Medicaid Provider.

Physicians with medical licenses who are participating in a Residency Training program may enroll with Alabama Medicaid to file for prescriptions issued to Medicaid recipients. An enrollment application for Ordering, Prescribing, and Referring (OPR) providers can be accessed at the website address indicated in the note box on page 2-2. In-state providers who are not yet licensed by the Alabama Board of Medical Examiners must use the NPI number of the supervising physician on claims

Physicians participating in an approved Residency Training program may not bill for services performed as part of the Residency Training program.

Supervising physicians may bill for services rendered to Medicaid recipients by residents who are rendering services as part of (through) the Residency Training program. See Chapter 28 for more information.

2.1 Completing an Application

A provider of medical services (including an out-of-state provider) who wants to be eligible for Medicaid reimbursement must complete the required Medicaid provider enrollment application and enter into a written provider agreement with the Alabama Medicaid Agency.

If a provider has more than one location, each location must be enrolled utilizing the provider's assigned National Provider Identifier (NPI) number. If a group consists of more than one physician, each physician must be enrolled utilizing the physician's assigned NPI number. This number identifies the provider only and does not change if the provider changes jobs or locations.

The HP Provider Enrollment Department is processing for supplying the application. To access the application, providers go to the following website under Provider Enrollment and complete the online application:

http://medicaid.alabama.gov

NOTE:

You can also use the Provider Enrollment website to access the Alabama Medicaid Participation Requirements document that outlines all documents required to enroll based on the type of provider enrolling.

It is important to complete applications as soon as possible for new enrollments and changes in enrollment status. Physicians and other individual practitioners should not wait until they have obtained Medicare approval to complete a Medicaid application. The provider will be assigned a Medicaid effective date which may change to the Medicare effective date when the provider has enrolled with Medicare.

NOTE:

Providers Who Have Obtained Medicare Approval

In order for HP to update providers' files so that their claims can automatically crossover from Medicare to Medicaid, providers must submit, by fax or mail, a copy of their Medicare notification letter received when they become a Medicare provider to HP's Provider Enrollment Unit. The letter should contain the provider's NPI number as well as secondary identifiers for all service locations. Once this letter is received, information will be updated and claims should begin to crossover.

HP's fax number is (334) 215-4298 and the mailing address is listed above.

2.2 Submitting the Application

Providers must complete the provider application and include any required attachments as directed in the accompanying instructions. Once the online application is complete, providers should submit the application to HP Provider Enrollment, along with all supporting documentation using the bar coded coversheet provided following application submission. .

HP reviews the application and approves, denies, or returns the application based on criteria set by Medicaid. Providers must correct and/or resubmit any returned applications for approval prior to enrollment in the Alabama Medicaid Program.

A provider will be enrolled utilizing his/her assigned National Provider Identifier (NPI) number after HP determines that the provider qualifies for participation in the Medicaid program based upon the qualifications set forth by Medicaid.

Providers will not be reimbursed for claims submitted without a valid NPI.

➢ To learn about enrollment requirements specific to your provider type, please refer to the appropriate chapter in Part II of this manual.

NOTE:

A provider who does not submit claims within a consecutive 24-month period will be disenrolled from the Medicaid program. To return to an active status, the provider must re-enroll.

2.3 Tracking the Application

HP tracks the status of each application as it moves from initial review to approval or denial. Upon receipt of the electronic application and supporting documentation, HP places the electronic application into a tracking system. A member of the HP enrollment team reviews the application based on state-defined criteria and makes a determination whether corrections are required within five business days.

- If the application is approved, HP generates an enrollment notification letter listing the NPI number submitted by the provider and then mails the letter to the provider within two business days of approval.
- If the application is denied, HP sends a letter to the provider listing the denial reason and providing a contact at Medicaid through which the provider may appeal the decision.
- If the application is incomplete, HP sends an email notification to the provider listing the necessary information HP requires to complete the enrollment process.

When HP returns an application to the provider, an enrollment representative logs the return date in the tracking system. When the provider corrects and returns the application, HP logs the date returned.

Providers may determine the status of their applications by contacting HP Provider Enrollment at 1 (888) 223-3630 or by accessing the enrollment portal and checking the enrollment status.

To check on the status of the application by phone, the enrollment representative will ask for the provider's name, NPI number, telephone number, and Social Security Number (SSN) or Federal Identification Number (FEIN).

HP maintains applications and includes additional correspondence received from providers on file.

3

3 Verifying Recipient Eligibility

The Alabama Medicaid Program is a medical assistance program that is jointly funded by the federal government and the State of Alabama to assist in providing medical care to individuals and families meeting eligibility requirements. Income, resources, and assets are considered when determining Medicaid eligibility.

Medicaid-eligible persons are referred to as recipients in the Alabama Medicaid Program. Medicaid reimburses providers for services rendered while the recipient is eligible for Medicaid benefits.

NOTE:

Providers who do not verify a recipient's eligibility prior to providing service risk a denial of reimbursement for those services. For this reason, it is important that every provider understand the terminology and processes associated with verifying recipient eligibility.

This chapter consists of three sections:

- *General Medicaid Eligibility*, which describes who determines eligibility and identifies the valid types of recipient identification
- *Confirming Eligibility*, which describes the various methods for verifying eligibility. *Please note that possession of a Recipient Identification (RID) card does not guarantee eligibility*
- *Understanding the Eligibility Response*, which provides explanations for the various programs and limitations that define recipient eligibility. **Providers should pay particular attention to this section, because there are several restrictions, limitations, and programs that may limit eligibility**

3.1 General Medicaid Eligibility

This section describes who grants eligibility, what constitutes Medicaid eligibility, and what identification recipients must provide.

3.1.1 Granting Eligibility

Medicaid eligibility is determined by policies established by and through the following agencies:

- Department of Human Resources
- Social Security Administration
- Alabama Medicaid

Names of eligible individuals and pertinent information are forwarded to Medicaid who, in turn, makes the information available to HP. Any questions concerning general or specific cases should be directed in writing to Medicaid or the appropriate certifying agency.

3.1.2 Eligibility Criteria

A person may be eligible for medical assistance through Medicaid if the following conditions are met:

- The applicant must be eligible for medical assistance for the date the service is provided. **Services cannot be paid under the Medicaid program if they are provided to the recipient before the effective date of his or her eligibility for Medicaid, or after the effective date of his or her termination of eligibility. Having an application in process for Medicaid eligibility is not a guarantee that the applicant will become eligible.**
- The service must be a benefit covered by Medicaid, determined medically necessary (exceptions are preventive family planning and EPSDT screenings) by the Medicaid program, and performed by an approved provider of the service.
- Applicants may be awarded retroactive eligibility to cover a time period prior to the application and award for eligibility. When applicants are awarded eligibility, they receive an award notice that includes the effective dates of coverage. The notice indicates whether retroactive eligibility has been awarded. Providers may contact the HP Provider Assistance Center at 1 (800) 688-7989 to verify retroactive eligibility dates.

Medicaid does not guarantee future eligibility. Providers should not assume future eligibility based on current eligibility. Providers who do not verify eligibility prior to providing a service risk claim denial due to ineligibility.

NOTE:

Based on eligibility criteria, recipients may be eligible for full Medicaid benefits, or for certain services only. A recipient's age, health care requirements, and place of residence may further define his or her eligibility for Medicaid programs or services. Additionally, a recipient's history of Medicaid benefits may render him or her eligible or ineligible for specific programs or services. For these reasons, it is very important that the providers verify recipient eligibility and ensure they understand all aspects of the eligibility response. Please refer to Section 3.3, Understanding the Eligibility Response, for more information.

3.1.3 Valid Types of Recipient Identification

This section describes the unique number used to identify Alabama Medicaid recipients and the valid forms of identification required for verifying recipient eligibility. Providers should begin the verification process by asking the recipient to present one of the following forms of identification:

- Plastic Alabama Medicaid Program identification card
- Notification letter for unborn or newborn child
- Notification letter for a recipient without a social security number
- Notification letter (or system print) for a recipient with retroactive eligibility
- Eligibility notification (in the form of a report) for nursing home residents

In addition to those identifications listed above, photo identification, such as a driver's license, should be requested from adult recipients, especially those without one of the above forms of eligibility notification.

NOTE:

Providers are encouraged to check photo identification of adult recipients, even if they have a plastic card or notification letter. If the recipient does not have a photo ID, providers should verify that the date of birth, sex, and race seem appropriate for the recipient requesting the service. This helps guard against fraud: for example, when an adult attempts to use a child's card.

Providers are responsible for verifying the identity of the recipient before accepting the card. **If at any time you suspect that the person receiving the service is not the person to whom the card belongs, report the occurrence to the Medicaid Fraud Hotline at the Alabama Medicaid Agency. Call the toll free number at 1-866-452-4930 and select the fraud option.**

Recipient Identification (RID) Number

Medicaid recipients are issued a unique, 13-digit Recipient ID number (RID). This number is composed of a twelve-digit number plus a check digit. The RID is used to verify eligibility, submit requests for prior authorization, and submit claims. The RID is maintained on the Medicaid system and all pertinent recipient information is associated with this unique number.

Although care is taken to ensure that recipients are issued only one RID, there are instances where multiple RIDs may be issued for the same recipient. This is especially likely when Medicaid issues a temporary RID for recipients who do not have a Social Security Number. When these recipients provide Medicaid with their SSN, they are issued a permanent plastic card and RID.

When you verify eligibility, the RID you enter and the ‘Current ID and check digit’ value returned by the system for the recipient may differ. When this occurs, it is often because a recipient was issued a temporary RID but has since been issued a permanent RID. Medicaid links all RIDs for a recipient and returns the most current RID as part of the eligibility verification process. Either the original RID or the current RID may be used to submit the claim or verify eligibility.

Plastic Identification Cards

Most Alabama Medicaid recipients have permanent plastic Medicaid cards. These cards are white, blue, and green and resemble a credit card. Each card is embossed on the front (with raised lettering) with the following:

- Recipient Identification (RID) number
- Name
- Date of birth
- Sex and race
- Two-digit card number

The magnetic stripe on the back of the card has been encoded with the RID for use with a point of service device or card swipe attached to a PC.

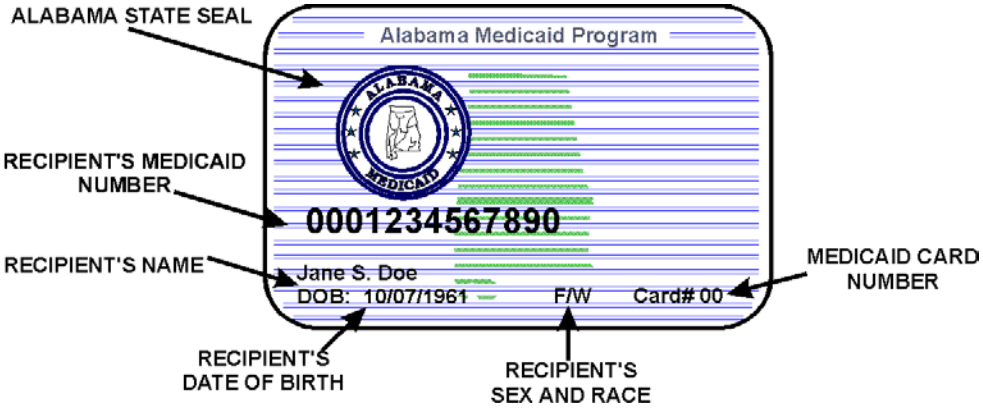
New recipients are issued permanent Medicaid cards within 10-14 working days of eligibility determination.

Providers should check the two-digit card number against the card number returned as part of the eligibility verification response. The first card issued has a number of ‘00’; the second, ‘01’; and so on. If the numbers do not match (for instance, if the plastic card number is ‘00’ but the eligibility response returns a card number of ‘01’) please notify the recipient they are using an old card and ask to see photo identification.

NOTE:

The Medicaid Agency has a Recipient Call Center available to assist recipients with questions regarding their Medicaid cards. The recipient Call Center may be reached at 1 (800) 362-1504.

Below is a sample Medicaid card:

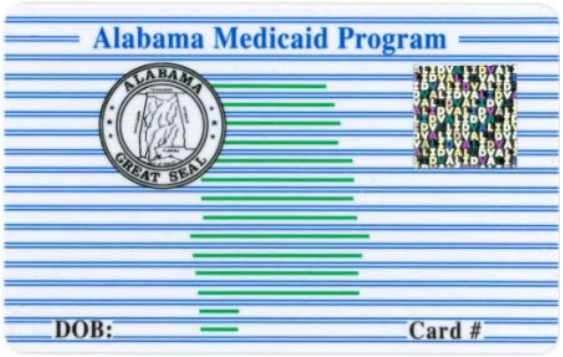


New Medicaid Cards to Contain a Security Hologram

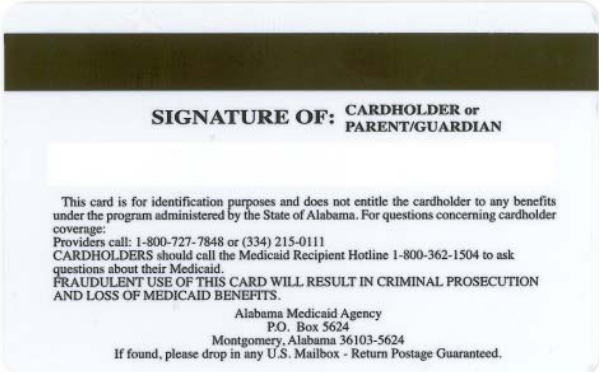
Beginning in June 2011, Medicaid cards will contain a hologram which will be located in the upper right corner. This hologram is designed to make card replication more difficult. New cards will only be issued upon recipient request. Medicaid IS NOT issuing new cards to all recipients.

As always providers should check eligibility prior to rendering services to Medicaid recipients.

Front



Back



Notification Letters

Recipients may not have a permanent plastic card for some of the following reasons:

- Recipients without a Social Security Number (SSN), such as unborn children, newborns, foster children, or some children who have been adopted
- Recipients with retroactive eligibility, but not current eligibility
- Recipients residing in a nursing facility who are not certified as QMB only

Examples of notification letters for recipients who do not have permanent plastic cards follow on the next 4 pages.

Eligibility Notification Letter for Newborns/Unborns

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

OCTOBER 1, 1999

PARENT/GUARDIAN OF
UNBORN C DOE
123 OAK LANE
MONTGOMERY, AL 12345-5555

MEDICAID: 000-555-05-5555-1

Dear UNBORN C DOE,

This is your unborn baby's Medicaid Eligibility card. Keep this letter and show it to the doctor's staff, the hospital staff, or whoever gives care to your baby. They will need to see this letter to make sure you are eligible to have Medicaid pay for your new baby's care. As soon as possible after your baby is born, give the baby's name and birth date to the agency that certified you for Medicaid. Once you receive the baby's Social Security Card, contact your worker to provide the number. Then you will get a plastic Medicaid card for your child. If you have any questions about your baby's Medicaid, call 1-800-362-1504. The call is free.

PROVIDER: To verify eligibility, call 1-800-727-7848.

Eligibility Notification Letter for Recipients without a Social Security Number

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

DO NOT THROW AWAY THIS MEDICAID LETTER

OCTOBER 1, 1998

TEST A. RECORD
SHADY ACRES N H
123 EVERGREEN ST.
MONTGOMERY, AL 36103-0000 MEDICAID: 999-999-99-9999

Dear TEST A. RECORD,

This letter is to be used as a temporary Medicaid card until you give your social security number to the agency that certified you for Medicaid. Then you will get a permanent plastic card that you can use as long as you remain eligible for the program. If you have questions about your Medicaid, call 1-800-362-1504. The call is free.

PROVIDER: To verify eligibility, call 1-800-727-7848

Eligibility Notification for Recipients with Closed or Retroactive Eligibility

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

OCTOBER 1, 1999

PARENT/GUARDIAN OF
JOHN R. DOE
123 MAIN STREET
MOBILE, AL 36606

MEDICAID NUMBER: 000-000-00-0000-0

The person named above was or is eligible for Medicaid for the most recent dates shown below:

04/97 – 05/97-Regular Medicaid	02/97 – 02/97-Regular Medicaid
06/95 – 08/96-Regular Medicaid	

Retroactive Eligibility Issued Within the Last 12 Months:

Date Issued	From To	Date Issued	From-To	Date Issued	From-To
05/02/97	02/97 02/97				

Pregnancy related services limited to:
Claims submitted one year beyond the date of service must be filed within one year of the date issued.

Eligibility Notification for Recipients in Nursing Homes

Nursing facility residents certified as QMB-only receive permanent plastic cards; however, other Medicaid-eligible nursing facility residents do not receive plastic cards. Each month, Medicaid sends nursing facilities a list of eligible recipients residing in that facility.

A sample list displays below:

Alabama Medicaid Agency

501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us

OCTOBER 1, 1999

STATE OF ALABAMA
ALABAMA MEDICAID AGENCY
501 DEXTER AVENUE

FACILITY: JOHN DOE MANOR INC.
123 MAIN STREET
MONTGOMERY, AL

THE PEOPLE LISTED BELOW, EXCEPT AS NOTED, ARE ELIGIBLE FOR MEDICAID FOR THE MONTH - JULY, 1999 NPI #

ELIGIBLE PERSON	JANE SMITH	JANE H. JONES	ROBERT JOHNS	JILL. DOE
MEDICAID NUMBER	999-999-99-9999	111-111-11-1111	444-444-44-4444	777-777-77-7777
SEX	F	F	F	F
RACE	W	W	W	W
BIRTHDATE	07/06/23	12/23/20	08/30/13	09/04/10
NEW 1ST				
AWARD ELIG				
AGENCY CODE	51	51	51	51
AID CAT	1	1	1	1
QMB	QMB	QMB	QMB	QMB
MEDICARE NUMBER	111111111D	222222222A	333333333A	444444444A
MEDICARE TYPE	A&B	A&B	A&B	A&B
INS. CODE	T-P	T-P	Q	S-P

RESTRICTED TO HUMANA FOR INPATIENT HOSPITAL SERVICES UNLESS EMERGENCY OR HUMANA PRIOR APPROVED.

* CERTAIN NURSING HOME SERVICES ARE RESTRICTED FOR THIS INDIVIDUAL. THIS PERSON IS ELIGIBLE FOR OTHER MEDICAID.

NOTE:

Only the first position of the aid category appears on this report. In the future, the full two-position aid category will appear.

3.2 Confirming Eligibility

Whenever possible, providers should verify eligibility prior to providing service. To verify eligibility, providers should perform the following:

Step 1 Request to see the recipient's plastic card, or a copy of the eligibility notification letter.

Step 2 Ask to see a driver's license or other picture identification for adult recipients.

Step 3 Perform eligibility verification using one of the methods described in Section 3.2, Confirming Eligibility.

Step 4 Review the entire eligibility response, as applicable, to ensure the recipient is eligible for the service(s) in question. Please note that the eligibility response provides lock-in, third party, managed care and dental information. You need all the available information to determine whether the recipient is eligible for Medicaid.

Step 5 **Maintain a paper copy of the eligibility response in the patient's file to reference, should the claim deny for eligibility.**

If the claim denies for ineligibility, the provider may contact the HP Provider Assistance Center to review the eligibility verification receipt and discuss the reasons the claim denied.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by HP
- Automated Voice Response System (AVRS) at 1 (800) 727-7848
- Contacting the HP Provider Assistance Center at 1 (800) 688-7989
- Web Portal https://www.medicaid.alabamaservices.org/ALPortal

Appendix B, Electronic Media Claims Guidelines, provides an overview of the HP Provider Electronic Solutions software, which providers may use to verify recipient eligibility and submit claims. Instructions for requesting the software are also included in this appendix.

Providers who use a billing service may be able to verify eligibility through the billing service's software, providing the service obtained a copy of the vendor specification. Please refer to Appendix B for contact information.

Appendix L, AVRS Quick Reference Guide, provides instructions for using AVRS to verify recipient eligibility. Providers can obtain a faxed response verifying eligibility by following the instructions provided.

Web User Guide provides instructions for using web portal to verify recipient eligibility. Instructions for accessing and login are also included in the guide.

NOTE:

Calling HP is not the preferred method for verifying eligibility. The Provider Assistance Center is intended to assist providers with problem claims and issues requiring further research. You can verify eligibility more quickly and completely by using the Provider Electronic Solutions software, or AVRS.

3.3 Understanding the Eligibility Response

When you use Provider Electronic Solutions software, or AVRS to verify eligibility, the system returns a detailed eligibility response. You will receive confirmation of the information displayed on the recipient's plastic card, along with verification that the recipient is eligible or ineligible for services performed on the requested From Date of Service (FDOS). The eligibility response also returns the following information:

- Recipient's aid category
- Lock-in information
- Managed Care or Medicare affiliation, if applicable
- Third party information
- Maternity Waiver
- Benefit Limits
- Dental Benefit Limits

This section provides a description of each as it applies to recipient eligibility.

3.3.1 Alabama Recipient Aid Categories

NOTE:

Programs such as Managed Care and Maternity Care, and restrictions such as lock-in, are not indicated by aid category. You must review and understand the entire eligibility response before determining the recipient is eligible for the proposed service.

There are many valid recipient aid categories. Below is a listing of aid categories that indicate restrictions. **Recipients with aid categories not identified in the following lists receive full Medicaid benefits.**

Partial Coverage

The following aid categories denote partial coverage:

5A Pregnancy-related services, family planning, and postpartum services only

5B Pregnancy-related services, postpartum, and family planning, plus Medicare deductibles and coinsurance for other services that Medicare covers

5C Pregnancy-related services, postpartum, and family planning, plus payment of the Medicare part B premiums

50 Family planning-related services only

58 Emergency Services for aliens, delivery/childbirth only

95 Medicare deductibles and coinsurance (cover services only if Medicare pays on the services) QMB-only (Category 1 recipients are described in Section 3.3.6, Medicare)

96 Medicare deductibles and coinsurance (cover services only if Medicare pays on the services) QMB-only (Category 1 recipients are described in Section 3.3.6, Medicare)

R2 Medicare deductible and coinsurance (cover services only if Medicare pays on the services) QMB-only (Category 1 recipients are described in Section 3.3.6, Medicare)

R4 Pregnancy-related services, family planning, and postpartum services only

R5 Pregnancy-related services, family planning, and postpartum services only (plus Medicare deductibles and coinsurance for other services that Medicare covers - retro)

R6 Emergency Services for aliens, delivery/childbirth only

Medicare Coverage

Category 2: See the description of Category 2 recipients in Section 3.3.5, Medicare.

The following aid categories denote full Medicaid coverage and ALL Medicare coinsurance and deductibles:

14	24	31	44	56	R3
15	25	33	45	57	R8*
17	27	35	47	59	
1E	2A	37	4A	5H	
	2E	3C	4E	5L	
		3D	4Q		
		3H	SQ		
		3K	TQ*		

Category 3: See the description of Category 3 recipients in Section 3.3.5, Medicare.

The following aid categories denote full Medicaid coverage, and coinsurance and deductibles ONLY for Medicaid-covered services up to Medicaid's benefit limit:

12	22	3E	42	5D
13	23	3F	43	5J
18	28		48	5M
1D	2B		4B	R7
	2D		4D	
			4L	
			SL	
			TL*	

*** These aid categories cover Private Duty Nursing.**

Special Coverage

The following aid categories denote full Medicaid coverage that includes private duty nursing services for adults.

Private Duty Nursing Service recipients are identified as adults who were formerly receiving private duty nursing services through the EPDST Program under the Medicaid State Plan, for whom private duty nursing services continue to be medically necessary based upon approved private duty nursing criteria. Waiver services provided are full Medicaid plus private duty nursing, personal care/attendant service, medical supplies, assistive technology, and targeted case management. Recipients may or may not also have Medicare. If they do have Medicare the eligibility verification will denote Medicare eligibility.

TT-R7 Full Medicaid plus private duty nursing services

TQ- R8 Full Medicaid coverage, all Medicare co-insurance and deductibles plus private duty nursing services

TL-R7 Full Medicaid coverage and co-insurance and deductibles only for Medicaid covered services up to Medicaid's benefit limit plus private duty nursing services

No Coverage

Recipients with aid categories 92, 93, 97 or R0 (zero) receive no Medicaid coverage.

3.3.2 Lock-in

The Alabama Medicaid Agency closely monitors program usage to identify recipients who may be potentially overusing or misusing Medicaid services and benefits. For those identified recipients, qualified Alabama Medicaid staff performs medical desk reviews to determine overuse or misuse of service. If the review indicates overuse and/or misuse of services, the recipient may be locked in to one physician and/or one pharmacy. Additional limitations may be placed on certain medications such as controlled drugs and/or other habit-forming drugs.

Recipients who are placed on lock-in status are notified by certified letter of the pending restriction. They are asked to contact the Recipient Review Unit at the Alabama Medicaid Agency with the names of their chosen physician and/or pharmacy. The physician and pharmacy are contacted by the Recipient Review Unit to determine if they will agree to serve as primary care physician/designated pharmacy while the recipient is restricted.

Referring Recipients with Lock-in Status

Physicians who serve as a restricted recipient's lock-in provider should use the Restricted Recipient Referral Form (SUR-1-92 or Form 192), provided by Medicaid to the lock-in physician, when referring the restricted recipient to another physician. The lock-in physician should retain the white copy in the recipient's file. The lock-in physician should mail the yellow copy to the referred physician or provide the copy to the restricted recipient. The referral may cover one visit or multiple visits so long as those visits are part of the plan of care and are medically necessary. No referral can last more than one year. Additional restricted recipient referral forms may be obtained by calling the Recipient Review Unit at the Alabama Medicaid Agency at 1 (334) 242-5430.

NOTE:

The message indicating the recipient is restricted is part of the general eligibility response provided AVRS or Provider Electronic Solutions software.

A copy of the Recipient Referral Form is shown on the next page.

ALABAMA MEDICAID AGENCY

Restricted Recipient Referral Form

Name of Referred Physician _____

Recipient's Name _____

Recipient's Medicaid Number _____

Date of Referral _____

Reason for Referral _____

_____

Primary Physician's National Provider Identifier (NPI)_____

Signature of Primary Physician _____

When billing Alabama Medicaid, the referred physician should place the Primary Physician's Medicaid Provider Number in Block 17a of the CMS-1500 claim form to be paid for the services.

White copy should be retained in the primary physician's office.

Yellow copy should be retained in the referred physician's office.

SUR-1-92
Form 192 (Revised 4/24/96)

3.3.3 Managed Care

During the eligibility verification process, providers should be aware of the Managed Care information that Medicaid provides. AVRS and Provider Electronic Solutions software reports Managed Care enrollment status under the following managed care plan:

- Medicare Complete

Refer to Chapter 39, Patient 1st, for more detailed information about managed care programs.

Patient 1st

Patient 1st is a statewide Primary Care Case Management (PCCM) system. Medicaid recipients eligible for this program are assigned to a Primary Medical Provider (PMP) who is responsible for primary care services and authorization of referrals.

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is enrolled in Patient 1st:

Verification of the recipient's enrollment in Patient 1st

- PMP's NPI
- PMP's telephone number (and 24-hour phone number, if applicable)
- Effective and End Dates of enrollment

The PMP must be contacted to authorize any service requiring a referral. Chapter 39, Patient 1st, provides information on referrals. Once the referral is obtained, the claim is filed directly to HP for processing.

Maternity Care Program

The Maternity Care Program is a statewide program that covers maternity services. The state is divided into 14 districts with a Maternity Care Primary Contractor in each district. The primary contractor is responsible for the coordination of care for recipients enrolled in the program.

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is eligible for the Maternity Care Program:

- Primary contractor's NPI
- Primary contractor's telephone number
- Effective and End Dates of enrollment

Claims for services covered under this program should be filed directly to the primary contractor. See Chapter, 24, Maternity Care, for more information on the maternity care program.

Medicaid's Medicare Advantage Managed Care Plan

There are currently four companies who contract with the Alabama Medicaid Agency and offer Medicare Advantage coverage in Alabama – United HealthCare's Medicare Complete, Viva Health's VIVA Medicare Plus, Windsor Health Care and Health Springs. When one of these companies notifies Medicaid that a Medicaid recipient has enrolled in their Medicare Advantage Plan, Medicaid makes a premium payment to the applicable plan. This payment covers all Medicare coinsurance and deductibles. Therefore, neither Medicaid nor the recipient will pay any co-payments, coinsurance or deductibles for Medicare services incurred during the time that the individual is enrolled in Medicaid's Medicare Advantage Plan.

Claims can be submitted to Medicaid for copays, deductibles or coinsurances for dates of service that are outside the dates that Medicaid has paid a premium to one of the four Plans listed above. These claims should be billed on a Medicare/Medicaid crossover claim and will be processed like any other Medicare paid claim. (See Section 5.7.1 for specific billing instructions)

There are several Medicare Advantage Plans that are servicing Medicaid recipients. However, the four Plans mentioned above are the only ones with whom Medicaid has a contract to pay premiums. Since Medicare Advantage Plans pay in place of Medicare, any secondary claims to Medicaid for copays, deductibles or coinsurance should be billed on a Medicare/Medicaid crossover claim and will be processed by Medicaid in the same manner as a Medicare paid claim. (See Section 5.7.1 for specific billing instructions)

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is enrolled in a Medicare Advantage Plan for which Medicaid is making a capitation payment:

- Verification of the recipient's enrollment in a Medicare Advantage Plan
- Plan telephone number

Claims for services covered under this plan must be filed directly to the applicable Medicare Advantage Plan.

3.3.4 Benefit Limits

The Alabama Medicaid Agency establishes annual benefit limits on certain covered services. Certain services are excluded, such as services rendered as a result of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. The EPSDT program covers recipients under 21 years of age. SOBRA pregnant women under 21 are not covered under EPSDT. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

NOTE:

Aid Categories 5A, 5B, 5C, 50, R4, R5, 58 and R6 are not covered under EPSDT.

The table below describes the benefit limitations documented as part of eligibility verification.

Benefit	***Limitation***
Inpatient hospital days	16 per year
Outpatient hospital days	3 per year
Physician office visits	14 per year
Eyeglass frames	Not covered for recipients age 21 years and older
Eyeglass lenses	Not covered for recipients age 21 years and older
Eyeglass fitting exams	1 exam every three years for recipients 21 years and older
Eyeglass exams	1 exam every three years for recipients 21 years and older
Home health visits	104 per year
Ambulatory surgery center	3 per year
Dialysis services	156 per year

NOTE:

Refer to specific program chapters for additional benefit limitation. To verify benefit limits, refer to Appendix B, Electronic Media Claims (EMC) Guidelines, or Appendix L, AVRS Quick Reference Guide.

3.3.5 Dental Benefit Limits

The Alabama Medicaid Agency establishes benefit limits on certain covered dental services. Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT program. See Chapter 13 of this manual for further information on Medicaid's Dental program.

The table below describes the benefit limitations documented as part of eligibility verification.

Benefit	***Limitation***
Dental Space Maintainer	2 per lifetime under 20 years, 3rd with PA
Dental Fluoride	<3 1 per 6 months >3 1 per 6 months
Dental Prophylaxis	1 per 6 months
Full or Panoramic Xray	1 per 3 years
Oral Exam	1 per 6 months
Oral Evaluation < 3 years of age	1 per year
Fluoride Varnish < 3 years of age	3 per calendar year
Fluoride Varnish > 3 years of age	1 per calendar year
Periapical Xray	5per calendar year
Bitewing Xray	1 per 6 months

3.3.6 Medicare

Medicare, the federal health insurance program for the aged and disabled, covers certain institutional (Part A) and medical (Part B) benefits for eligible beneficiaries. The Title XIX Medicaid Program pays the Part B Medicare monthly premiums for Medicaid/Medicare eligible recipients through a buy-in agreement with the Social Security Administration (SSA). As a result of the Medicare Catastrophic Coverage Act, there are three different categories of Medicare recipients for which Medicaid is responsible for the deductible and/or co-insurance:

Category	***Description***
Category 1 QMB-only Medicare recipients	QMB-only Medicare recipients are identified as QMB ONLY by using the Provider Electronic Solutions software, AVRS (Automated Voice Response System) or the Provider Assistance Center. These recipients are eligible only for crossover services and ARE NOT eligible for Medicaid only services. That is, if Medicare covers the service, Medicaid will consider for payment the deductible and/or co-insurance. Premiums and copayment will be considered for payment if the individual is enrolled in a Medicare Advantage Plan.
Category 2 QMB Medicare/Medicaid recipients	QMB Medicare/Medicaid recipients are identified as having Medicaid and QMB (QMB+) when eligibility is verified through the Provider Electronic Solutions software, AVRS, or the Provider Assistance Center. These recipients are eligible for the same benefits as QMB-only recipients (category 1) and Medicaid/Medicare recipients (category 3).

Category	*Description*
Category 3 Medicare/Medicaid recipients	Medicare/Medicaid recipients who do not qualify as QMB are identified as having part 'A', 'B', or 'A & B' when their eligibility is verified through the Provider Electronic Solutions software, AVRS, or the Provider Assistance Center. Medicare-related claims for Medicare/Medicaid recipients will be paid only if the services are covered under the Alabama Medicaid Program.

NOTE:

A QMB (Qualified Medicare Beneficiary) recipient is a Part A Medicare beneficiary whose verified income does not exceed certain levels.

Part A Medicare/Medicaid Claims - Medicaid will pay the Medicare co-insurance and deductible for services covered by Medicare for QMB recipients. For non-QMB recipients, Part A claims are limited to those services that are covered benefits under Medicaid and would have been paid had the recipient not been eligible for Medicare. Medicaid will not pay Medicare coinsurance and deductibles for individuals enrolled in Medicaid's managed care program for Medicare Advantage enrollees. For these individuals, Medicaid's premium payment covers Medicare coinsurance and deductibles.

Part B Medicare/Medicaid Claims – Effective for claims with date of service November 11, 1997 and after: For QMB recipients, Medicaid will pay Medicare coinsurance and deductibles only for services covered by Medicare and only to the extent of the lesser or lower of Medicaid and Medicare reimbursement. For dates of service 5/14/2010 and after, ambulance providers will no longer be paid the full deductible and coinsurance amounts. For non-QMB recipients, any Medicaid non-covered services will be denied. In no instance will total reimbursement to the provider (Medicare plus Medicaid) exceed the lesser of the total Medicaid allowed amount or the Medicare paid amount. If the amount allowed by Medicaid is less than or equal to the amount paid by Medicare, Medicaid will pay nothing for the procedure. Medicaid will not pay Medicare coinsurance and deductibles for individuals enrolled in Medicaid's Medicare Advantage premium program. For these individuals, Medicaid's premium payment covers Medicare coinsurance and deductibles.

3.3.7 Third Party Liability

Providers should verify whether a Medicaid recipient has other insurance prior to submitting a claim to Medicaid. Because federal Medicaid regulations require that any resources currently available to a recipient are to be considered in determining liability for payments of medical services, providers have an obligation to investigate and report the existence of other insurance or liability to Medicaid. Cooperation is essential to the functioning of the Alabama Medicaid Program.

NOTE:

Medicare Advantage Plans should not be reported as Third Party insurance since they are paying in place of Medicare. Medicaid's MMIS system will continue to edit claims for Medicare coverage when a recipient is enrolled in a Medicare Advantage Plan.

This section discusses the following:

- Verifying Other Insurance
- Submitting Claims to Other Insurance
- Submitting Paid and Partially Paid Claims to Medicaid
- Submitting Denied Claims to Medicaid
- Medicare Crossover Claims
- Duplicate Payment by a Third Party

NOTE:

Verifying third party resources reduces the risk of your claim denying because of additional third party insurance. This is especially true in situations where the recipient is enrolled in a plan that requires the recipient to use certain providers or meet plan restrictions, such as pre-certification or obtaining physician referrals. Medicaid payment may be denied or recouped retroactively if the recipient's health plan requirements are not met.

Verifying Other Insurance

Recipients may be covered through a variety of health insurance resources. Please ask the recipient about the following types of insurance coverage:

Insurance Coverage Scenarios	***Health Insurance Resources***
If the recipient is married or working	Request information about possible health insurance through the recipient's or spouse's employer
If the recipient is a minor	Request information about insurance the mother, father, or guardian may carry on the recipient
If the recipient is active or retired military personnel	Request information about CHAMPUS coverage and a Social Security number of the policyholder
If the recipient is over 65 or disabled	Request information about a Medicare HIC number; ask if the recipient has health insurance such as a Medicare supplement policy, cancer, accident, or indemnity policy, group health insurance, or individual insurance

If the recipient receives treatment for an injury, question the recipient to determine if there are potential third party resources. Examples include automobile and homeowner's insurance; malpractice insurance; retention of legal counsel; product liability; and workman's compensation coverage.

COVERAGE TYPE	DESCRIPTION COVERAGE TYPE
01	MEDICARE PART A
02	MEDICARE PART B
03	MAJOR MEDICAL MATERNITY
04	MAJOR MEDICAL NO MATERNITY
05	MAJOR MEDICAL MATENITY – MANAGED CARE
06	MAJOR MEDICAL NO MATERNITY – MANAGED CARE
07	PRESCRIPTION DRUGS – COST AVOID
08	PRESCRIPTION DRUGS PAY – PAY AND CHASE
09	MAIL ORDER PRESCRIPTION DRUGS
10	DENTAL
11	DENTAL MANAGED CARE
12	ACCIDENT
13	CANCER
14	HOSPITAL/SURGICAL
15	HOSPITAL INDEMNITY
16	LONG TERM CARE
17	LONG TERM CARE – SKILLED ONLY
18	OPTICAL
19	MEDICARE SUPPLEMENT

NOTE:

Medicaid copayment received from the recipient is not considered a third party resource and should not be recorded on the claim.

You can also verify other insurance while you verify recipient eligibility. HP Provider Electronic Solutions software and AVRS provide third party information when you verify recipient eligibility. Please refer to Appendix B, Electronic Media Claims (EMC) Guidelines, and Appendix L, AVRS Quick Reference Guide, for more information.

NOTE:

If the other insurance data provided by AVRS/PES is incomplete, please check with the patient for further information. If the recipient has never been covered by the insurance listed or the policy is not in force, please contact the appropriate third party representative, as listed below, based on the recipient's last name. Please provide, if possible, the month, day, and year the coverage ended.

A through F – 334/242-5249

G through K – 334/242-5280

L through Q – 334/242-5254

R through Z – 334/242-5253

You may also report coverage changes by going to Medicaid's website and completing an email or faxable form to update health insurance: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.1_Benefit_Coordination.aspx Select: **Update Health Insurance Information** to choose the preferred method to report the change.

Submitting Claims to Other Insurance

When you identify a third party resource, you should submit the claim to that resource using the address from the recipient. When you identify a third party resource through eligibility verification, obtain the company code from the eligibility response. Then refer to Appendix K, Top 200 Third Party Carrier Codes for a list of company names (and addresses) that correspond to the carrier codes.

Claims filed to third party resources on behalf of a Medicaid recipient may fully pay, partially pay, or deny. Refer to Section 5.1.8, Submitting Paid and Partially Paid Claims to Medicaid, or Section 5.1.9, Submitting Denied Claims to Medicaid, for details.

Medicare Crossover Claims

Please refer to Section 5.6, Crossover Claim Filing, for information on filing Medicare crossover claims.

For claims retroactively identified as Medicare-related, HP will withdraw Medicaid payment and the provider will be instructed to file the claim with Medicare. The provider may refile the claim with Medicaid for the balance of the allowed charges after the Medicare claim has been filed with Medicare.

Duplicate Payment by a Third Party

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts.

If providers receive duplicate payments from a third party and Medicaid, all duplicate third party payments must be refunded within 60 days. Providers must do **one** of the following:

- Send a refund of insurance payment to the Third Party Division, Medicaid
- Request an adjustment of Medicaid payment

If a provider releases medical records and/or information pertaining to a claim paid by Medicaid and, as a result of the release of that information, a third party makes payment to a source other than the provider or Medicaid, the provider is responsible for reimbursing Medicaid for its payment.

NOTE:

If you have reason to believe other insurance exists that is not on Medicaid's file, please call Third Party, Medicaid Agency at (334) 242-5269 to report other insurance.

4 Obtaining Prior Authorization

Prior authorization serves as a cost-monitoring, utilization review measure and quality assurance mechanism for the Alabama Medicaid program. Federal regulations permit the Alabama Medicaid Agency to require prior authorization (PA) for any service where it is anticipated or known that the service could either be abused by providers or recipients, or easily result in excessive, uncontrollable Medicaid costs.

This chapter describes the following:

- Identifying services requiring prior authorization
- Submitting a prior authorization request
- Receiving approval or denial of the request
- Using AVRS to review approved prior authorizations
- Submitting claims for prior authorized services

4.1 Identifying Services Requiring Prior Authorization

The Alabama Medicaid Agency is responsible for identifying services that require prior approval. Prior authorization is generally limited to specified non-emergency services. The following criteria may further limit or further define the conditions under which a particular service is authorized:

- Benefit limits (number of units or services billable for a recipient during a given amount of time)
- Age (whether the procedure, product, or service is generally provided to a recipient based on age)
- Sex (whether the procedure, product, or service is generally provided to a recipient based on gender)

To determine whether a procedure or service requires prior authorization, access the Automated Voice Response System (AVRS). Refer to Section L.6, Accessing Pricing Information, of the AVRS Quick Reference Guide (Appendix L) for more information.

For all Magnetic Resonance Imaging (MRI) scans, Magnetic Resonance Angiogram (MRA) scans, Computed Tomography (CT) scans, Computed Tomography Angiogram (CTA) scans, and Positron Emission Tomography (PET) scans performed on or after March 2, 2009, providers will be required to request prior authorization from MedSolutions. Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement. Refer to Chapter 22, Independent Radiology, for the diagnostic imaging procedure codes that require prior authorization.

Prior authorization requests for outpatient diagnostic imaging procedures may be made to MedSolutions by phone at (888) 693-3211 or by fax at (888) 693-3210 during normal business hours 7:00 a.m. to 8:00 p.m. C.T. Requests can also be submitted through MedSolutions' secure website at www.MedSolutionsOnline.com.

The program services chapters in Part II of this manual may also provide program-specific prior authorization information.

NOTE:

When a recipient has third party insurance and Medicaid, prior authorization must be obtained from Medicaid if an item ordinarily requires prior authorization. This policy does not apply to Medicare/Medicaid recipients.

4.2 Submitting a Prior Authorization Request

To receive approval for a PA request, you must submit a complete request using one of the approved submission forms. This section describes how to submit online and paper PA requests, and includes the following sections:

- Submitting PAs (278 Health Care Services Review-Request for Review and Response) using Provider Electronic Solutions
- Submitting Paper PA Requests
- Submitting PAs using the web portal

NOTE:

PAs are approved only for eligible recipients. It is therefore recommended that provider verify recipient eligibility prior to submitting a PA request. Refer to Chapter 3, Verifying Recipient Eligibility, for more information.

In the case of a retroactive request (retroactive eligibility), the recipient must have been eligible on the date of service requested. The provider must submit the PA request within 90 calendar days of the retroactive eligibility award (issue) date. If a retroactive PA request is submitted and does not reference retroactive eligibility, the request will be denied.

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center.

If a medical emergency is referenced, the provider must submit the PA request **within 30 days** of the date of service. Supporting documentation must provide evidence that the service was not scheduled and that delays greater than 72 hours would have resulted in serious injury or harm.

Added: Medical records must…to meet criteria.

Medical records must be submitted to justify the medical necessity of the requested item or service. Checklists are not sufficient documentation to meet criteria.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Beginning December 1, 1999, you can submit electronic PA requests using HP Provider Electronic Solutions software, available to you at no charge. If you already use this software, you will be mailed an upgrade; if you do not currently use the software, but would like to order a copy, refer to Appendix B, Electronic Media Claims Guidelines, for contact information. The electronic 278 Health Care Services Review- Request for Review and Response claim is not limited to the use of the Provider Electronic Software. Providers may use other vendor's software to submit a 278 electronic claim.

Electronic PA Requests Requiring Attachments

If attachments are required for PA review, the attachments must be sent to HP within 48 hours to be scanned into the system to prevent a delay in review and/or a denial for "no documentation" to support the PA request. Do not fax this information to the Alabama Medicaid Agency unless a request is made for specific information by the agency reviewer. Attachments scanned can be located in the system and are linked by the PA number on the Prior Authorization response returned by the system. Refer to Chapter 15 of the *Provider Electronic Solutions Manual* for specific information. This chapter provides instructions for submitting electronic 278 requests. Please be aware that the need to link the attachments sent hard copy with a PA request submitted electronically has resulted in delays in PA processing. In an effort to expedite this process follow the instructions below taken from Chapter 15, *Submitting Prior Authorization Requests, Provider Electronic Solutions Manual.*

NOTE:

Please print a copy of the Prior Authorization response, which is received after your submission, and attach the response to your attachments. It is also recommended that the PA number received be written on each page of the attachments. Fax them to (334) 215-4140, Attn: PA Unit, or mail the attachments to:

Attn: PA Unit P. O. Box 244032 Montgomery, AL 36124

4.2.2 Submitting Paper PA Requests

In the absence of electronic applications, providers may submit requests for prior authorization using the Alabama Prior Review and Authorization Request Form (Form 342). No other form or substitute will be accepted. Completed requests should be sent to the following address:

HP Prior Authorization Unit
P.O. Box 244032
Montgomery, AL 36124-4032

For a hardcopy request, the provider or authorized representative must personally sign the form in the appropriate area or place his/her initials next to a typewritten or stamped signature to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient.

4.2.3 Submitting PA Requests Using the Web Portal

Providers may also submit PA requests through the interactive web portal. Please use this link for the Alabama Medicaid Agency AMMIS Interactive Services Website User Manual:

http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7.1_January_2013/6.7.7.1_Jan13_Webuser.pdf

See Section 13 of the AMMIS Interactive Services Website User Manual, Prior Authorization, starting on page 174, for information about this process.

4.3 Completing the Alabama Prior Review and Authorization Request Form

Providers use the Alabama Prior Review and Authorization Request Form to submit non-dental PAs on paper. These forms are available through the Medicaid Agency and are on the following website link:

http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Form_342_Revised_Fillable_12-7-11.pdf

Deleted: ~~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~~.

Added: http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7.1_January_2013/6.7.7.1_Jan13_Webuser.pdf

Deleted: ~~http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Form_342_fillable_12-7-11.pdf~~

Added: http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Form_342_Revised_Fillable_12-7-11.pdf

4.3.1 Blank Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required if Medicaid Provider) PMP ☐

Requesting Provider NPI # _____

Phone with Area Code _____

Name _____

Recipient Medicaid # _____

Name _____

Address _____

City/State/Zip _____

EPSDT Screening Date _____ DOB _____

Prescription Date CCYYMMDD _____

Rendering Provider NPI # _____

Phone with Area Code _____

Fax with Area Code _____

Name _____

Address _____

City/State/Zip _____

Ambulance Transport Code _____

Ambulance Transport Reason Code _____

DME Equipment: _____ New _____ Used

First Diagnosis _____.____ Second Diagnosis _____.____

Assignment/Service Code ____ Patient Condition ____ Prognosis Code ____

(01)	Medical Care	(44)	Home Health Visits	(AD)	Occupational Therapy
(02)	Surgical	(54)	LTC Waiver	(AE)	Physical Therapy
(12)	DME-Purchase	(56)	Medically-Related Transportation		
(18)	DME-Rental	(69)	Maternity	(A4)	Psychiatric*
(35)	Dental Care	(72)	Inhalation Therapy	(AF)	Speech Therapy
(40)	Oral Surgery	(74)	Private Duty Nursing	(AL)	Vision-Optometry
(42)	Home Health Care	(75)	Prosthetic Device	(CQ)	Case Management

Line Item	DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____

_____

_____

_____

_____

_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider _____ Date _____

FORWARD TO: HP, P.O. Box 244032 Montgomery, Alabama 36124-4032

Form 342
Revised 12-2011

Alabama Medicaid Agency
www.medicaid.alabama.gov

4.3.2 Instructions for completing the Alabama Prior Review and Authorization Request Form

Section 1: Requesting Provider Information (Required)

PMP	Check if the patient has been assigned to a Primary medical provider (PMP) under the Primary Care Case Management (PCCM) program, known as Patient 1st.
License # or NPI	Enter the license number or the National Provider Identifier (NPI) of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting physician.
Name	Enter the name of the prescribing physician.

Section 2: Rendering Provider Information (Required)

Rendering Provider NPI Number	Enter the National Provider Identifier of the provider rendering services.
Phone	Enter the current area code and telephone number for the provider rendering services.
Fax	Enter the current area code and fax number for the provider rendering services.
Name	Enter the name of the provider rendering services.
Address	Enter the physical address of the provider rendering services.
City/State/Zip	Enter the city, state, and zip code for the address of the provider rendering services.
Ambulance Transport Code	Enter code to specify the type of ambulance transportation. Refer to “Ambulance Transport Codes” in the section below for appropriate codes. **Used for ambulance services only**.
Ambulance Transport Reason Code	Enter code to specify the reason for ambulance transportation. Refer to “Ambulance Transport Reason Codes” in the section below for appropriate codes. **Used for ambulance services only**.
DME Equipment	Enter a check mark indicating if the DME Equipment is New or Used.

Section 3: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient’s full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient’s current address.
City/State/Zip	Enter the city, state, and zip code for the address of the recipient.

Section 4: Other Information

EPSDT Screening Date CCYYMMDD	**Required field for all requests.** Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
DOB	Enter the date of birth of recipient.
Prescription Date CCYYMMDD	**Required field for all requests.** Enter the date of the prescription from the attending physician. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
First Diagnosis	**Required field for all requests.** Enter the primary diagnosis code.
Second Diagnosis	Enter the secondary diagnosis code.
Service Type	**Required field for all requests.** Outpatient hospitals requesting physical therapy must use Service type 01 (medical) and not Service Type AE (physical therapy.).
Patient Condition	Enter the code that best describes the patient’s condition. Refer to “Patient Condition Codes” in the section below for appropriate codes. **Used for non-emergency ground transport, > 100 miles, ambulance services and DME providers only.**

Prognosis Code	**Required field for Service Types: 42, 44, and 74.**

Section 5: Procedure Information (Required)

Dates of Service	Enter the line item (1, 2, 3, etc) along with start and stop dates requested. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
Place of Service	Enter a valid place of service (POS) code.
Procedure Code*	Enter the five-digit procedure code requiring prior authorization. If this PA is for inpatient stay, a procedure code is not required.
Modifier 1	Enter modifier, if applicable.
Units	Enter total number of units.
Cost/Dollars	Enter price in dollars.
Clinical Statement	Provide a clinical statement including the current prognosis and the rehabilitation potential as a result of this item or service. Be very specific.
Signature of requesting provider	After reading the provider certification, the provider signs the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.
Date	Enter the date of the signature.

NOTE:

Additional information may be required depending on the type of request.

Procedure Code Modifiers

Procedure code modifiers are not available with the current electronic 278 Health Care Services Review – Request for Review transaction. If procedure code modifiers are necessary for a claim to process correctly, providers may submit a paper PA form.

Ambulance Transport Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the type of trip for ambulance service requests.

Code	***Description***
I	Initial Trip
R	Return Trip
T	Transfer Trip
X	Round Trip

Ambulance Transport Reason Codes (Ambulance Services Only)

Use this table for the appropriate code to describe the reason for the ambulance transport request.

Code	***Description***
A	Patient was transported to nearest facility for care of symptoms.
B	Patient was transported for the benefit of a preferred physician.
C	Patient was transported for the nearness of family member.
D	Patient was transported for the care of a specialist or for availability of specialized equipment.
E	Patient transferred to rehabilitation facility.
F	Patient transferred to residential facility.

Patient Condition Codes

The table below lists condition codes which may be used in different programs. Some codes may not be appropriate for all provider types. Please refer to the provider specific chapter of the Alabama Medicaid Provider Manual for acceptable patient condition codes. **(Used for non-emergency ground transport, > 100 miles, for ambulance services.)**

Code	*Description*
01	Patient was admitted to a hospital
02	Patient was bed confined before the ambulance service
03	Patient was bed confined after the ambulance service
04	Patient was moved by stretcher
05	Patient was unconscious or in shock
06	Patient was transported in an emergency situation
07	Patient had to be physically restrained
08	Patient had visible hemorrhaging
09	Ambulance service was medically necessary
10	Patient is ambulatory
11	Ambulation is impaired and walking aid is used for therapy or mobility
12	Patient is confined to a bed or chair
13	Patient is confined to a room or an area without bathroom facilities
14	Ambulation is impaired and walking aid is used for mobility
15	Patient condition requires positioning of the body or attachments which would not be feasible with the use of an ordinary bed
16	Patient needs a trapeze bar to sit up due to respiratory condition or change body positions for other medical reasons
17	Patient's ability to breathe is severely impaired
18	Patient condition requires frequent and/or immediate changes in body positions
19	Patient can operate controls
20	Side rails are to be attached to a hospital bed owned by the beneficiary
21	Patient owns equipment
22	Mattress or side rails are being used with prescribed medically necessary hospital bed owned by the beneficiary
23	Patient needs lift to get in or out of bed or to assist in transfer from bed to wheelchair
24	Patient has an orthopedic impairment requiring traction equipment which prevents ambulation during period of use
25	Item has been prescribed as part of a planned regimen of treatment in patient's home
26	Patient is highly susceptible to decubitus ulcers
27	Patient or a caregiver has been instructed in use of equipment
28	Patient has poor diabetic control
29	A 6-7 hour nocturnal study documents 30 episodes of apnea each lasting more than 10 seconds
30	Without the equipment, the patient would require surgery
31	Patient has had a total knee replacement
32	Patient has intractable lymphedema of the extremities
33	Patient is in a nursing home
34	Patient is conscious
35	This feeding is the only form of nutritional intake for this patient
37	Oxygen delivery equipment is stationary
38	Certification signed by the physician is on file at the supplier's office
39	Patient has mobilizing respiratory tract secretions
40	Patient or caregiver is capable of using the equipment without technical or professional supervision
41	Patient or caregiver is unable to propel or lift a standard weight wheelchair

Code	*Description*
42	Patient requires leg elevation for edema or body alignment
43	Patient weight or usage needs necessitate a heavy duty wheelchair
44	Patient requires reclining function of a wheelchair
45	Patient is unable to operate a wheelchair manually
46	Patient or caregiver requires side transfer into wheelchair, commode or other
58	Durable Medical Equipment (DME) purchased new
59	Durable Medical Equipment (DME) Is under warranty
5A	Treatment is rendered related to the terminal illness
60	Transportation was to the nearest facility
68	Severe
69	Moderate
9D	Lack of appropriate facility within reasonable distance to treat patient in the event of complications
9E	Sudden onset of disorientation
9F	Sudden onset of severe, incapacitating pain
9H	Patient requires intensive IV therapy
9J	Patient requires protective Isolation
9K	Patient requires frequent monitoring
AA	Amputation
AG	Agitated
AL	Ambulation limitations
BL	Bowel limitations, bladder limitations, or both (incontinence)
BPD	Beneficiary is partially dependent
BR	Bedrest BRP (bathroom privileges)
BTD	Beneficiary is totally dependent
CA	Cane required
CB	Complete bedrest
CM	Comatose
CNJ	Cumulative injury
CO	Contracture
CR	Crutches required
DI	Disoriented
DP	Depressed
DY	Dyspnea with minimal exertion
EL	Endurance limitations
EP	Exercises prescribed
FO	Forgetful
HL	Hearing limitations
HO	Hostile
IH	Independent at home
LB	Legally blind
LE	Lethargic
MC	Other mental condition
NR	No restrictions
OL	Other limitation
OT	Oriented
PA	Paralysis
PW	Partial weight bearing
SL	Speech limitations
TNJ	Traumatic injury
TR	Transfer to bed, or chair, or both
UN	Uncooperative
UT	Up as tolerated
WA	Walker required

Code	Description
WR	Wheelchair required

Patient Assignment Codes

Use this table to determine the appropriate patient assignment code.

Code	Description
01	Medical Care
02	Surgical
12	Durable Medical Equipment - Purchase
18	Durable Medical Equipment - Rental
35	Dental Care
40	Oral Surgery
42	Home Health Care
44	Home Health Visit
54	Long Term Care Waiver Services
56	Medically Related Transportation
69	Maternity
72	Inhalation Therapy
74	Private Duty Nursing
75	Prosthetic Devices
A4	Psychiatric
AD	Occupational Therapy
AE	Physical Therapy
AF	Speech Therapy
AL	Vision - Optometry
CQ	Case Management

Prognosis Codes (Home Health and Private Duty Nursing Services Only)

Use this table for the appropriate code to describe the patient's prognosis.

Code	Description
1 - 2	Good
4 - 6	Fair
7 - 8	Poor

4.3.3 Requesting a Revision to a Prior Authorization

Providers may request a change to a prior authorization for DME and certain medical services by completing Form 471. Prior authorizations, for which a claim has been paid, may not be revised until the claim has been voided. The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs or for procedure code changes. Providers must submit reconsideration for a denied PA following the usual process of faxing or mailing the PA denial letter to HP, along with the supporting documentation for reconsideration. Providers may submit a new PA for procedure code changes. Complete the appropriate sections on the form and fax to the Alabama Medicaid Agency at (334) 353-9352 or (334) 353-4909. Please allow three business days for processing. The form may be accessed at http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_Form%20471_PA_Change_Request_fillable_12-8-11.pdf

Deleted: ~~http://www.medicaid.alabama.gov/documents/Billing/5-F_Forms.Billing/5F-2_Prior.Auth.Forms/5F-2a_PA_Change_Request_Form_471_8-10-10.pdf.~~

Added: http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_Form%20471_PA_Change_Request_fillable_12-8-11.pdf

NOTE:

Form 471 may not be used for dental, pharmacy or for Magnetic Resonance Imaging (MRI) scan Magnetic Resonance Angiogram (MRA) scan, Computed Tomography (CT) scan, Computed Tomography Angiogram (CTA) scan, and Positron Emission Tomography (PET) scan prior authorizations. Prior Authorization documents must support the requested change(s) or the request will be denied.

Deleted: ~~If the prior…Montgomery, AL 36103-5624~~

Providers use this form to submit dental PAs on paper. These forms are available through the Alabama Medicaid Agency. Dental prior authorizations may also be submitted electronically through the Web Portal.

Replaced form

4.3.4 Blank Alabama Prior Review and Authorization Dental Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone ( ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

Section III

DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

_____

_____

3. Brief Dental/Medical History:_____

_____

_____

_____

_____

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____

FORWARD TO: HP, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343
Revised 5/28/13

Alabama Medicaid Agency
www.medicaid.alabama.gov

4.3.5 Instructions for Completing the Alabama Prior Review and Authorization Dental Request Form

Section 1: Requesting Provider Information (Required)

Requesting NPI or License #	Enter the NPI or license number of the physician requesting or prescribing services.
Phone	Enter the current area code and telephone number for the requesting dental provider.
Name	Enter the name of the dental provider.
National Provider Identifier	Enter the 10-digit NPI of the requesting provider.

Section 2: Recipient Information (Required)

Recipient Medicaid Number	Enter the 13-digit RID number.
Name	Enter the recipient's full name as it appears on the Medicaid eligibility transaction.
Address	Enter the recipient's current address.
City/State/Zip	Enter the city, state, and zip code for the address of the recipient.
Telephone Number	Enter the recipient's most current phone number.

Section 3: Procedure Information

Dates of Service	Enter the start and stop dates of service requested. Enter dates using the format CCYYMMDD. Use the date you complete the form and add six months. For example, 20050401 (April 1, 2005) through 20051001(October 1, 2005).
Place of Service	Circle the appropriate two-digit place of service.
Procedure Code	Enter the five digit procedure code requiring prior authorization. Use the correct CDT2005 procedure code.
Quantity Requested	Enter the number of times the procedure code will be used/billed.
Tooth Number	Enter the tooth number(s) or area of the mouth in relation to the procedure code requested.

Section 4: Medical Information

Complete Items 1-3 with the information requested. Documentation must be legible. If x-rays are sent, place them in a separate sealed envelope marked with recipient's name and Medicaid number.

Indicate whether the recipient has missing teeth and indicate the missing teeth with an X on the diagram.

After reading the provider certification, the provider signs and dates the form. In place of signing the form, the provider or authorized representative initials the provider's stamped, computer generated, or typed name, or indicate authorized signature agreement on file.

The completed form should be forwarded to HP at the address given on the form.

4.4 Receiving Approval or Denial of the Request

Letters of approval will be sent to the provider indicating the approved ten-digit PA number, dates of service, place of service, procedure code, modifiers, and authorized units or dollars. This information should be used when filing the claim form. All electronic claims (278) will generate a 278 Health Care Services Review – Response, to notify the requester that of the response. Once the State has made a decision on the request, it will trigger an electronic 278 response to the provider. The electronic 278 response will either contain the PA number, rejection code or cancellation code information.

Section 1: Decision Codes

Current Decision Codes:		HIPAA Decision Codes:	
A	Approved	X	Cancelled
E	Evaluating	Z	Rejected
D	Denied		
M	Modified PA Request		
P	Pending		
S	Dismissed No Hearing Approved		
R	Rejected		

Letters of denial will also be sent to the provider and recipient indicating the reason for denial.

Letters of approval or denial will be sent to both the provider and recipient for private duty nursing PAs.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). The Alabama Medicaid Agency must receive this request for appeal **within 30 days** from the date of the denial letter, or the decision will be final and no further review will be available.

Deleted: ~~within 30 days~~

Added: **within 30 days**

NOTE:

Providers may NOT bill a Medicaid recipient for an item for which a PA was denied.

4.5 Using AVRS to Review Approved Prior Authorizations

AVRS allows the provider to access information about an approved prior authorization number to confirm start and stop dates, procedure code(s), total units, and dollar amount authorized.

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu, then AVRS prompts you for the following:

- Your National Provider Identifier (NPI), followed by the pound sign
- The ten-digit prior authorization number, followed by the pound sign

  AVRS performs a query and responds with the following information for the PA:

- Recipient number
- Procedure code or NDC, if applicable (some PAs do not require procedure codes or NDCs)

- Start and stop dates
- Units authorized
- Dollars Authorized
- Units used
- Dollars Used

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another Procedure Code or NDC for the same provider
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

4.6 Submitting Claims for Prior Authorized Services

Once the approved ten-digit PA has been received, providers may submit the claim electronically. The claim must match the approved PA with respect to procedure code, modifier, if any, approved dates, units and servicing provider NPI. The claims processing system will match the approved PA to the claim submitted.

NOTE:
Providers must also have the appropriate Patient 1st referral for certain patients and/or services. Refer to Chapter 39.

5

5 Filing Claims

Because Medicaid cannot make payments to recipients, the provider who performed the service must file an assigned claim and agree to accept the allowable reimbursement as full payment.

Federal regulations prohibit providers from charging recipients, the Alabama Medicaid Agency, or HP a fee for completing or filing Medicaid claim forms. The cost of claims filing is considered a part of the usual and customary charges to all recipients.

Effective March 1, 2010, all claims which do not require attachments or an Administrative Review override by Medicaid must be submitted electronically. This chapter provides basic information for filing claims. The information is not specific to provider type; it is intended to give all providers an understanding of the various methods for claims submission and instructions on completing claims forms. Once you understand the information in this section, you can refer to the chapter in Part II that corresponds to your provider type for additional claims filing information.

This chapter contains the following sections:

- *Before You Submit Your Claim,* which describes how claims are processed, which claim forms are approved for submission to Medicaid, and other general claim-related information
- *Completing the CMS-1500 Claim Form*, which provides detailed billing instructions for the CMS-1500 claim form
- *Completing the UB-04 Claim Form*, which provides detailed billing instructions for the UB-04 claim form
- *Completing the ADA Dental Claim Form*, which provides detailed billing instructions for the ADA Dental claim form
- *Completing the Pharmacy Claim Form*, which provides detailed billing instructions for the Pharmacy claim form
- *Crossover Claim Filing*, which provides billing instructions for the medical claim form. **Please note that for an administrative or manual review Alabama Medicaid requires paper crossovers for professional claims to be submitted using the approved Medical Medicaid/Medicare-related crossover claim form. Institutional providers should use the UB-04 claim form for crossovers.**
- *Required Attachments*, which lists and describes the Alabama Medicaid required attachments
- *Adjustments,* which provides instructions for submitting online adjustments.
- *Refunds,* which provides instructions on receiving refunds
- *Inquiring about Claim and Payment Status,* which describes various methods for contacting HP to inquire about claim and payment status

5.1 Before You Submit Your Claim

This section discusses claim types, how HP processes claims, and the various methods for submitting claims. It includes the following topics:

- Valid Alabama Medicaid claim types
- How claims are processed
- Methods for submitting claims with attachments
- Electronic claims submission
- Filing limits and approved exceptions
- Recipient signatures
- Provider signatures

5.1.1 Valid Alabama Medicaid Claim Types

Alabama Medicaid processes eight different claim types (Managed Care claims are described in Chapter 39, Patient 1st). The claims must be submitted in electronic format. Alabama recognizes two standard claim forms (UB-04 and CMS-1500) and three Medicaid non-standard claim forms (Pharmacy, Dental, and one Medicare/Medicaid-related claim form). The provider's provider type determines which claim type to bill, as illustrated in the table below.

Claim Type	***Claim Form***	***HIPAA Transaction***	***Providers Who Bill Using This Claim Type***
Medical	CMS-1500	837 Professional	• Physicians • Physician Employed Practitioners (CRNP and PA) • Independent Labs • Independent Radiology • Transportation • Prosthetic Services • DME • Podiatrists • Chiropractors • Psychologists • Audiologists • Therapists (Physical, Speech, Occupational) • Optometrists/Opticians • Optical Dispensing Contractor • Clinics • Rural Health Clinics (IRHC, PBRHC) • FQHC • County Health Departments • Targeted Case Management • Independent Nurse Practitioner • Hearing Aid Dealer • Waiver Services (Homebound, Elderly and Disabled, MR/DD) • Maternity Care • State Rehab Services (Mental Health Centers, DYS, DHR) • CRNA • Nurse Midwife

Claim Type	*Claim Form*	*HIPAA Transaction*	*Providers Who Bill Using This Claim Type*
Dental	2006 ADA	837 Dental	Dentists/Oral Surgeons when billing CDT codes
Pharmacy	XIX-BC-10-93	NCPDP	Pharmacists
Inpatient	UB-04	837 Institutional	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient	UB-04	837 Institutional	• Hospitals • Ambulatory Surgical Centers (straight Medicaid) • Hemodialysis • Private Duty Nursing • Hospice Facility • Home Health Services • Lithotripsy (ESWL)
Medical crossover	Medical Medicare/Medicaid-Related Claim	837 Professional	All providers listed under the medical claim type • Ambulatory Surgical Centers (crossover claims)

5.1.2 How Claims are Processed

This section briefly describes claims processing, from assigning a unique tracking number to a claim, to generating and mailing the payment.

Internal Control Number

All claims entered into the HP system for processing are assigned a unique 13-digit Internal Control Number (ICN). The ICN indicates when the claim was received and whether it was sent by paper or through electronic media. The ICN is used to track the claim throughout processing, on the Remittance Advice (RA), and in claims history.

For more information about the ICN numbering system used for claims processing, refer to Appendix F, Medicaid Internal Control Numbers.

Claims Processing

HP verifies that the claim contains all of the information necessary for processing. The claim is processed using both clerical and automated procedures.

First, the system performs validation edits to ensure the claim is filled out correctly and contains sufficient information for processing. Edits ensure the recipient's name matches the recipient identification number (RID); the procedure code is valid for the diagnosis; the recipient is eligible and the provider is active for the dates of service; and other similar criteria are met.

For electronically submitted claims, the edit process is performed several times per day; for paper claims, it is performed five times per week. If a claim fails any of these edits, it is returned to the provider.

The system then performs the National Correct Coding Initiative (NCCI) procedure to procedure and medically unlikely edits.

Once claims pass through edits, the system reviews each claim to make sure it complies with Alabama Medicaid policy and performs cost avoidance. Cost avoidance is a method that ensures Medicaid is responsible for paying for all services listed on the claim. Because Medicaid is the payer of last resort, the system confirms that a third party resource is not responsible for services on the claim.

The system then performs audits by validating claims history information against information on the current claim. Audits check for duplicate services, limited services, and related services and compares them to Alabama Medicaid policy.

The system then prices the claim using a State-determined pricing methodology applied to each service by provider type, claim type, recipient benefits, or policy limitations.

Once the system completes claims processing, it assigns each claim a status: approved to pay, denied, or suspended. Approved to pay and denied claims are processed through the financial cycle twice a month, at which time a Remittance Advice (RA) report is produced and checks are written, if applicable. Suspended claims must be worked by HP personnel or reviewed by Alabama Medicaid Agency personnel, as required.

Claims approved for payment are paid with a single check or electronic funds transfer (EFT) transaction according to the checkwriting schedule published in the *Provider Insider*, the Alabama Medicaid provider bulletin produced by HP. The check is sent to the provider's payee address. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the provider's bank account. Effective March 1, 2010, Medicaid no longer prints and distributes paper Remittance Advices (RAs) to providers. RAs are described in Chapter 6, Receiving Reimbursement.

5.1.3 Methods for Submitting Claims

HP accepts all claims which do not require attachments or an Administrative Review override by Medicaid in electronic format. Paper claims submitted for an administrative or manual review must be submitted using the approved claim formats listed in the table in Section 5.1.1, Valid Alabama Medicaid Claim Types.

To improve hard copy claims processing, HP now scans paper claims and performs Optical Character Recognition (OCR) to enter data from the claims into the Medicaid system. All CMS-1500 and UB-04 paper claims must be submitted using red dropout forms. The scanner drops any red or blue markings on the claim form, leaving only the data the provider entered on the claim form.

NOTE:

All claim forms must be completed in dark **BLACK** ink. Do not circle, underline, or highlight any information on the claim. **Send original claim forms only;** do not send copies.

Providers should submit typewritten or computer-generated paper claims whenever possible to speed up the data entry process. Keep in mind the following guidelines:

- Make sure typed information does not fall outside the specific boxes.
- Change printer ribbons often, since claims with print too light to be scanned will be returned.

Providers can obtain Medicaid/Medicare-related claim forms free of charge from HP.

5.1.4 Electronic Claims Submission

Electronic claims may be submitted using a variety of methods:

- Provider Electronic Solutions software, provided at no charge to Alabama Medicaid providers
- Value Added Networks (VANs) or billing services on behalf of an Alabama Medicaid provider
- Tapes or other electronic media, as mutually agreed to by the Alabama Medicaid Agency and the vendor

Electronic Claims Submission (ECS) offers providers a faster and easier way to submit Medicaid claims. When you send your claims electronically, there is no need to complete paper Medicaid forms. Your claim information is submitted directly from your computer to HP.

If filing claims using the PES software, please refer to the Provider Electronic Solutions User Manual for the appropriate claim filing instructions and values.

Electronic claims begin processing as soon as they are received by the system. Paper claims must go through lengthy processing procedures, which could result in delayed payment on the claims. An electronically submitted claim displays on the next Remittance Advice (RA) following the claim submission. Unless your claim suspends for medical policy reasons, it should finalize (pay or deny) in the checkwriting step.

All of the Electronic Claims Submission (ECS) options are provided free of charge. Providers also have the option of using software from a software vendor or programmer. HP furnishes file specifications at no charge. **If you have further questions or wish to order software, contact the HP Electronic Claims Submission (ECS) Help Desk at 1(800) 456-1242** (out of state providers call (334) 215-0111).

5.1.5 Filing Limits and Approved Exceptions

Generally, Medicaid requires all claims to be filed within one year of the date of service; however, some programs have different claims filing time limit limitations. Refer to your particular provider type program chapter for clarification.

Claims more than one year old may be processed under the following circumstances:

- Claims filed in a timely manner with Medicare or other third party payers may be processed if received by the fiscal agent within 120 days of the third party disposition date. These claims may be filed electronically. Providers should enter the TPL paid date in the appropriate field. The HP claims processing system will then compare the TPL paid date to the assigned ICN; if the claim is received within 120 days it will process. Claims for services rendered to a recipient, during a retroactive eligibility period, may be processed if received by the fiscal agent **within one year** from the date of the retroactive award. Providers must submit these claims electronically.

- Claims for services that were previously paid by Medicaid and later taken back, either at Medicaid's request or the provider's request, may be processed if received by the fiscal agent **within 120 days** of the recoupment. This date must be indicated in the appropriate remarks section of the claim as specified in the claim billing instructions for each type of provider in the following format: "Recouped Claim 11-01-02" or "Recouped Claim Nov. 1, 2002". A copy of the Medicaid Remittance Advice (RA), showing the recoupment and the date must be attached to the claim.

Submit claims more than one year old that meet the above criteria, to the following address:

HP Provider Assistance Center
P.O. Box 244032
Montgomery, AL 36124-4032

NOTE:

Refer to Section 7.2.1, Administrative Review and Fair Hearings, for more information regarding administrative reviews.

5.1.6 Recipient Signatures

While a recipient signature is not required on individual claim forms, all providers must obtain a signature to be kept on file, (such as release forms or sign-in sheets) as verification that the recipient was present on the date of service for which the provider seeks payment. Exceptions to the recipient signature are listed below:

- The recipient signature is not required when there is no personal contact between recipient and provider, as is usually the case for laboratory or radiology.
- Illiterate recipients may make their mark, for example, "X," witnessed by someone with his dated signature after the phrase "witnessed by."
- A representative may sign for a recipient who is not competent to sign because of age, mental, or physical impairment.
- The recipient signature is not required when a physician makes a home visit. The physician must provide documentation in the medical record that the services were rendered.
- For services rendered in a licensed facility setting other than the provider's office, the recipient's signature on file in the facility's record is acceptable.

NOTE:

The use of Sign-In Sheets, as verification that the recipient was present on the date of service for which the provider seeks payment, is permissible under the Privacy Rule, but should be limited to the minimum necessary. For example, it should not have a column asking for "reason for visit." A provider's sign-in sheet may simply ask for the patient's name and nothing more.

5.1.7 Provider Signatures

This section discusses the various requirements for provider signatures when filing electronic or hard copy claims.

Medical Claims

The provider's signature on a claim form/medical submission agreement or the Provider Agreement certifies that the services filed were performed by the provider or supervised by the provider and were medically necessary.

NOTE:

Prior to October 1999, individual practitioners (not groups or clinics) may have signed a Medical Claims Submission Agreement with Medicaid for the submission of paper claims instead of signing individual claim forms. Effective October 1, 1999, the Medical Claims Submission Agreement was incorporated into the Alabama Medicaid Provider Agreement which must be completed and signed by all providers.

By signing the Provider Agreement, the provider agrees to keep any records necessary to enable the provider to perform the following responsibilities:

- Disclose the extent of services the provider furnishes to recipients
- Furnish Medicaid, the Secretary of HHS, or the state Medicaid Fraud Control Unit, upon request, any information regarding payments received by the provider for furnishing services
- Certify that the information on the claim is true, accurate, and complete, and the claim is unpaid
- Affirm the provider understands that the claim will be paid from federal and state funds, and any falsification or concealment of a material fact may be prosecuted under federal and state laws

Providers who have either a completed Medical Claims Submission Agreement or Provider Agreement on file should place the words "**Agreement on File**" in block 31.

The individual practitioner may also personally sign the claim form in the appropriate area and must initial the claim form beside a typewritten or stamped signature. An individual practitioner's name or initials may be signed by another person who has power of attorney from the practitioner.

Tape Billers

Providers submitting claims through a tape biller must have a contract on file with HP signed by the provider or the billing agent authorizing tape submission of claims.

Tapes that HP receives must be accompanied by a transmittal form signed by the billing provider or the billing agent.

Electronic Billers

Providers billing electronically must have a contract signed by the provider on file with HP. When applicable, the billing agent's signature must also appear on the contract.

Diskette Billers

Providers submitting claims on diskette to HP must have a contract signed by the provider on file with HP.

Computer Generated Claim Forms

Computer generated claim forms may be submitted with the provider's name generated on the form. In which case, the provider's handwritten name or initials must accompany the name.

"Agreement on File" may also be printed on computer generated claim forms in lieu of the provider's signature, if either a Medical Claim Submission Agreement or Provider Agreement is on file.

The policy provisions for provider signatures can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 1.

5.1.8 Submitting Paid and Partially Paid Claims to Medicaid

Providers may submit paid, partially paid, and deductible applied third party claims to Medicaid using the approved paper or online filing methods as described in Chapter 5, Filing Claims. Additionally, to capture third party payment information, a TPL panel (for electronic claims) or a Medicaid Other Insurance Attachment form (for paper claims) is required to provide the other payer amounts that were applied to the following: paid amount, deductible amount, coinsurance amount, and co-pay amount. Completion instructions for the TPL panel may be found in the Provider Electronic Solutions (PES) User Guide and the interactive Service-Web User Guide. Completion instructions for the Medicaid Other Insurance attachment form may be found in section 5.8 of this chapter. **The following third party-related information is also required on the claim,** in addition to the other required claim data:

Claim Form	***Include the Following Third Party Information***	***In These Claim Fields***
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL paid dates	• Blocks 9-9d • Block 10 • Block 19
UB-04	• Other payer name • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL paid date	• Block 50 • Block 58 • Block 60 • Block 61 • Block 62 • Block 73 • Block 80
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Policyholder/Subscriber ID (SSN or ID#) • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL payment	• TPL carrier information • TPL payment/denial information

NOTE:

The Medicaid Other Insurance Attachment form is not required in addition to the Pharmacy claim form.

NOTE:

Failure to list the third party payment in the appropriate space on the claim may result in a denied claim.

If the claim is less than one year old and the other payer processed a payment or applied all the allowed charges toward the patient's responsibility, (ie. deductible, coinsurance, or co-pay), then the claim may be submitted electronically and Medicaid does not require the attachment of the third party Remittance Advice (RA) Claims more than one year old may be submitted electronically if 1) the third party payer has made a payment or applied the charges toward patient responsibility and 2) the claim submission date is within 120 days of the third party payment. If a claim is more than one year old and the third party payer has denied the claim, the claim must be submitted on paper, along with an attached copy of the third party Remittance Advice (RA). Claims more than one year old must be submitted within 120 days of the third party payment.

Claims meeting the requirements for Medicaid payment will be paid in the following manner if a third party payment is indicated on the claim:

- Other payer patient responsibility amounts (the deductible, coinsurance, and co-pay amounts) will be captured by Medicaid and used in determining the amount of Medicaid payment. In order for claims to be considered for payment, the patient responsibility must be greater than zero or the claim will be denied with the denial message "TPL Patient Responsibility is Zero for payor". Patient responsibility will be calculated by adding together any co-payment, coinsurance, and deductible.
- For professional claims, other payer amounts will be captured at the header and the detail levels. The total submitted at the header should balance the totals submitted at the detail. Medicaid will pay the lesser of the other payer patient responsibility or the Medicaid allowed amount minus the other payer paid amount.
- Other payer-paid amounts exceeding the Medicaid allowed amount will receive no further payment from Medicaid. Medicaid will place a zero paid amount on the claim and include an explanatory EOB code on the Remittance Advice (RA). **Patients cannot be billed under this condition.**

The Medicaid Other Insurance Attachment form is required only when a claim must be submitted on paper for administrative or manual review, and third party insurance has made a payment or applied charges to patient responsibility.

NOTE:

Providers cannot charge the recipient for other insurance co-pays when the service is billed to Medicaid. As stated above, other payer co-pays, coinsurance, and deductibles are to be submitted to Medicaid as other payer patient responsibility amounts and are considered for payment during Medicaid's claims processing.

5.1.9 Submitting Denied Claims to Medicaid

Providers may submit denied third party claims to Medicaid. **The following third party-related information is required on the claim,** in addition to the other required claim data:

Claim Form	*Include the Following Third Party Information*	*In These Claim Fields*
CMS-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL denied dates	• Blocks 9-9d • Block 10 • Block 19
UB-04	• Other payer name • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL denied date	• Block 50 • Block 58 • Block 60 • Block 61 • Block 62 • Block 73 • Block 80
ADA Dental	• Is patient covered under another dental plan? • Other Insured's Name (Last, First, Middle Initial, Suffix) • Policyholder/Subscriber ID (SSN or ID#) • Plan/Group Number • Relationship to Insured • Other Carrier Name, address, and zip code • TPL Denial Date (with EOB ATTACHED)	• Block 4 • Block 5 • Block 8 • Block 9 • Block 10 • Block 11 • Block 35 Remarks
Pharmacy	• Carrier code/name/policy number • Other insurance dollars paid (if applicable) and reason code for TPL denial	• TPL carrier information • TPL payment/denial information

All claims with a third party denial **must** be submitted on paper with a copy of the third party denial attached. Claims with a third party denial **cannot** be submitted electronically.

Providers must submit legible copies of third party denials when billing Medicaid for services denied by the third party. For claims with dates of service over one year to be considered for payment, the denial must be dated by the insurance company and the claim must be submitted within 120 days of third party denial.

NOTE:

Be sure to indicate on the claim form that it denied for TPL. The table above lists, by claim type and block number, the fields that must be filled out to submit a claim that denied for TPL.

5.2 Completing the CMS-1500 Claim Form

This section describes how to complete the CMS-1500 claim form for submission to HP. For a list of providers who bill for services using the CMS-1500 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use by all providers who bill using this claim form. For program-specific billing information, please refer to the chapter in Part II that corresponds to your provider type.

CMS-1500 Electronic Billing

Electronic billers must submit CMS-1500/837 Professional claims in approved formats. The 837 Professional transaction allows providers to bill up to 50 details per Professional (837 transaction) claim type.

Providers can obtain Provider Electronic Solutions software from HP free of charge. Providers may also utilize Medicaid's Interactive Web Portal. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

CMS-1500 Claims Form Paper Billing

CMS-1500 forms may be purchased through HP. Providers may also obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard CMS format using red dropout ink.

Claims must contain the billing provider's complete name, address, and NPI.

Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number – NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Payee's 10-digit NPI
- Rendering (performing) provider's 10-digit NPI (on each line item)

A claim lacking any of the critical claim information cannot be processed. Also, each claim form must have a provider signature, initials, a stamped signature, or have an agreement on file with HP to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

Guidance Regarding NDC's on the CMS-1500 Form

Effective August 2008, Alabama Medicaid mandated that the National Drug Code (NDC) number be included on the CMS-1500 claim form for the Top 20 physician administered drugs as defined by CMS. Effective October 1, 2010, the NDC number will be mandatory on **ALL** physician-administered drugs in the following ranges: J0000-J9999, S0000-S9999 and Q0000-Q9999. Refer to Appendix H for more information. Medicaid requires that each submitted NDC contain 11-digits (no dashes or spaces). The first 5-digits identify the labeler code of the manufacturer of the drug. The next 4-digits identify the specific strength, dosage form, and formulation of that drug. The last 2-digits identify the package size of the drug.

There may be some instances when an NDC does not contain all eleven digits on the product's container. In the following instances, the correct format for submission of the NDC in Item Number 24D is given:

- xxxx-xxxx-xx; in this case a zero (0) would need to be added in front of the first set of numbers.

  Result: 0xxxxxxxxxx.

- xxxxx-xxx-xx: in this case a zero (0) would need to be added in front of the second set of numbers.

  Result: xxxxx0xxxxx.

- xxxxx-xxxx-x: in this case a zero (0) would need to be added in front of the third set of numbers.

  Result: xxxxxxxxx0x.

Deleted: ~~http://www.fda.gov/cder/ndc/index.htm~~.

Added: http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm

Please refer to the Food and Drug Administration (FDA) website below for more information regarding the National Drug Code, http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

For additional questions regarding physician administered drugs, please contact Pharmacy Services at (334) 242-5050.

5.2.1 CMS-1500 Blank Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

13. INSURED OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate items 1, 2, 3 or 4 to item 24E by Line)

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. b.

33. BILLING PROVIDER INFO & PH # ( ) a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

Printed on Recycled Paper

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

5.2.2 CMS-1500 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the CMS-1500 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

Block No.	*Description*	*Guidelines*
1a	Insured's ID no.	Enter the patient's 13-digit recipient number (12 digits plus the check digit) from the Medicaid identification card and/or eligibility verification response. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
2	Patient's name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID number you entered in Block 1.** If a recipient has two initials instead of a first name, enter the first initial along with a long space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
3	Patient's date of birth Patient's sex	Enter the month, day, and year (MM/DD/YY) the recipient was born. Indicate the recipient's sex by checking the appropriate box.
5	Patient's address	Enter the patient's complete address as described (city, state, and ZIP code).
9-9d	Other insured's name	If the recipient has other health insurance coverage, enter all pertinent information. **Providers must submit the claim to other insurers prior to submitting the claim to Medicaid.**
10	Was condition related to: A) Patient's employment B) Auto accident C) Other accident	Indicate by checking the appropriate box. If applicable, enter all available information in Block 11, "Other Health Insurance Coverage."
17	Name of referring physician or other source	Enter one of the following, if applicable: • The name of the referring Patient 1st provider • The EPSDT referring provider if the services are the result of an EPSDT screening • The referring lock-in physician if the eligibility verification response indicates the recipient has Lock-In status Please refer to Section 3.3, Understanding the Eligibility Response, for information on Lock-in or as they relate to recipient eligibility Appendix A, EPSDT, provides referral instructions for EPSDT.

Block No.	*Description*	*Guidelines*
17B	Referring NPI number	A referring NPI should only be included for lock-in, Patient 1st, EPSDT or anesthesia referrals.
19	Reserved for Local use	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • Home accident • Treatment due to disease • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date The substitute provider's name may also be indicated here.
21	Diagnosis or nature of illness or injury	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not include diagnosis descriptions. Do not use decimal points in the diagnosis code field.
23	Prior Authorization Number	For prior authorization requests approved by Medicaid, the prior authorization number will be automatically entered into the claims system by Medicaid's contractor. For general information regarding prior authorization, refer to Chapter 4, Obtaining Prior Authorization. For program-specific prior authorization information, refer to the chapter in Part II that corresponds to your provider or program type. **Do not use for any other number. Leave blank if this does not apply.**
24a	Date of service (DOS)	Enter the date of service for each procedure provided in a MM/DD/YY format. If identical services (and charges) are performed on the same day, enter the same date of service in both "from" and "to" spaces, and enter the units perform in Block 24g. **Exception**: Provider visits to residents in nursing facilities must be billed showing one visit per line.
24b	Place of service (POS)	Enter a valid place of service (POS) code for each procedure. For program-specific POS values, refer to the chapter in Part II that corresponds to your provider or program type.
24c	EMG	This field is used to indicate certain co-payment exemptions: • Enter an "A" for Native American Indian with an active user letter • Enter an "E" for certified emergency • Enter a "P" for pregnancy Do not enter Y or N.
24d	Procedures, Services, or Supplies CPT/HCPCS and MODIFIER	Enter the appropriate five-digit procedure code (and two-digit modifier, as applicable) for each procedure or service billed. Use the current CPT-4 book as a reference. If entering NDC information, enter N4 qualifier in the first two positions, left justified, followed immediately by the 11 character NDC number (no hyphens). Note: Up to 4 modifiers can be entered per procedure code.
24e	Diagnosis code	Enter the line item reference (1, 2, 3, or 4) for each service or procedure as it relates to the primary ICD-9 code identified in Block 21. If a procedure is related to more than one diagnosis, the primary diagnosis to which the procedure is related must be the one identified. Enter only one digit in this block.
24f	Charges	Indicate your usual and customary charges for each service listed. Charges must not be higher than fees charged to private-pay patients.

Block No.	***Description***	***Guidelines***
24g	Units	Enter the appropriate number of units. Be sure that span-billed visits equal the units in this block. Use whole numbers only.
24h	EPSDT Family Planning	Enter one of the following values, if applicable: • "1" if the procedure billed is a result of an EPSDT referral • "2" if the procedure is related to Family Planning • "3" if the procedure is a Patient 1st referral • "4" if the procedure is EPSDT and Patient 1st referral
24I	ID Qual	Enter in the shaded area of 24I the qualifier identifying if the number is a non-NPI. This will only be used for providers that are not required to obtain an NPI. These providers should use the following identifier in 24I: ID which identifies the number being used as a Medicaid provider number. Should a provider need to use a taxonomy code on a claim, use the following: ZZ which identifies the number being used is a provider taxonomy code.
24J	Rendering provider ID	The individual provider performing the service is reported in 24J. If not entering an NPI, the number should appear in the shaded area of the field. The NPI number should be entered in the non-shaded area. Secondary ID: Enter the secondary identifier for the performing provider in the shaded area of the field. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
26	Patient account number	This field is optional. Up to 20 alphanumeric characters may be entered in this field. If entered, the number appears on the provider's Remittance Advice (RA) to assist in patient identification.
28	Total charge	Enter the sum of all charges entered in Block 24f lines 1-6.
30	Balance due	Subtract Block 29 from Block 28 and enter the balance.
31	Signature of physician or supplier	After reading the provider certification on the back of the claim form, sign the claim. In lieu of signing the claim form, a signed Medicaid Claims Submission Agreement or the Provider Agreement, must be on file with HP. The statement "Agreement on File" must be entered in this block. The provider or authorized representative must initial the provider's stamped, computer generated, or typed name.
33	Billing Provider Info and Phone Number	1st Line: Name of the Payee provider as it appears in the HP system 2nd Line: Address 3rd Line: City, State and Zip Code (include zip+4) 33A: Enter the payee (group) NPI 33B: Enter the two-digit qualifier (G2) identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and the number. (Only for providers who do not qualify to receive an NPI).

5.3 Completing the UB-04 Claim Form

This section describes how to complete the UB-04 claim form for submission to HP. For a list of providers who bill for services using the UB-04 claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use by all providers who bill using this claim form. For program-specific billing information, please refer to the chapter that corresponds to your provider type.

UB-04 Electronic Billing

Electronic billers must submit UB-04/837 Institutional claims in approved formats. The 837 Institutional transaction allows providers to bill up to 999 details per Institutional (837 Institutional transaction) claim type. Providers can obtain Provider Electronic Solutions software from HP free of charge. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

UB-04 Claims Form Paper Billing

HP does not supply the UB-04 claim form. Providers may obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed in the standard UB-04 format using red dropout ink.

Claims must contain the billing provider's complete name, address, and NPI. Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number– NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Provider's 10-digit NPI

A claim lacking any of the critical claim information cannot be processed.

NOTE:
Multiple page claims are not accepted for the paper UB-04s.

Guidance Regarding NDC's on the UB-04 Form

Effective September 2008, Alabama Medicaid mandated that the National Drug Code (NDC) number be included on the UB-04 claim form for the Top 20 physician administered drugs as defined by CMS. Effective October 1, 2010, the NDC number will be mandatory on **ALL** physician-administered drugs in the following ranges: J0000-J9999, S0000-S9999 and Q0000-Q9999. Refer to Appendix H for more information. Alabama Medicaid would like to clarify the required format for the NDC number that is submitted on this claim form. Medicaid requires that each submitted NDC contain 11-digits (no dashes or spaces). The first 5-digits identify the labeler code of the manufacturer of the drug. The next 4-digits identify the

specific strength, dosage form, and formulation of that drug. The last 2-digits identify the package size of the drug.

There may be some instances when an NDC does not contain all eleven digits on the product's container. In the following instances, the correct format for submission of the NDC in Form Locator 43 (Description) is given:

- xxxx-xxxx-xx; in this case a zero (0) would need to be added in front of the first set of numbers.

  Result: 0xxxxxxxxxx.

- xxxxx-xxx-xx: in this case a zero (0) would need to be added in front of the second set of numbers.

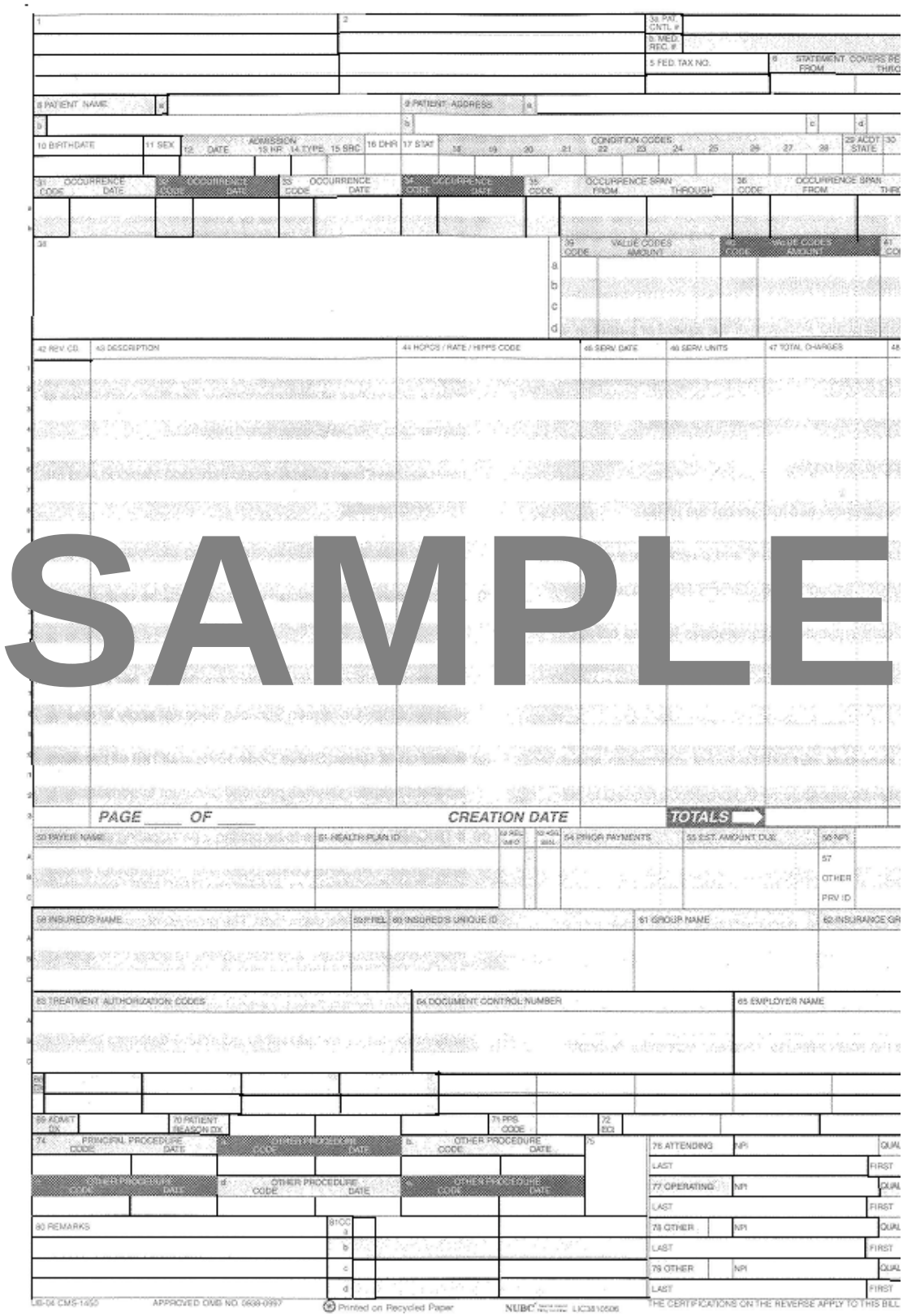
  Result: xxxxx0xxxxx.

- xxxxx-xxxx-x: in this case a zero (0) would need to be added in front of the third set of numbers.

  Result: xxxxxxxxx0x.

Please refer to the Food and Drug Administration (FDA) website below for more information regarding the National Drug Code, *http://www.fda.gov/cder/ndc/index.htm*. For additional questions regarding the CMS list of Top 20 physician administered drugs, please contact Pharmacy Services at (334) 242-5050.

5.3.1 UB-04 Blank Claim Form



5.4 UB-04 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the UB-04 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

Block No.	***Description***	***Guidelines***
1	Provider name, address, and telephone number	Enter the provider name, street address, city, state, ZIP code, and telephone number of the service location.
2	Pay to name/address	Required when the pay-to name and address information is different from the billing information in block 1. If used, providers must include, name, address, city, state, and zip.
3A 3B	Patient control number	**Optional**: Enter patient's unique number assigned by the provider to facilitate retrieval of individual's account of services containing the financial billing records. **3B**: Enter the patient's medical record number assigned to the hospital. This number will be referenced on the provider's Remittance Advice for patient identification. Up to twenty-four numeric characters may be entered in this field. .

Block No.	***Description***	***Guidelines***
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Non-patient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice 831 Ambulatory Surgical Center	Enter the four-digit type of bill (TOB) code: **1st Digit – Type of Facility** 1 Hospital 2 Long Term Care 3 Home Health Agency 7 Clinic (RHC, FQHC) *** see note** 8 Special Facility **** see note** **2nd Digit – Bill Classification** 1 Inpatient (including Medicare Part A) 2 Inpatient (Medicare Part B only) 3 Outpatient 4 Other (for hospital-reference diagnostic services; for example, laboratories and x-rays) **3rd Digit – Frequency** 0 Nonpayment/zero claim 1 Admit through discharge 2 Interim – first claim 3 Interim – continuing claim 4 Interim – last claim 5 Late charge(s) only claim ***Clinic requires one of the following as the 2nd Digit – Bill Classification:** 1 Rural Health 2 Hospital-Based or Independent Renal Dialysis Center 3 Free-Standing 4 Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facility (CORF) 6-8 Reserved for National Assignment 9 Other ****Special Facility requires one of the following as the 2nd Digit – Bill Classification:** 1 Hospice (non-hospital-based) 2 Hospice (hospital-based) 3 Ambulatory Surgical Center 4 Free-Standing Birthing Center 5 Critical Access Hospital 6 Residential Facility 7-8 Reserved for national assignment 9 Other
6	Statement covers period	Enter the beginning and ending dates of service billed. For inpatient hospital claims, these are usually the date of admission and discharge.

Block No.	***Description***	***Guidelines***
8	Patient's Name	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you entered in Block 60.** If a recipient has two initials instead of a first name, enter the first initial along with a space, then the second initial and no periods. If a recipient's first name contains an apostrophe, enter the first name including the apostrophe. **Examples:** For recipient A. B. Doe, enter "Doe A B" with no punctuation. For recipient D'Andre Doe, enter "Doe D'Andre" with an apostrophe and no spaces.
12	Admission Date/Start Date of Care	Enter the total days represented on this claim that are not covered. This is not required for outpatient claims. Enter numerically the date (MM/DD/YY) of admission for inpatient claims; date of service for outpatient claims; or start of care (SOC) for home health claims.
13	Admission hour (required field)	Military time (00 to 23) must be used for the time of admission for inpatient claims or time of treatment for outpatient claims. Code 99 is not acceptable. This block is not required for outpatients (TOB 141) or home health claims (TOB 331).
14	Type of admission	Enter the appropriate type of admission code for inpatient claims: 1 Emergency 2 Urgent 3 Elective 4 Newborn (This code requires the use of special source of admission code in Block 20) 5 Trauma Center
15	Source of admission	Enter the appropriate source of admission code for inpatient claims. For type of admission 1, 2, or 3 1 Physician referral 2 Clinic referral 3 HMO referral 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/Law enforcement 9 Information not available For type of admission 4 (newborn) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available 6 Transfer from another health care facility

Block No.	***Description***	***Guidelines***
16	Discharge hour	For inpatient claims, enter the hour of discharge or death. Use military time (00 to 23) to express the hour of discharge. If this is an interim bill (patient status of "30"), leave the block blank. Code 99 is not acceptable.
17	Patient discharge status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date. Refer to the UB-04 Billing Manual for the valid patient status codes. If status code 30, the total days in blocks 7 and 8 should include all days listed in the statement covers period. If any other status code is used, do not count the last date of service (discharge date).
18-28	Condition Codes	Used to indicate EPSDT-Referrals, Family Planning Services, and Co-payment exemptions. A1 Denotes services rendered as the result of an EPSDT screening. Block 78 must also contain the screening 10-digit NPI number. A4 Denotes services rendered as the result of family planning and will exempt the claim from copay. AJ – Denotes services rendered for Native American Indian with an active user letter and will exempt the claim from copay.
29	Accident State	REQUIRED ONLY IF AUTO ACCIDENT: Indicate two-digit state abbreviation where the accident occurred.
31-34	Occurrence Codes	Accident related occurrence codes are required for diagnoses between 80000-99499.
39-41	Value Codes and Amounts	Enter the appropriate value code and amount according to the following: 73 Denotes the Medicare Paid Amount 74 Denotes the Medicare Allowed Amount 80 Denotes the Covered Days 81 Denotes the Non-Covered Days 82 Denotes the Co-Insurance Days 83 Lifetime Reserve Days A1 Denotes the Medicare Deductible Amount A2 Denotes the Medicare Co-Insurance Amount
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed. Revenue 001 (total) must appear on each claim. If entering NDC information, enter N4 qualifier in the first two positions, left justified, followed immediately by the 11 character NDC number (no hyphens).

Added: Family Planning Services

Deleted: ~~exemption~~

Added: exemptions

Deleted: ~~for Native American Indians: The following UB-04 condition codes are valid for EPSDT referrals:~~

Added: services rendered as the result of

Deleted: ~~the $3~~

Deleted: ~~If A1 is…in block 78~~

Deleted: ~~The following UB-04… for copayment exemption:~~

Added: services rendered

Deleted: ~~copayment exemption:~~

Added: and will exempt the claim from copay.

Block No.	***Description***	***Guidelines***
44	HCPCS/Rates	Inpatient: Enter the accommodation rate per day. Home Health: Home Health agencies must have the appropriate HCPCS procedure code. Outpatient: Outpatient claims must have the appropriate HCPCS, procedure code. The UB-04 claim form is limited to 23 detail charges.
45	Service date	Outpatient: Enter the date of service that the outpatient procedure was performed. Nursing Homes: Enter the beginning date of service for the revenue code being billed. Span Billing: When filing for services such as therapies, home health visits, dialysis, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator (FL) 6 (statement covers period). In FL 45, the service date should be the first date in the statement covers period. The number of units should match the number of services reflected in the medical record.
46	Units of service	Enter total number of units of service for outpatient and inpatient services. For inpatient claims, this will be same as covered plus non-covered days.
47	Total charges	Enter the total charges for each service provided.
48	Non-covered charges	Enter the portion of the total that is non-covered for each line item.
50	Payer	Enter the name identifying each payer organization from which the provider might accept some payment for the charges.
56	NPI Number	Enter the 10- digit NPI Number
58	Insured's name	Enter the insured's name.
60	Insurance identification number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response and the policy numbers for any other insurance on file. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
61	Insured group's name	Enter the name of the group or plan through which the insurance is provided to the insured.
62	Insurance group number	Enter the group number of the other health insurance.
66	ICD Version Indicator	The qualifier denotes the version of the ICD reported. 9=Ninth Revision 0=Tenth Revision.

Block No.	***Description***	***Guidelines***
67	Principal diagnosis code Present on admission indicator	Enter the ICD-9 diagnosis code for the principal diagnosis to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field. Enter the present on admission (POA) indicator in shaded part of the field. This indicator is required for certain diagnosis codes and only on inpatient claims. Valid values are: Y – Diagnosis was present at time of inpatient admission. N – Diagnosis was not present at the time of inpatient admission. U – Documentation insufficient to determine if 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 if inpatient admission.
67A-67Q	Other diagnosis codes Present on admission indicator	Enter the ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5) for each additional diagnosis. Do not use decimal points in the diagnosis code field. Enter one diagnosis per block. Enter the present on admission (POA) indicator in the shaded part of the field. This indicator is required for certain diagnosis codes and only on inpatient claims.
69	Admitting diagnosis	**For Inpatient Claims**: Enter the admitting ICD-9 diagnosis code to the highest number of digits possible (3, 4, or 5). Do not use decimal points in the diagnosis code field.
70	Patient Reason DX	**For Outpatient claims only**- Enter the diagnosis for reason the recipient came in for treatment. **NOTE:**, This diagnosis is not always the same as the primary diagnosis.
73	Medicaid emergency/accident indicator	Enter an "H" to indicate that the service was rendered as a result of a home accident or treatment due to disease. Enter an "E" to indicate a certified emergency. A certified emergency ER claim must be certified by the attending physician. Both values may be entered, as applicable.
74a-74e	Principal and other procedure codes and dates	For inpatient hospital claims only, enter the ICD-9 procedure code for each surgical procedure and the date performed. Up to 5 surgical procedure codes and dates may be entered into this field.
76	Attending Physician ID	Enter the attending physician's NPI number and the appropriate qualifier "0B" followed by the physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
77	Operating physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Block 74, enter the surgeon's NPI number and the appropriate qualifier "0B" followed by the surgeon's license number.

Block No.	***Description***	***Guidelines***
78	Other physician ID	**Enter the referring physician's NPI number followed by the appropriate qualifier "DN" for the following types of referrals:** **• EPSDT referrals** **• Patient 1st referrals** **• Lock-in Physician referrals** **If not applicable, leave blank**
80	Remarks	Use this block to provide remarks, as appropriate. Examples include, but are not limited to the following: • TPL paid (MM/DD/YY) • TPL denied (MM/DD/YY) • Retroactive eligibility award date

5.5 Completing the ADA Dental Form

This section describes how to complete the 2006 ADA Dental form for submission to HP. For a list of providers who bill for services using the ADA Dental form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use for all providers who bill using this claim form; for program-specific billing information, please refer to Chapter 13, Dental.

Only version 2006 ADA Dental form is acceptable. If you experience problems with HP processing your forms, contact HP for resolution.

ADA Dental Electronic Billing

Electronic billers must submit ADA Dental claims in approved formats. Providers may bill up to 50 details per dental (837 Dental transaction) claim type.

Providers can obtain Provider Electronic Solutions software from HP free of charge. Providers may also use Medicaid's Interactive Web Portal. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

ADA Dental Claim Form Paper Billing

HP does not supply the ADA Dental claim form. Providers may obtain copies of the claim form from a printer of their choice.

Claims must contain the billing provider's complete name, address, and NPI. Critical claim information includes:

- Recipient's first and last name as it appears when verifying eligibility. NOTE: Recipient's Medicaid cards can have the name spelled differently that what is in our system.
- Recipient's 13-digit Medicaid number– NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Provider's 10-digit NPI

A claim without the above information cannot be processed. Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with HP to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

NOTE:

Because HP uses a new scanning process, **do not use a blue pen to complete paper claims.** Do not circle, underline, write notes or highlight any information on the claim. **Send original claim forms only;** do not send copies.

Providers should submit typewritten or computer-generated paper claims whenever possible to speed up the data entry process. Keep in mind the following guidelines:

- Make sure typed information does not fall outside the specific boxes.
- Change printer ribbons often, since claims with print too light to be scanned will be returned.

5.5.1 ADA Dental Blank Claim Form

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☐ Request for Predetermination / Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY)
14. Gender ☐ M ☐ F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. E[illegible]

PATIENT INFORMATION

18. Relationship to Policy[illegible]/Subscriber in #12 Above ☐ Self ☐ [illegible] ☐ Dependent Child ☐ [illegible]
19. [illegible]ent Status ☐ FTS ☐ PTS
20. Name (Last, First, Mid[illegible] Ini[illegible] Suffix), Address, City, State, [illegible]
21. Da[illegible] Birth (M[illegible]D/CCYY)
22. G[illegible]er ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH [illegible]RMATION

34. (Place an 'X' on e[illegible]

Permanent																Primary									
	2	3		5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	[illegible]	[illegible]	[illegible]	[illegible]	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treat[illegible] and associated fees. I agree to be responsible for all charges for dental services and materi[illegible] paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) –
52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number ( ) –
58. Additional Provider ID

©2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

SAMPLE

5.5.2 ADA Dental Filing Instructions

The instructions describe information that is required to be entered in each of the block numbers on the ADA Dental Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by HP.**

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
3	Company/Plan Name, Address, City State, Zip Code	For Medicaid Claims enter: HP, P.O.Box 244032, Montgomery, AL 36124-4032
4-11	Other Coverage *[These blocks are only required if patient has other insurance*]*.*	4. Other Dental or Medical Coverage? Check the applicable box 5. Name of Policyholder/subscriber in #4. Enter other insured's name (Last, First, Middle Initial, Suffix) 8. Policy Holder/Subscriber Identifier (SSN or ID#) Enter the Other Insurance Policy Number 9. Plan/Group Number Enter the plan/group number 10. Relationship to Insured Check the applicable box 11. Other insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
12	Policyholder/subscriber name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code [*Medicaid Recipient Information]*	Enter the Medicaid recipient's name as Last, First. Enter the name EXACTLY as it is given to you as a result of the eligibility verification transaction. Please note the name on the claim must match the information on the HP system for the Medicaid number**.** If the recipient has two initials instead of a first name, enter the first initial with a space, then the second initial without periods. If a recipient's name contains an apostrophe, enter the first name including the apostrophe. Examples: For recipient A. B. Doe, enter Doe, A B without punctuation. For recipient D'Andre Doe, enter Doe, D'Andre with an apostrophe and no spaces.
15	Subscriber Identifier (SSN or ID#)	Enter the recipient's 13-digit Medicaid Number (RID) from the Medicaid eligibility verification response. For instructions on performing eligibility verification transaction, please refer to Chapter 3 of the provider billing manual, Verifying Recipient Eligibility. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
24	Procedure Date (MM/DD/CCYY)	Enter numerically (MM/DD/CCYY) the date of service for each procedure provided.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
25	Area of the Oral Cavity	If applicable, enter the Oral Cavity Designation Code associated with the procedure being performed on a specific tooth. 00 —Full Mouth 01 —Upper Arch 02 —Lower Arch 09 —Other Area of Oral Cavity 10 —Upper Right Quadrant 20 —Upper Left Quadrant 30 —Lower Left Quadrant 40 —Lower Right Quadrant L —Left R—Right There are few procedures that require an oral cavity designation code. Some of these include but are not limited to D4341, D4355, D4910, D7970 and D7971.
27	Tooth Number(s) or Letter(s)	Enter the appropriate tooth number for the permanent teeth (01-32) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. Enter AS – TS for children and 51-82 for adults with supernumerary teeth regardless of location in maxilla or mandible. Permanent teeth must be two-digit fields. For tooth number 1-9, you must indicate 01-09.
28	Tooth Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL, MODBL). The block is left blank for exams, X-rays, fluoride and crowns. M – Mesial F – Facial; Labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal B —Buccal; Labial
29	Procedure Code	Enter the appropriate ADA procedure code(s) for the procedure.
31	Fee	Enter the usual and customary charges for each line of service listed. Charges must not be higher than the fees charged to private pay patients.
35	Remarks	The only information that should be written in this section is “TPL Denial Attached” and the date of the third party denial (other insurance) Make sure the EOB denial statement is attached. NO OTHER comments should be written in this section.
38	Place of Treatment	Check applicable box. ***Use the Hospital box to indicate outpatient hospital or inpatient hospital.
45-47	Treatment Resulting from	If applicable, check applicable box. If auto accident, provide date of accident (mm/dd/ccyy) and the two-digit state abbreviation of the state in which the accident happened.
48	Billing Dentist or Dental Entity (Name, Address, City, State, Zip Code)	Enter the billing provider's name, street address, city, state, and zip code.
49	NPI	Enter the Organizational/**Billing** NPI number.
52A	Additional Provider ID	Enter the **billing** provider’s Alabama Medicaid provider number.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
53	Treating Dentist and Treatment Location Information [provider's signature]	Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with HP to omit signature requirement. Refer to the Alabama Medicaid Provider Manual, Chapter 5 section 5.1.7, Provider Signatures, for appropriate signature requirements.
54	NPI	Enter the NPI of the actual dentist performing the service, i.e. the **treating** (rendering or performing) NPI number.
56A	Provider Specialty Code	Enter the taxonomy code of the **treating** (rendering or performing) dentist.
58	Additional Provider ID	Enter the **treating** (rendering or performing) provider's Alabama Medicaid provider number.

5.6 Completing the Pharmacy Claim Form

This section describes how to complete the pharmacy claim form for submission to HP. For a list of providers who bill for services using the pharmacy claim form, please refer to Section 5.1.1, Valid Alabama Medicaid Claim Types.

These instructions are intended for use for all providers who bill using this claim form; for program-specific billing information, please refer to Chapter 27, Pharmacy.

Pharmacy Electronic Billing

Electronic billers must submit pharmacy claims in approved formats. Providers can obtain Provider Electronic Solutions software from HP free of charge. Providers may also use Medicaid's Interactive Web Portal. HP also provides specifications to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1(800) 456-1242.

Pharmacy Paper Billing

Medicaid pharmacy claim forms may be purchased through HP. Providers may also obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms must be printed using red dropout ink.

Claims must contain the billing provider's complete name, address, and NPI.
Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number– NOTE: Effective January 17, 2011, the Medicaid number submitted must begin with a "5". Medicaid will DENY any claims received on or after January 17, 2011, that are submitted with the old Medicaid ID number (number beginning with "000").
- First two characters of the provider group name
- Provider's 10-digit NPI
- Rx number (cannot be more than 7 digits)

A claim without the above information cannot be processed. Each claim form must have a provider signature, initials by a stamped signature, or an agreement on file with HP to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.6.1 Pharmacy Blank Claim Form

ALABAMA MEDICAID PHARMACY CLAIM XIX-DC-10-93

RECIPIENT NAME		ORIG RX DATE	TPL CARRIER INFORMATION	PHYSICIAN LICENSE NO.
		1	CARRIER CODE/ CO. NAME	
MEDICAID NUMBER		2		
		3	POLICY NO.	

SUBMIT TO
HP
P.O. BOX 244032
MONTGOMERY, ALABAMA 36124-4032

PHARMACY PROVIDER NO./NAME	DATE DISPENSED
PHARMACY ADDRESS	

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE CLAIM IS UNPAID. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PHARMACIST

	COPAY	PRIOR AUTHORIZATION NO.
1		
2		
3		

SAMPLE

	G CODE				EFILL(S)			
	LA R NO.	PRODUCT DE G.	N	QU TY	S PLY	TH	NO.	AND CUSTOMARY CENTS
2								
3								
							TOTAL	

	DOLLARS	CENTS	REASON CODE		DOLLARS	CENTS	REASON CODE		DOLLARS	CENTS	REASON CODE
1				2				3			

5.6.2 Pharmacy Filing Instructions

The instructions describe information that must be entered in each of the fields on the Pharmacy Form. **Fields not referenced in the table may be left blank. They are not required for claims processing by HP.**

Field Description	*Guidelines*
Recipient name and Medicaid number	Enter the recipient's name **exactly** as it is given to you as a result of the eligibility verification transaction. **Please note that the recipient name on the claim form must match the name on file for the RID you entered in the Medicaid Number block.** Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011. For recipients who have two initials for their first name, enter the first initial with a long space, then the second initial and no periods. For example, A. B. Doe would be filed as Doe A B. For recipients who have an apostrophe in their first name, enter the first letter of the first name and the apostrophe. For example, D'Andre Doe would be filed as Doe D'Andre.
Orig. Rx Date	Enter the date of the original prescription
TPL Carrier Information	Complete this portion only if the recipient has other insurance. Carrier code/Co. name — The insurance company name or carrier code may be obtained from Appendix K of this manual or by calling the HP Provider Assistance Center at 1 (800) 688-7989. Policy no. — The insured's insurance policy number
Physician's license no.	Enter the physician's state license number or National Provider Identifier (NPI), which should display on the prescription
Pharmacy license no./name	Enter the 10-digit NPI and name
Date dispensed	Enter the date the prescription is dispensed to the recipient
Pharmacy address	Enter the pharmacy street address, city, state, and zip code.
Pharmacist	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
Received by	Obtain the recipient's signature or enter "Signature on file" if the provider has the recipient's signature on file (such as a sign in sheet) as verification that the recipient was present on the date of service for which the provider seeks payment.
Copay	Enter "P" if the recipient is pregnant to indicate copay exemptions. Enter "A" if the recipient is a Native American Indian with an active user letter to indicate copay exemptions.
Prior Authorization	For prior authorization requests approved by Medicaid, the prior authorization number will be automatically entered into the claims system by Medicaid's contractor. Enter the ten-digit prior authorization number (0000999527) only when using the 72 hour emergency supply prior authorization number.
Rx number	Enter the prescription number
Drug code	Enter the NDC code

Field Description	*Guidelines*
B/N	Brand Necessary. This field is also known as the "Dispense as Written (DAW)" or Product Selection field. Valid values are as follows: **Ø=No Product Selection Indicated-**This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed. **1=Substitution Not Allowed by Prescriber**-This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written. **2=Substitution Allowed-Patient Requested Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. 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. *(Not permitted by Alabama Medicaid)* **3=Substitution Allowed-Pharmacist Selected Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources. **4=Substitution Allowed-Generic Drug Not in Stock**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace. **5=Substitution Allowed-Brand Drug Dispensed as a Generic**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity. **6=Override** *(Not permitted by Alabama Medicaid)* **7=Substitution Not Allowed-Brand Drug Mandated by Law**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace. **8=Substitution Allowed-Generic Drug Not Available in Marketplace**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. **9=Substitution Allowed- Plan Requests Brand Dispensed –** This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic is permitted, but the plan's formulary requests the brand product to be dispensed. **Note: These "Dispense as Written" values are required for the DAW field for electronic pharmacy claims. For more information on DAW, please visit Chapter 27 of the Billing Manual.**

Field Description	*Guidelines*
Quantity	Enter the quantity or number of units dispensed. **Please note there are five (5) spaces on the claim form for quantity. All five spaces must be completed.** There are three dispensing units: • Each (ea): tablets, capsules, suppositories, patches, and insulin syringes. For example, one package of Loestrin should be coded on the claim form as 00021. • Milliliter (ml): Most suspensions and liquids will be billed per milliliter. Most injectables that are supplied in solution are also billed per milliliter. For example, a 5ml of ophthalmic solution should be coded 00005. • Gram (gm): Most creams, ointments, and powders will be billed per gram. For example, a 45gm tube of ointment should be coded as 00045. **If a product is supplied in fractional units (for instance, a 3.5gm tube of ointment), Medicaid providers should submit claims involving decimal package sizes for the exact amount being dispensed. In this example, the quantity billed should be 0003.5**
Days supply	Enter the amount of time the medication dispensed should last. The days supply is limited to 34.
Refills	Enter the number of refills authorized by the prescribing physician. Values can be 0-11 for non-controlled drugs, 0-5 for Class III-V narcotics, or 0 for Class II narcotics. Alabama Medicaid will not recognize values greater than 11.
Usual and customary	Enter the amount (dollars and cents) of your customary charge.
TPL payment/denial information	These fields are completed only if the recipient has other insurance. If the other insurance makes a payment, it should be indicated in the dollars/cents field. The appropriate NCPDP other coverage reason code must also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the NCPDP other coverage reason code must be included.

5.7 Crossover Claim Filing

Medical and inpatient institutional claims filed to Medicare (at BCBS Alabama) crossover directly to Medicaid weekly for claims processing. Providers should wait **at least 21 days** from the date of the Medicare Explanation of Medical Benefits (EOMB) before electronically filing a medical or inpatient crossover claim to HP Outpatient institutional claims, out-of-state Medicare claims, and those medical and inpatient claims 21 days old or older must be submitted electronically to HP using the appropriate Medicare/Medicaid-related Claim Form.

Electronic billers must submit crossover claims in approved formats. *Provider Electronic Solutions* software allows crossover billing via the 837 Institutional transactions and is available from HP free of charge for providers. Providers may also use Medicaid's Interactive Web Portal. Specifications are also available to providers developing in-house systems, software developers, and vendors. Because each software developer is different, location of fields may vary. Contact the software developer or vendor for this information. Direct development requirements and questions to the HP Electronic Claims Submission Help Desk at 1 (800) 456-1242.

5.7.1 Medical Medicaid/Medicare-related Claim Filing Instructions

The Medical Medicaid/Medicare-related claim form may be obtained from HP at no charge when an Administrative Review is being requested. For scanning purposes, only those forms printed with red dropout ink will be accepted.

A copy of the Medical Medicaid/Medicare-related claim form displays on the following page.

NOTE:

Providers must use the Medical Medicaid/Medicare-related claim form when billing Medicaid for Medicare Advantage plan co pays. These claims will be processed by Medicaid in the same manner as a Medicare paid claim. When providers file a secondary claim to Medicaid, they should use the original Medicare number in the HIC # field on the crossover claim rather than the Medicare Advantage Plan's assigned number. Medicare Advantage co pays should be reported in the Medicare Coinsurance field.

Refer to Appendix L, AVRS Quick Reference Guide, for information on checking claim status.

Medical Medicaid/Medicare-related Blank Claim Form

Do not write in this space. Do not use red ink to complete this form.

MEDICAL
MEDICAID/MEDICARE
RELATED CLAIM

RECIPIENT INFORMATION

Medicaid ID	
First Name	
Last Name	
Med. Rec. #	
Patient Acct. # (Optional)	

OTHER INSURANCE INFORMATION

Covered by other insurance? Enter Y if yes (Except Medicare)	
Name of other insurance company (Except Medicare)	
Insurance Company. Carrier Code	
If payment was received from other insurance, post that amount here. (Do NOT put Medicare payment here.)	$

If other insurance rejected, attach rejection to completed claim and mail to EDS. * See remarks.

Diagnosis Codes

1st DX		2nd DX		3rd DX		4th DX	

	Dates of Service		POS	NDC	Mod	Unit	Charges	Medicare			
	From	Thru		Procedure Code				Allowed	Coins.	Deductible	Paid
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
					TOTALS						

Remarks

**Enter TPL Denied (MM/DD/YY)*

Billing Provider Name				
Billing Provider ID	NPI	Taxonomy	Qu	Secondary ID
Performing Provider Name				
Performing Provider ID	NPI	Taxonomy	Qu	Secondary ID

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment date is less than 120 days old.

Submit completed claim to:

EDS
Post Office Box 244032
Montgomery, AL 36124-4032

Form 340 Revised 12/08

Provider mailing address required in block below:

Medical Medicaid/Medicare-related Claim Filing Instructions

This form is required for all medical Medicare-related claims in lieu of the CMS-1500 claim form and the Medicare EOMB. **The only required attachments are for third party denials.** The Medicare EOMB is no longer required.

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Field Description	***Guidelines***
Medicaid ID #	Enter the recipient's 13-digit RID number. Effective January 17, 2011, the Alabama Medicaid Agency is phasing out the acceptance of the old Medicaid ID Number (number beginning with '000"). Only the new Medicaid ID number (number beginning with a "5") will be accepted for claims processing purposes for claims received on or after January 17, 2011.
First Name	Enter the recipient's first name.
Last Name	Enter the recipient's last name.
Med. Rec.#	Enter the recipient's medical record number. (Optional)
Patient Account #	Enter recipient's patient account number (to be referenced on the Remittance Advice (RA) for patient identification). Up to 20 characters may be entered into this field.
Covered by other insurance?	Enter a "Y" here if recipient has a commercial insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other commercial insurance company (except Medicare).
Insurance company carrier code	Not used at this time.
1st DX, 2nd DX, 3rd DX, 4th DX	Enter the diagnosis codes in these blocks to the highest number of digits possible (3, 4, or 5). Do not enter decimal points in the DX fields.
Dates of service	Enter the from and through dates in MMDDYY format.
POS	Enter the two-digit place of service as filed to Medicare.
NDC	Enter identifier N4 and the National Drug Code (NDC) for the procedure, if required.
Procedure Code	Enter the five-digit procedure code.
Modifiers	Enter the modifiers for the procedure code. Enter up to 4 modifiers.
Units	Enter the number of units of service.
Charges	Enter the charge for each line item.
Allowed	Enter the Medicare allowed amount for each line item. *FQHC, PBRHC, and IRHC should enter the per diem encounter rate established by Medicaid for the facility for each line item.
Coinsurance	Enter the Medicare coinsurance amount for each line item. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**
Deductible	Enter the amount applied to the Medicare deductible for each line item.
Paid	Enter the Medicare paid amount for each line item. *FQHC, PBRHC, and IRHC should enter the Medicare per diem paid amount for each line item.
Totals	Total each column.
Billing Provider Name	Enter the billing/payee provider name.

Field Description	*Guidelines*
Billing Provider ID	NPI: Enter the NPI of the billing/payee provider Taxonomy: Enter the taxonomy code of the billing provider (optional) Qu: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, use qualifier code "1D". Secondary ID: Enter the secondary identifier for the billing provider ID. The secondary identifier should be the legacy Medicaid provider number. This is an optional field, but is required for providers with multiple service locations.
Performing Provider Name	Enter the name of the provider which performed the service.
Performing Provider ID	NPI: Enter the NPI of the provider which performed the service. Taxonomy: Enter the taxonomy code for the provider which performed the service. (Optional) Qu: Enter the appropriate qualifier code for the secondary identifier. If using the legacy Medicaid provider number, use qualifier code "1D". Secondary ID: Enter the secondary identifier for the performing provider. The secondary identifier should be the legacy Medicaid provider number of provider which rendered the service. This is an optional field, but is required for providers with multiple service locations.
Provider Mailing Address	Enter the billing address, city, state, and zip code for the rendering (performing) provider.
Remarks	Enter Medicare Paid/Denial Date (MMDDYY).

Effective January 1, 2009, the Institutional Medicaid/Medicare related claim form is no longer accepted. Please refer to instructions on completing the UB-04 claim form to indicate Medicare information.

5.8 Required Attachments

Providers are required to submit attachments for particular services. The table below describes Alabama Medicaid required attachments.

Attachment	*Guidelines*
Third party denials other than Medicare	Providers must submit legible copies of third party denials when billing Medicaid services denied by a third party.
Third party payment other than Medicare	When a claim must be submitted on paper for an administrative or manual review and a third party payment was made, attach form ALTPL-01 10/12.

NOTE:

All third party denials must be attached with the claim and sent hard copy. Claims with third party denials may not be sent electronically.

NOTE:

When a claim must be submitted on paper for administrative or manual review and third party insurance has made a payment or applied charges to patient responsibility, Form ALTPL-01 10/12 – Medicaid Other Insurance Attachment must be attached with the claim and sent hard copy.

5.9 Required Consent Forms

Consent forms are no longer required attachments with the claim form. The accompanying claim may be sent electronically however, the actual forms must be sent hard copy to the claims address. These forms are scanned and matched electronically with the related claims before processing.

Consent Form	***Guidelines***
Sterilization consent form	A sterilization consent form is required for tubal ligations and vasectomies.
Hysterectomy consent form	A hysterectomy consent form is required when seeking payment for reasons of medical necessity, and not for purpose of sterilization.
Abortion certification form	An abortion certification and documentation of abortion form are required for abortions. Medicaid will not pay for any abortion or services related to an abortion unless the life of the mother would be endangered if the fetus were carried to term.

5.10 Adjustments

Adjustments may be performed only on claims **paid** in error (for example, overpayments, underpayments, and payments for wrong procedure code, incorrect units, or other errors). The adjustment process allows the system to "take back" or cancel the incorrect payment and reprocess the claim as if it were a new claim. Providers must submit their adjustment requests electronically. For all waiver provider claims adjustment refer to Chapter 107 – Waiver Services.

5.10.1 Online Adjustments

Providers can submit electronic adjustments using the HP Provider Electronic Software or vendor-supplied software designed using specifications received from HP. Through this process, providers can recoup previously paid claims with dates of service up to three years old. Claims within the timely filing limit may be adjusted for correction and resubmitted for accurate payment the same day the electronic adjustment is made.

To submit electronic online adjustments, providers must use accurate information relating to the previously paid claim. The HP Provider Electronic Solutions software or provider's vendor system will require that provider submit a new (837) Professional, Institutional or Dental transaction, with *Original Internal Control Number (ICN)* field populated. This electronic adjustment claim will be assigned a new ICN number with a region of 52.

The adjustment claim will process accordingly, and result in a new (835) electronic Remittance Advice (RA) and the original claim information will appear on the 835 (RA) as a void, if processed within the same check write cycle.

Adjustments appear in the *Adjusted Claims* section of the provider Remittance Advice (RA) and consist of two segments: **Credit** (Repaid at lower amount/denied) and **Debit** (Repaid at higher/same amount). The **Credit** segment lists the amount owed to HP from the original paid claim. This amount will also display in the *Financial Items* section of the RA as a deduction.

The **Debit** segment indicates there is a repayment of an original claim and provides a complete breakdown of corrected information. The paid amount is included in the total paid claims amount.

An Adjustment occasionally results in a denied claim. Denied Adjustments do not display in the *Adjusted Claims* section on the RA; they are listed in the *Denied Claims* section. The amount is withheld from the current explanation of payment and listed in the *Financial Items* section.

Refer to Chapter 6, Receiving Reimbursement, for more information relating to adjustments as described in the RA.

NOTE:

The filing deadline applies to any claim that must be resubmitted due to an adjustment.

5.11 Refunds

If you receive payment for a recipient who is not your patient or are paid more than once for the same service, it is your responsibility to refund the Alabama Medicaid Program.

Provide refunds to the Medicaid Program by using the Check Refund Form (a sample can be found in Appendix E) accompanied by a check for the refund amount. Make the check payable to:

HP – Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Please provide the following information in the appropriate fields on the Check Refund Request exactly as it appears on your Remittance Advice (RA) for each refund you send to HP:

- Provider Name and NPI
- Your check number, check date, check amount
- 13-digit claim number or ICN (from RA)
- Recipient's Medicaid ID number and name (from RA)
- Dates of service
- Date of Medicaid payment
- Date of service being refunded
- Services being refunded
- Amount of refund
- Amount of insurance received, if applicable (third party source other than Medicare)
- Insurance name, address and policy number
- Reason for return (from codes listed on form)
- Signature, date and telephone number

This information will allow your refunds to be processed accurately and efficiently.

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts. **If providers receive duplicate payments from a third party and Medicaid, all duplicate party payments must be refunded within 60 days by**:

- Sending a refund of insurance payment to the Third Party Division, Medicaid; or
- Requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

Providers are responsible for ensuring that Medicaid is reimbursed from any third party payment made to a source other than Medicaid as a result of the provider releasing information to the recipient, the recipient's representative, or a third party.

5.12 Inquiring about Claim and Payment Status

Providers may use any of several options to inquire about claim and payment status:

- Call AVRS Provider Electronic Solutions Software
- Review the Remittance Advice (RA) for the corresponding checkwrite
- Contact the HP Provider Assistance Center at 1(800) 688-7989
- Contact HP Provider Relations in writing at **HP Attn: Provider Relations P.O. Box 241685 Montgomery, AL 36124-1685.**
- Access the Alabama Medicaid Agency Interactive Services Website at https://www.medicaid.alabamaservices.org/ALPortal.

Calling AVRS

Please refer to Appendix L, AVRS Quick Reference Guide, for instructions on using AVRS to inquire about claim and payment status.

Contacting the HP Provider Assistance Center

The HP Provider Assistance Center (PAC) is available Monday through Friday, 8:00 a.m. – 5:00 p.m. at 1(800) 688-7989. An assistance center representative can answer your questions about claim status, eligibility, or other claims related issues. **It is recommended that you use AVRS, Provider Electronic Solutions Software or access the Alabama Medicaid Agency Interactive Services website before calling the HP Provider Assistance Center. To ensure the Assistance Center is available to all providers, HP must limit providers to three transactions per telephone call. Through AVRS, however, providers may perform up to ten inquiries, including prior authorization requirements, claim status inquiries, and multiple eligibility verification requests.**

When a provider calls the Provider Assistance Center, the PAC representative logs a "ticket" in the call tracking system, including the NPI, contact name and number, and a description of the problem, question, or issue. If the issue is resolved during the call, the PAC representative records the resolution and closes the ticket. If the issue requires research, the PAC representative records the issue and keeps the ticket in an open status. Other HP and Medicaid personnel can review the open ticket and participate in the resolution of the issue. The ticket stays open in the call tracking system until the issue is resolved. This enables HP to monitor its service to providers.

Contacting HP in Writing

Providers may contact HP in writing to resolve more complex billing issues. This correspondence will be reviewed by HP Provider Relations, which is composed of field representatives who are expert in Medicaid billing policy. HP will respond to written inquiries within seven (7) business days and telephone inquiries by the end of the next business day.

The difference in response time occurs because HP' Provider Assistance Center is fully staffed during regular business hours, and can receive, resolve, or forward all billing and claim-related calls, ensuring they are answered in a timely fashion. Provider Representatives, who provide responses to written requests, travel on a regular basis, providing billing assistance to the Alabama Medicaid provider community. It is therefore recommended that providers contact the Provider Assistance Center to begin the inquiry process, and follow up with written correspondence as the need arises.

Accessing the Alabama Medicaid Agency Interactive Services Website

The Alabama Medicaid Agency Interactive Services secure website gives you the opportunity to view claim status and eligibility verification inquiries and to upload and download standard X12 and NCPDP transactions.

Contact HP Helpdesk if you need a User ID and Password.

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6

6 Receiving Reimbursement

This chapter describes the Remittance Advice (RA) report and the reimbursement schedule for Medicaid fee-for-service claims.

NOTE:

Reimbursement information specific to managed care is described in Chapter 39, Patient 1st, of this manual.

6.1 Remittance Advice (RA) Report

It is the responsibility of each provider to follow up on claims submitted to HP. The Remittance Advice (RA) is a vital tool for this process. The RA indicates claims that have been adjudicated (paid or denied) and lists claims that are currently in process (suspended claims). Providers are urged to examine each RA carefully and to maintain the document for future reference. Claims listed as claims in process are being processed and will appear on one of the next two RAs as paid, denied, or still in process.

Effective March 1, 2010, Medicaid no longer prints and distributes paper RAs to providers. A provider can receive an electronic copy of the RA or download a copy from the WEB. The electronic copy is the 835 Health Care Claim Payment/Advice. The electronic media has been expanded to include more information. Providers wishing to receive the 835 must be assigned a ‘submitter ID” and an indicator must be set in the system to generate the electronic report*. The Electronic Remittance Advice Agreement Form is available on the Alabama Medicaid website.*

The EOB (Explanation of Benefit) code that displays next to a paid or denied claim explains the adjudication of the claim. A provider who wishes to question a paid or denied claim should do so by calling the HP Provider Assistance Center at 1(800) 688-7989. To request an adjustment of a previously paid claim, refer to Section 5.10, Adjustments, for more information.

Any claim that does not appear on an RA within forty-five working days from the time of submission should be resubmitted immediately. Before resubmitting, please verify that the claim has not been returned to you for correction or additional information.

Providers are required to maintain a copy of each claim submitted. The claim copies should be used for comparison if there are questions concerning the disposition of claims as shown on the RA.

6.1.1 Provider Remittance Advice (RA)

Twice a month, providers are issued a single remittance check or Electronic Funds Transfer (EFT) transaction for all claims that have been processed for payment for that checkwrite's pay period.

The RA displays the paid or denied status of adjudicated (settled) claims, as well as lists claims currently in process, claims credited to the Medicaid Agency, and any refunds that are processed. The sections of the RA are described in the following paragraphs.

Each page displays the payee provider's submitter ID, name, address, National Provider Identifier (NPI) and the service location name, if different from the payee name, printed as it currently appears on HP' provider file. The RA number and checkwrite date display on each page of the RA as well.

The columns that display at the top of every page correspond to the header information in the sections that list paid and denied claims. Detail information for each claim has heading descriptions on each claim.

Claim data pages sort together by claim type, then in Adjusted, Paid, Denied and In Process within claim type. The exception is Inpatient Encounter claims. These claims sort within the inpatient claim type following each inpatient claim status section.

First Page

A "Banner Message" from HP appears on this page. The "Banner Message" delivers information to the provider community and includes updates to current policies and procedures.

Paid Claims

The RA lists a payment for each claim in alphabetical order by recipient last name.

Claims are grouped by claim type, with a total for each. A grand total of paid claims and paid amounts displays at the end of this section.

Paid claims may include an EOB code to provide more information about the payment amount. For example, a provider may bill an amount higher than Medicaid allows for a procedure. The EOB code next to this paid claim explains why the provider received a lower payment than he submitted.

Paid claims have been finalized. No additional action will be taken on them unless the provider or Medicaid requests an adjustment and makes appropriate corrections.

Denied Claims

The RA lists each denied claim in alphabetical order by recipient last name. An EOB appears beside each claim. Please reference the listing at the end of each RA that defines the codes used on that RA.

Claims are grouped by claim type, with a total for each. A grand total of denied claims and billed amounts displays at the end of this section.

Denied claims are finalized. No additional action will be taken on them unless the provider makes appropriate corrections and refiles the claim. This section also includes denied adjustments.

Claims In Process

The Claims In Process section of the RA lists claims currently in process for the provider, in alphabetical order by recipient last name. Claims that appear in this section are paid, denied or suspended as appropriate on a future RA. Providers should not submit inquiries or resubmit suspended claims as long as they appear on the RA as suspended. If a claim appears in this section for more than two remits, please contact the HP Provider Assistance Center to verify the status of this claim.

RA Claim Page Field Descriptions

Most of the field descriptions for each of the claim type Adjusted, Paid, Denied, and In Process are the same. Each claim type/Status may have fewer of the fields and a few have fields specific to the claim type. For example, Dental contains tooth references, Drug contains NDC codes.

The following table lists the fields in all the claims sections. The table includes all fields that display on all claim types. The Adjustments pages contain a few more fields that are described in the next section.

Note: The fields listed in the following tables are based on information available at the time of publication. The information is subject to change based on further review.

Field	***Description***
Name	Displays the recipient's last name, and first name. Claims are displayed in alphabetical order by last name.
Pat Acct No.	Displays the Patient Account Number assigned to the recipient by the provider.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
Rendering Provider	Displays the National Provider Identifier (NPI) of the rendering provider.
Attending ID	Displays the National Provider Identifier (NPI) of the attending physician, if applicable.
Recipient ID	Displays the 12 digit recipient Medicaid ID number as submitted by the provider.
Admit Date	Displays the admitting date submitted on the claim, if applicable.

Field	***Description***
Dispense Date	Displays the dispense date submitted on the claim, if applicable.
Days	Displays the number of days submitted on the claim, if applicable.
Dates Of Service First Date Of Service - Last Date Of Service,	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.
Dist Plan (District Plan)	Displays the District Plan Code for the inpatient claim, if applicable
Surf (Tooth Surface)	Displays the tooth surface on the detail line, if applicable.
POS Or PL SERV (Place Of Service)	Displays the place of service as submitted on the claim, if applicable.
TN (Tooth Number)	Displays the tooth number on the detail line, if applicable.
Procedure/Revenue/ NDC Code	Displays these codes as they were submitted on the claim. This displays for each line item billed, if applicable.
Modifiers	Displays the procedure code modifiers as they were submitted on the claim.
Desc	Displays the first six characters of the NDC code description
Billed Amount	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.
Allowed Amount	Displays the amount of the billed amount that Medicaid will cover. This displays for each line item billed, if applicable.
Patient Liability	This displays the patient liability applied to the claim payment, if applicable.
TPL Amount	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. This displays for each line item billed, if applicable.
HEADER And DETAIL EOBS	Displays an Explanation Of Benefit code about claim adjudication. This displays for each header and line item billed, if applicable.
Copay Amount	This displays the copay applied to the claim payment, if applicable.
QTY Or UNITS	Displays the quantity or units submitted.
Rx No.	Displays the prescription number.
Total Billed	Displays the total billed for all the claim.

Field	*Description*
Total Non Allowed	Displays the total payment that Medicaid will not cover for all the claims.
Total Allowed	Displays the total allowed amount for all the claims.
Total Patient Liability	Displays the total patient liability for all the claims.
Total Copay Amount	Displays the total copay for all the claims.
Total TPL Amount	Displays the total TPL for all the claims.
Total Paid Amount	Displays the total amount of Medicaid payment for the claims.

Adjusted Claims

This section of the RA lists adjustments made to correct payment errors in alphabetical order by recipient last name. Each adjustment has a single 'mother' line with the Internal Control Number (ICN) of the claim that is adjusted, followed by the 'daughter' claim with the adjustment ICN.

- Additional Payment: If the adjustment generates an additional payment, the additional amount is displayed below that adjustment.
- Net Overpayment (AR): If the adjustment generates an accounts receivable, the amount due is displayed below that adjustment.
- Refund: If a cash receipt is posted for a claim, the amount applied is displayed below that adjustment.

Financial Transactions Page

There are three sections:

- Payouts: This lists non-claim expenditures made to the provider.
- Refunds: This lists cash receipts received from the provider.
- Accounts Receivable: This lists both non-claim and claim accounts receivables. A non-claim AR may be set up to be reduced for a specific dollar amount or percentage per financial cycle. This section displays the original amount, the amount applied and the remaining balance for each AR.

Summary Page

This page of the RA is divided into two sections. Claim activity reports first, followed by payment reporting.

Payment reporting is displayed as follows:

- The ‘top’ of the payment section contains payment information and the check/EFT amount appears as NET PAYMENT. If a credit balance is due to Medicaid, this number will appear as $0.00. The amount owed to Medicaid is contained on the CREDIT BALANCE DUE ‘letter’ at the end of the RA.
- If you are to receive a Capitation Payment, it will appear as a single line and the amount in this ‘top’ section.
- The ‘bottom’ of the payment section displays any other financial data that may affect your NET EARNINGS.
- If any of your payment is being sent to the IRS, the deduction amount is noted in the ‘bottom’ section, and detailed in a message at the very bottom of the page.

Each section displays current and year-to-date totals.

NOTE:

The last RA issued for the calendar year notifies providers of the amount submitted to the Internal Revenue Service for tax reporting.

Third Party Insurance Information

If a claim has denied for third party insurance, the claim ICN will post on this page with the third party carrier and policy information.

EOB Codes

Following the summary page is a listing of definitions for the EOB codes used on each statement. This section also contains Adjustment codes identifying adjustments.

Encounter Data

These sections of the RA contain encounter claim data and follow each of the Inpatient pages as the main part of the RA. The encounter data is for informational purposes only and does not show any dollar amounts paid. However, the provider should resubmit any correctable denied encounter data claims for payment. The plan code identifies the payer of these claims followed by the district. Example: PXX would be a Maternity Care claim processed by the Maternity Contractor in district XX and HXX would be a PHP claim processed by district XX.

6.2 Reimbursement Schedule

Claims that have been accepted for processing either through electronic submission or manually by HP staff are processed on a daily basis. Payment for these claims is disbursed based on the twice a month checkwriting schedule as approved by the Alabama Medicaid Agency.

Information regarding checkwriting schedules is listed in the bimonthly publication of the Alabama Medicaid Provider Bulletin and can also be obtained on the Medicaid website at www.medicaid.alabama.gov.

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7

7 Understanding Your Rights and Responsibilities as a Provider

This chapter describes provider rights and responsibilities as mandated by the *Alabama Medicaid Agency Administrative Code*. The chapter contains the following sections:

- Provider Responsibilities
- Medicare/Medicaid Fraud and Abuse Policy
- Refunds

7.1 Provider Responsibilities

Providers who agree to accept Medicaid payment must agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, (such as, epidurals or spinal anesthetic) these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. Medicaid covers these services. Providers may not bill Medicaid recipients they have accepted as patients for covered labor and delivery-related pain management services.

Providers, including those under contract, must be aware of participation requirements that may be imposed due to managed care systems operating in the medical community. In those areas operating under a managed care system, services offered by providers may be limited to certain eligibility groups or certain geographic locations.

This section describes provider responsibilities such as maintenance of provider information, retention of records, release of confidential information, compliance with federal legislation, billing recipients, and agreement to the certification statement described in the *Alabama Medicaid Agency Administrative Code.*

7.1.1 Maintenance of Provider Information

Providers must promptly advise the HP Provider Enrollment Department in writing of changes in address (physical or accounting), telephone number, name, ownership status, tax ID, and any other information pertaining to the structure of the provider's organization (for example, rendering providers). Failure to notify HP of changes affects accurate processing and timely claims payment.

Send change requests to HP Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

7.1.2 Reporting Change of Ownership Information

Medicaid requires the owner of a Medicaid enrolled facility to report any change of ownership to Medicaid 30 business days prior to making such change. A change of ownership requires that all parties involved shall collaborate to ensure that services are billed and paid to the correct owner using the correct NPI number.

Effective January 1, 2009, currently enrolled providers will be required to complete the Change of Ownership Information form and mail to the System Support Unit, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103. This information will be used in determining how the change in ownership will be processed. If necessary, Medicaid will instruct HP to close the provider's file. This form can be obtained by accessing Medicaid's website: www.alabama.medicaid.gov.

The new owner must submit a complete Medicaid Provider Enrollment Application packet to enroll as a Medicaid provider. The effective date of the new owner's enrollment is either the date of the sale or the date the application is received, whichever is later.

7.1.3 Retention of Records

The provider must maintain and retain all necessary records, Remittance Advices (RAs), and claims to fully document the services and supplies provided to a recipient with Medicaid coverage. These must be available, upon request, for full disclosure to the Alabama Medicaid Agency. The *Alabama Medicaid Agency Administrative Code,* Chapter 1, states the following:

> *Alabama Medicaid providers will keep detailed records in Alabama, of such quality, sufficiency, and completeness except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.*

In the event of ongoing audits, litigation, or investigation, records must be retained until resolution of the ongoing action.

The provider must be able to provide, upon request and at no charge to Medicaid, related state or federal agencies, or the Alabama Medicaid fiscal agent, HP, original records. These records may include, but are not limited to, documents relating to diagnostic tests, treatment, service, laboratory results, and x-rays.

Providers will make all such records available for inspection and audit by authorized representatives of the Secretary of Health and Human Services, the Alabama Medicaid Agency, and other agencies of the State of Alabama. Provider records and operating facilities shall be made available for inspection during normal business hours.

Providers participating in the Alabama Medicaid program shall make available, free of charge, within ten (10) days, the necessary records and information to Medicaid investigators, members of the Attorney General's staff, or other designated Medicaid representatives who, in the course of conducting reviews or investigations, have need of such documentation to determine fraud, abuse, and/or other deliberate misuse of the Medicaid program. Depending on the number of records requested, Medicaid may provide a reasonable extension.

Failure to supply requested records might result in recoupment of the paid claims in question and additional action as deemed necessary by Medicaid including referral to law enforcement agencies.

Information pertaining to a patient's charges or care may be released only as directed by the Medicaid Regulations (see the *Alabama Medicaid Agency Administrative Code*, Chapter 20, for information pertaining to Third Party).

7.1.4 Release of Confidential Information

Information about the diagnosis, evaluation, or treatment of a recipient with Medicaid coverage by a person licensed or certified to perform the diagnosis, evaluation, or treatment of any medical, mental or emotional disorder, or drug abuse, is usually confidential information that the provider may disclose only to authorized people. Family planning information is sensitive, and confidentiality must be assured for all recipients.

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in the rules and regulations of the U.S. Department of Health and Human Services (HHS) or on the express authorization of the Commissioner of Social Security. The regulations of HHS regarding the confidentiality of records and information apply to both governmental and private agencies participating in the administration of the Program; to institutions, facilities, agencies, and persons providing services; and to those administrative services under an agreement with a provider of services. The rules governing release of private information and disclosure of classified information are contained in Chapters 20 and 27 of the *Alabama Medicaid Agency Administrative Code*, which is available to all Alabama Medicaid providers.

Information furnished specifically for purposes of establishing a claim under the Medicaid Program is subject to these rules. Such information includes the individual’s Medical Assistance (Medicaid Title XIX) Identification (ID) Number, facts relating to entitlement to Medicaid benefits, other medical information obtained from state of Alabama agencies or the Medicaid Fiscal Agent, HP.

7.1.5 Compliance with Federal Legislation

Participating providers of services under the Medicaid Program must comply with the requirements of Titles VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990.

Under the provisions of these Acts, a participating provider or vendor of services receiving federal funds is prohibited from making a distinction based on race, color, sex, creed, handicap, national origin, or age.

Once accepted, recipients must have access to all portions of the facility and to all services without discrimination. Recipients may not be segregated within any portion of the facility, provided a different quality of service, or restricted in privileges because of race, color, sex, creed, national origin, age, or handicap.

Medicaid is responsible for investigating complaints of noncompliance. Send written complaints of noncompliance to the following address:

Alabama Medicaid Agency Commissioner
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624

7.1.6 Utilization Control – General Provisions

Title XIX of the Social Security Act, Sections 1902 and 1903, mandates utilization control of all Medicaid services under regulations found at Title 42, *Code of Federal Regulations*, Part 456. Utilization review activities required by the Medicaid program are completed through a series of monitoring systems developed to ensure services are necessary and in the appropriate quality and quantity. Both recipients and providers are subject to utilization review monitoring.

Utilization control procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by the Alabama Medicaid Agency. Most monitoring is performed using the Surveillance and Utilization Review (SUR) system, and the Quality Improvement and Standards Division. However, utilization review may also involve an examination of particular claims or services not within the normal screening when a specific review is requested by the Alabama Medicaid Agency or any related state or federal agency.

All providers identified as a result of provider review are made available to the Provider Review Department of the Alabama Medicaid Agency.

The primary goal of utilization review is to identify providers with practice patterns inconsistent with the federal requirements and the Alabama Medicaid Program scope of benefits. This review relies on a number of parameters including comparison of resource utilization with that of the provider's peer group.

The principal approach to resolution of inappropriate use is education of the provider. The education may include a provider representative visit or letter to assist with the technical aspects of the program, and (or) a physician education visit or letter to explain program guidelines relative to medical necessity, intensity of service, and the appropriateness of the service.

Depending on the intensity of the identified problem, the letter or visit may result in a review of claims before payment. This is indicated on the provider records maintained by HP, and may refer to claims for similar services, or all claims submitted by a particular provider. All claims that match the review criteria determined by Medicaid will suspend for manual review. As part of the review process, providers may be required to submit supporting documentation (for example, the medical record extract) for billed services. The documentation is used to ascertain the medical necessity for the services rendered.

7.1.7 Provider Certification

The Medicaid Program is funded by both the state and the federal government. Therefore, the providers of medical services are required to certify compliance with, or agreement to, various provisions of both state and federal laws and regulations. The agreements required by the Medicaid Program are explained in the following paragraphs.

Payment for services is made on behalf of recipients to the provider of service in accordance with the limitations and procedures of each program.

Offering incentives and advertising discounts.

Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of Medicaid recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of Medicaid on the Medicaid claim form, or such other method as Medicaid may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize Medicaid to recover same by then existing administrative recoupment procedures or legal proceedings.

Advertising the waiver of, or routinely waiving, Medicaid copayments is a prohibited “remuneration” under Section 22-1-11, Code of Alabama and 1128B of the Social Security Act (SSA)**.** Section 1128A (i) (6) of the SSA defines “remuneration” to include waiver of coinsurance and deductible amounts, unless (1) the waiver is not part of an advertisement or solicitation, (2) the provider does not routinely waive deductibles and copays, and (3) the provider either waives the amount after determining the recipient is in financial need or fails to collect the payment after making reasonable collection efforts.

Medicaid payment can never be made directly to recipients.

By submitting Medicaid claims, the provider agrees to abide by policies and procedures of the Program as reflected by the information and instructions in the *Alabama Medicaid Agency Administrative Code*. The provider also agrees to the following certification statement: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws." The requirements for this certification may be found in 42 Code of Federal Regulations §447.18.

Services must be reasonable and medically necessary.

Medicaid is continuously evaluating and updating medical necessity for claims payment. In an effort to ensure accurate coding and payment of claims, diagnosis/procedure code criteria is applied. The correct use of a CPT or ICD-9 code alone does not guarantee coverage of a service. All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.

7.1.8 Billing Recipients

When the provider of medical care and services files a claim with the Medicaid Program, the provider must agree to accept assignment. By accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that which is paid on allowed services.

NOTE:
Recipients may not be billed for claims rejected due to provider-correctable errors or failure to submit claims in a timely manner.

The recipient may be billed for services that are non-covered and for which Medicaid will not make any payment. Services that exceed the set limitation (for example, physician visits, hospital visits, or eyeglasses limit) are considered non-covered services. Medicaid does not reimburse providers for completing forms for school, family medical leave or other purposes not requested at the time of service. Providers may bill the recipient for this service under certain conditions. Providers are requested to confer with and inform recipients prior to the provision of services about their responsibilities for payment of services not covered by the Medicaid program. The requirements for payment can be found in 42 Code of Federal Regulations §455.18.

Recipients under 21 may qualify for additional Medicaid covered services beyond the yearly benefit limit. If treatment is deemed medically necessary to correct or improve conditions identified through the EPSDT screening process, these services will not be considered in the normal benefit limitations.

7.1.9 Payment Adjustment for Provider Preventable Conditions (PPC's)

Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPC's) and Other Provider Preventable Conditions (OPPCs).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

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.

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonable preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.

- The PPC must be clearly and unambiguously the results of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPC's for considerations 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 30 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 internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

Inpatient Hospitals must report Hospital Acquired Conditions (HACs) on the UB-04 claims form. Refer to Provider Manual Chapters 19 (Hospital) and 33 (Psychiatric Treatment Facilities).

All providers must report OPPCs via encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov.

Providers that do not currently have a password for the Adverse Event reporting may require one by contacting Jerri Jackson at Jerri.Jackson@medicaid.alabama.gov or via phone at 334-242-5630.

Reportable OPPCs include but are not limited to:

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

The following information is required for reporting:

- Recipient first and last name
- Date of Birth
- Medicaid number
- Date event occurred
- Event type

A sample form is on the Alabama Medicaid Agency website at http://www.medicaid.alabama.gov under Programs/Medical Services/Hospital Services. Providers may submit their own form as long as it contains all of the required information.

7.1.10 340 B Entities

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible 340B entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

Eligible 340B entities are defined in 42 U.S.C. § 256b(a)(4).

When an eligible 340B entity, other than a disproportionate share hospital, a children's hospital excluded from the Medicare prospective payment system, a free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital, submits a bill to the Medicaid Agency for a drug purchased by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency.

A disproportionate share hospital, children's hospital excluded from the Medicare prospective payment system, free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital may bill Medicaid the total charges for the drug. As manufacturer price changes occur, the entities must ensure that their billings are updated accordingly.

Eligible 340B entities are identified on the Department of Health and Human Service's website. These entities shall notify Medicaid of their designation as a 340B provider.

Audits of the eligible 340B entities' (claims submissions and invoices) will be conducted by the Medicaid Agency. Eligible 340B entities, other than the providers listed above, must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency in accordance with Chapter 33 of the Administrative Code.

7.2 Provider Rights

This section describes the fair hearings process, informal conferences, appeals, and HP and Alabama Medicaid Agency responsibilities towards providers participating in the Alabama Medicaid Program.

Providers have freedom of choice to accept or deny Medicaid assignment for medically necessary services rendered during a particular visit. This is true for new or established recipients.

The provider (or their staff) must advise each recipient when Medicaid payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted **must be recorded** in the recipient's medical record.

7.2.1 Administrative Review and Fair Hearings

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code.*

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated**. In addition to a clean claim, the provider should send all relevant RAs and previous correspondence with HP or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

Administrative Review
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

Include the program area in the address (for instance, write "Attn: System Support").

NOTE:

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing

NCCI Administrative Review and Fair Hearing

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

1. Redetermination Request—see section 7.2.4 below
2. Administrative Review – see below
3. Fair Hearing – see below

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.

Administrative Review

Added: as long as the claim is within the timely filing limit.

Deleted: ~~A written request…denial from HP.~~

When the redetermination request results in a denial by HP, the provider may request an *administrative review* of the claim as long as the claim is within the timely filing limit. The request should clearly explain why the provider disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI) Administrative Review http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx

Deleted: ~~Correct~~

Added: Corrected, ONLY, for NCCI.

Added: The corrected claim…the applicable modifier(s)

- Corrected Paper Claim for ONLY the procedure codes that denied for NCCI. The corrected claim must include the applicable modifier(s)
- Copy of previous request for redetermination correspondence sent to HP
- Copies of all relevant remittances advices or HP's redetermination denial notification
- Copy of any other useful documentation

Send the request for an 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.

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

7.2.2 Informal Conferences

A provider who disagrees with the findings of a utilization review may request an informal conference. Providers must make the request in writing to the Alabama Medicaid Agency at the above address. The informal conference is the intermediate step between the Administrative Review and the Fair Hearing process.

7.2.3 HP Responsibilities

The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims submitted by providers of medical care, services, and equipment authorized under the Alabama Title XIX State Plan. The present fiscal agent contract is with HP, P.O. Box 244032, Montgomery, Alabama 36124-4032. Their toll free telephone number is 1(800) 688-7989.

HP provides current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. HP prepares and distributes the *Alabama Medicaid Agency Provider Manual* to providers of Medicaid services. This manual is for guidance of providers in filing and preparing claims.

Providers with questions about claims should contact HP. Only unsolved problems or provider dissatisfaction with the response of HP should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, or by calling (334) 242-5000.

7.2.4 NCCI Redetermination 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 is 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.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

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.

First Level of Appeal: Redetermination Request

HP is responsible for the redeterminations, which is the **first** level of appeals and adjudication functions.

When a claim is denied for NCCI, the provider may request a redetermination as long as the claim is within the timely filing limit. A *redetermination* is an examination of a claim and operative notes/medical justification by HP personnel. The provider must complete the HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:

Added: When a claim…timely filing limit.

Deleted: ~~The provider has…request a determination.~~

- Completed NCCI Redetermination Review form
  http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx
- Corrected Paper Claim for ONLY the procedure codes that denied for NCCI. The corrected claim must include the applicable modifier(s)
- Operative Notes/Medical Justification/Supportive reports

Added: ONLY, for NCC

Added: The corrected claim…the applicable modifier(s)

Added: Supportive reports

Send the request for a Redetermination Review along with all supporting documentation to:

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

HP 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.

7.2.5 Alabama Medicaid Agency's Responsibilities

The Alabama Medicaid Agency is responsible for mandating and enforcing Medicaid policy for the Alabama Medicaid Program.

7.3 Medicare/Medicaid Fraud and Abuse Policy

The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse and/or misuse in the Medicaid Program. This includes verifying that medical services are appropriate and rendered as billed, that services are provided by qualified providers to eligible recipients, that payments for those services are correct, and that all funds identified for collection are pursued.

Federal regulations require the State Plan for Medical Assistance to provide for the establishment and implementation of a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate utilization of care and services and excess payments. The Alabama Medicaid Agency has designated the Program Integrity Division through its Provider Review, Recipient Review, and Investigations Units to perform this function. These units are responsible for detecting fraud and abuse within the Medicaid Program through reviewing paid claims history and conducting field reviews and investigations to determine provider/recipient abuse, deliberate misuse, and suspicion of fraud. In addition, these units are utilized to aid in program management and system improvement.

Cases of suspected recipient fraud are referred to local law enforcement authorities for prosecution upon completion of investigation. Cases of suspected provider fraud and patient abuse are referred to the Medicaid Fraud Control Unit in the Alabama Attorney General's Office. This office was established under Public Law 95-142 and Health and Human Services guidelines to investigate, for possible prosecution, alleged provider fraud and patient abuse in the Medicaid Program. The requirements can be found in 42 Code of Federal Regulations Part 455, Program Integrity: Medicaid.

7.3.1 Providers Must Screen for Excluded Individuals

The HHS Office of Inspector General (HHS-OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, and 1156.

When the HHS-OIG has excluded a provider, Federal health care programs (including Medicaid and SCHIP programs) are generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. (Section 1903(i) (2) of the Act; and 42 CFR section 1001.1901(b)) This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

• All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;

• Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and

• Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. (42 CFR section 1001.1901(b))

The listing below sets forth some examples of types of items or services that are reimbursed by Medicaid which, when provided by excluded parties, are not reimbursable:

• Services performed by excluded nurses, technicians, or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a pay per service or a bundled payment) by a Medicaid program, even if the individuals do not furnish direct care to Medicaid recipients;

•Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in

any way in filling prescriptions for drugs reimbursed, directly or indirectly, by a Medicaid program;

• Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Medicaid program, to hospital patients or nursing home residents;

• Services performed for program recipients by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Medicaid program;

• Services performed by excluded social workers who are employed by health care entities to provide services to Medicaid recipients, and whose services are reimbursed, directly or indirectly, by a Medicaid program;

• Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Medicaid program;

• Items or services provided to a Medicaid recipient by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Medicaid program; and

• Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of recipients and reimbursed, directly or indirectly, by a Medicaid program.

To further protect against payments for items and services furnished or ordered by excluded parties, all current providers and providers applying to participate in the Medicaid program **must** take the following steps to determine whether their employees and contractors are excluded individuals or entities:

• Screen all employees and contractors to determine whether any of them have been excluded by searching the exclusion list located on the Alabama Medicaid Agency's website. All providers must check the list prior to hiring staff to ensure potential staff has not been excluded from participation in the program. All providers must check the list again monthly to ensure existing staff have not been excluded from participation in the program since the last search.

• Search the HHS-OIG website by the names of any individual or entity. All providers must search the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search.

• Providers must immediately report to Medicaid any exclusion information discovered.

Civil monetary penalties may be imposed against Medicaid providers and managed care entities (MCEs) who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients. (Section 1128A (a) (6) of the Act; and 42 CFR section 1003.102(a) (2)).

Where Providers Can Look for Excluded Parties

Deleted: ~~http://www.oig.hhs.gov/fraud/exclusions.asp~~

Added: http://oig.hhs.gov/exclusions/index.asp

While the MED is not readily available to providers, the HHS-OIG maintains the List of Excluded Individuals/Entities (LEIE), a database accessible to the general public that provides information about parties excluded from participation in Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at http://oig.hhs.gov/exclusions/index.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

Additionally, Medicaid maintains an exclusion list, pursuant to 42 CFR section 1002.210, which includes individuals and entities that the State has barred from participating in State government programs. The exclusion list is located on the Medicaid website under the Fraud/Abuse Prevention tab. All providers are obligated to search this list monthly whenever they search the LEIE.

7.4 Appeals

If eligibility of a provider has been terminated because of a criminal conviction for Medicaid fraud or abuse, or because of loss of required licensure, then no fair hearing need be given. A certified copy of the judgment of conviction or of the decision to revoke or suspend a provider's license shall be conclusive proof of ineligibility for further participation in the Medicaid Program. The pending status of an appeal for any such conviction or license revocation or suspension shall not abate the termination of Medicaid eligibility. If a conviction, license revocation, or suspension is reversed on appeal, the recipient or provider may apply for reinstatement to the Medicaid program. However, Medicaid will examine the reasons for the reversal and reinstatement will be at the sole discretion of the Commissioner.

7.5 Refunds

Medicaid Refunds

If you receive payment for a recipient who is not your patient, or are paid more than once for the same service, please complete the Check Refund form. Refer to Section 5.11, Refunds, for instructions on completing the form. Appendix E, Medicaid Forms, contains a sample of the form.

Medicaid Adjustments

If you wish to have an overpayment deducted from a future remittance, do not attach a check. Instead, state that you wish to have funds deducted from a future remittance. If you require an adjustment on a fully or partially paid claim, please use one of the following methods:

- Complete an online adjustment using Medicaid’s Interactive Web Portal an online adjustment using Medicaid’s Interactive Web Portal.
- Complete an online adjustment using Provider Electronic Solutions software or approved vendor software as described in Section 5.10, Adjustments.

NOTE:

For large numbers of adjustments, please contact the Provider Assistance Center at 1 (800) 688-7989.

All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts.

If providers receive duplicate payments from a third party and Medicaid, all duplicate third party payments must be refunded within 60 days by:

- Sending a refund of insurance payment to the Third Party Division, Medicaid
- Requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

If the provider releases medical records and/or information pertaining to a claim paid by Medicaid and, as a result of the release of that information, a third party makes payment to a source other than the provider or Medicaid, the provider is responsible for reimbursing Medicaid for its payment.

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8 Ambulance (Ground & Air)

Medicaid covers transportation costs to and from medical care facilities for eligible recipients. The approved plan includes the following services:

- Reimbursement of ambulance service for emergency and non-emergency situations
- Reimbursement of non-emergency transportation coordinated by the Alabama Medicaid Agency (See Appendix G, Non-Emergency Transportation (NET Program)

The policy provisions for transportation providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 18.

8.1 Enrollment

HP enrolls transportation providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

For ambulance providers, Medicaid requires a new service contract in the following instances:

- Expiration of state license and issuance of new license
- Change of ownership

HP is responsible for enrolling any qualified ambulance service that wishes to enroll in the Medicaid Transportation Program.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a transportation provider is added-to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for transportation-related claims.

NOTE:

The current 10 digit National Provider Identifier (NPI) is required when filing a claim.

Transportation providers are assigned a provider type of 26 (Transportation).

Valid specialties for transportation providers include the following:

- Emergency Ground Ambulance (260)
- Helicopter (261)
- Fixed Wing (268)

Enrollment Policy for Transportation Providers

To participate in the Alabama Medicaid Program, transportation providers must meet the following requirements:

- Must be certified for Medicare Title XVIII
- Must maintain a disclosure of the extent and cost of services, equipment, and supplies furnished to eligible recipients
- Must be licensed in the state of Alabama and/or the state in which services are provided
- The effective date of enrollment of an Ambulance Provider will be the date of Medicare certification. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by Medicaid's Fiscal Agent.

8.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Please refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid reimburses a maximum of one round trip per date of service per recipient. A round trip consists of the transport from home base (home, nursing home, etc) to the destination (physician's office, hospital, etc) and transport from the destination back to home base on the same date of service.

Medicaid requires that the recipient be taken to the nearest hospital that has appropriate facilities, physicians, or physician specialists needed to treat the recipient's condition. The hospital must have a bed or specialized treatment unit immediately available. If the recipient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick-up point to the nearest appropriate hospital.

All transportation must be medically necessary and reasonable. Documentation must state the condition(s) that necessitate ambulance service and indicate why the recipient cannot be transported by another mode of transportation. Medicaid will not reimburse ambulance service if some other means of transportation could have been used without endangering the recipient's health.

8.2.1 Non-Emergency Transportation (NET) Program Services

To eliminate transportation barriers for recipients, Medicaid operates the Non-Emergency Transportation Program (NET). The NET Program ensures that necessary non-ambulance transportation services are available to recipients. See Appendix G, Non-Emergency Transportation (NET) Program, for specifics about the program.

All payments for NET services require authorization.

8.2.2 Non-Emergency Ambulance Services

Medicaid reimburses non-emergency ambulance services provided to eligible recipients for the following origins and destinations:

- Hospital to home following hospital admission
- Home to hospitals or specialized clinics for diagnostic tests or procedures for non-ambulatory recipients
- Home to treatment facility for recipients designated on Home Health Care Program who are confined as "bedfast" recipients
- Nursing facility to hospital or specialized clinic for diagnostic tests within the state when medically necessary and out of state with Alabama Medicaid determined placement only.
- Nursing facility to nursing facility
- Hospital to hospital
- Hospital to nursing facility following hospital admission
- Physician’s Office

8.2.3 Emergency Ambulance Services

Medicaid reimburses emergency ambulance services provided to eligible recipients for the following origins and destinations:

- Location of emergency to a local hospital
- Nursing facility to a local hospital
- Hospital to hospital

Medicaid reimburses emergency ambulance services if the recipient expires during transport, but not if the recipient was pronounced dead by authorized medical personnel before transport.

If more than one recipient is transferred in the same ambulance at the same time, please file a separate claim form for each recipient.

8.2.4 Air Transportation Services

Medicaid reimburses air transportation services for all Medicaid recipients with prior authorization approval only. Air transportation for adults is reimbursed at the ground ambulance rate.

Air transportation may be rendered only when basic and advanced life support land ambulance services are not appropriate. Medical necessity applies when transport by land or the instability or inaccessibility to land transportation threatens survival or seriously endangers the recipient's health. Medicaid may authorize air transportation in certain cases when the time required to transport by land as opposed to air endangers the recipient's life or health. Medicaid will not reimburse air transportation when provided for convenience.

Medicaid requires that the recipient be taken to the nearest hospital that has appropriate facilities, physicians, or physician specialists needed to treat the recipient's condition. The hospital must have a bed or specialized treatment unit immediately available. If the recipient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick-up point to the nearest appropriate hospital.

NOTE:

Medicaid does not consider trips of less than 75 loaded miles to be appropriate unless extreme, extenuating circumstances are present and documented.

NOTE:

If more than one recipient is transferred in the same air transport trip, only one recipients transport will be reimbursed.

If Medicaid determines that land ambulance service would have been more appropriate, payment for air transportation will be based on the amount payable for land transportation.

8.3 Prior Authorization and Referral Requirements

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

When requesting prior authorization, please give the recipient's name, RID number, address, diagnosis, attending physician, reason for movement (from and to), and the name of the ambulance provider who will be used. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

In the case of Retroactive Eligibility, the provider has 90 days after the date on which the award of retroactive eligibility was made to submit their request for prior approval. It is the provider's responsibility to submit a copy of the retroactive eligibility determination along with the prior approval request to Medicaid.

NOTE:

"Clean" Prior Authorization (PA) requests must be received by our Fiscal Agent (HP) within thirty (30) business days from the date of service. A"Clean" PA request is one where valid information is submitted on both the provider and the recipient regarding services that were rendered on a specific date of service and without any RTPs (Return To Provider) which would create a delay for your request.

Prior Authorization for Non-Emergency Transportation

All non-emergency ambulance services 100 miles or greater one way requires prior authorization. However, the provider has thirty (30) business days from the date the service was rendered to obtain the prior authorization (PA).

When submitting Prior Authorization requests for non-emergency ground ambulance transport >100 miles, the following condition codes are the only ones recognized by Alabama Medicaid:

Condition Code	***Description***
02	Bed confined before the ambulance service
04	Moved by stretcher
05	Unconscious or in shock
07	Physically restrained
08	Visible hemorrhaging

Authorization for Air Transportation

All payments for air transportation services require authorization from Medicaid.

The following steps must be followed for air ambulance providers to receive reimbursement:

1. Medicaid's Fiscal Agent must receive authorization requests no later than the thirtieth (30th) business day after the service was rendered. **Please include the following:**
   - Air versus ground time and/or distance
   - Age of recipient
   - Diagnosis and severity of condition
   - Any other pertinent medical data as deemed necessary to document air transportation
2. The provider must supply the above documentation for any service requiring immediate transportation. The documentation must also include a copy of the flight record, progress notes from institution that requested air transport, and documentation of reason why ground transport is not feasible.
3. Medicaid's Fiscal Agent assigns a prior authorization number and forwards the request to the Medicaid Prior Approval Program for review.
4. The Prior Approval Program reviews the request and forwards it to the contracted Medicaid designee reviewer for approval/denial.

5. If Medicaid or the contracted Medicaid designee reviewer determines that air transportation is not medically necessary and the criteria are met for ground transportation, the request is approved at the emergency ground rate. The provider will bill authorized amount and be reimbursed at the emergency ground rate.
6. Providers who are dissatisfied with the decision of Medicaid or the contracted Medicaid designee reviewer must request an informal review of medical information. The request must be in writing and received by Medicaid within thirty days of the modified approval letter. If additional information is not submitted for review, the decision will be final and no further review will be available.
7. Provider is instructed to submit claim to Medicaid's Fiscal Agent for payment with the assigned prior authorization number.
8. Prior authorization requests will be accepted from newly enrolled providers for dates retroactive to the first day of the month preceding the month of the effective date provider is added to the Medicaid system.

NOTE:

In the event an air transport provider is unable to verify a recipient's eligibility prior to or at the time of the transport due to the patient being unconscious or disoriented and no family member being available, the provider's prior authorization request will be reviewed on a case by case basis. The request must include documentation detailing the reason eligibility was not verified prior to transport.

NOTE:

Prior authorization requests may be submitted to Medicaid's Fiscal Agent per FAX or regular mail. Providers are instructed to follow-up with the fiscal agent within four to five days to be certain request was received, and again in two weeks, if no reply has been received.

8.4 Cost Sharing (Copayment)

The copayment does not apply to services provided by transportation providers.

8.5 Billing Recipients

By filing a claim with the Medicaid Program, a provider is agreeing to accept assignment and by accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount (copay) to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that, if any, which is paid on an allowed service.

8.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Transportation providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

8.6.1 Time Limit for Filing Claims

Medicaid requires all claims for transportation to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

8.6.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

Ground transportation providers must use a valid diagnosis code. Ground transportation providers may use more than one diagnosis code from the approved list per claim.

NOTE:

Air transportation providers should only bill diagnosis code used on the prior authorization.

Diagnosis codes for **emergency ground transportation** are listed below. If you bill a diagnosis code for an **emergency ground transport** that is not on this list, your claim will deny. For non-emergency ground transport, any valid ICD-9 diagnosis code may be used.

Covered

* An asterisk indicates additional digits are required. See the ICD-9 manual for appropriate digit(s).

NOTE: This chart displays diagnosis codes with the decimal point to facilitate code lookup in the ICD-9 manual. Do not include the decimal point when entering a diagnosis code on the claim form.

040.82	413.9	426.54	437.1	511.8	638.6	771.81	801.2*	805.5	807.2	820.03	852.2*
250.1*	414.12	426.6	437.2	511.9	638.7	772.0	801.3*	805.6	807.3	820.09	852.3*
250.2*	414.8	426.7	437.3	512.0	639.1	772.3	801.4*	805.7	807.4	820.10	852.4*
250.3*	415.0	426.81	437.4	512.1	639.2	772.4	801.5*	806	807.5	820.11	852.5*
251.0	415.19	426.82	437.5	512.8	639.3	773.3	801.6*	806.0	807.6	820.12	853.0*
282.62	415.12	426.89	437.6	518.0	639.5	775.3	801.7*	806.00	808.0	820.13	853.1*
290.3	416.0	426.9	437.7	518.1	639.6	775.6	801.8*	806.01	808.1	820.19	854.0*
290.41	416.1	427.0	443.21	518.4	639.8	776.0	801.9*	806.02	808.2	820.20	854.1*
291.0	416.8	427.1	443.22	518.5	639.9	776.2	802.0	806.03	808.3	820.21	860.0
291.3	416.9	427.2	443.23	518.81	640	777.5	802.1	806.04	808.41	820.22	860.1
291.4	417.0	427.31	443.24	518.82	640.0*	778.4	802.20	806.05	808.42	820.30	860.2
291.5	417.1	427.32	443.29	518.84	640.8*	778.5	802.21	806.06	808.43	820.31	860.3
292.0	417.8	427.41	444.0	518.89	641.1*	779	802.22	806.07	808.49	820.32	860.4
292.11	417.9	427.42	444.1	519.01	641.2*	779.0	802.23	806.08	808.51	820.8	860.5
292.12	420.0	427.5	444.2*	519.09	641.3*	779.2	802.24	806.09	808.52	820.9	861.00
292.2	420.90	427.60	444.8	519.11	641.8*	779.4	802.25	806.1	808.53	821.00	861.01
292.81	420.91	427.61	444.81	519.2	641.9*	779.5	802.26	806.10	808.59	821.01	861.02
293.0	420.99	427.69	444.89	537.83	642.5*	779.81	802.27	806.11	808.8	821.10	861.03
295.0*	421.0	427.81	444.9	537.84	642.6*	779.82	802.28	806.12	808.9	821.11	861.10
295.1*	421.1	427.89	445.01	540	642.7	779.85	802.29	806.13	810.1*	821.20	861.11
295.2*	421.9	427.9	445.02	540.0	644.0*	780.0*	802.30	806.14	811.1*	821.21	861.12
295.3*	422.0	428.0	445.81	540.1	644.1*	780.1	802.31	806.15	812.10	821.22	861.13
295.4*	422.90	428.1	445.89	569.69	644.2*	780.2	802.32	806.16	812.11	821.23	861.20
295.5*	422.91	428.20	449	569.85	652.7*	780.31	802.33	806.17	812.12	821.29	861.21
295.6*	422.92	428.21	453.9	569.86	659.3	780.32	802.34	806.18	812.13	821.30	861.22
295.7*	422.93	428.23	465.9	572.2	661.3*	780.39	802.35	806.19	812.19	821.31	861.30
295.8*	422.99	428.30	480.0	578.0	663.0*	785.50	802.36	806.20	812.30	821.32	861.31
296.0*	423.0	428.31	480.1	578.1	663.1*	785.51	802.37	806.21	812.31	821.33	861.32
296.1*	423.1	428.33	480.2	578.9	663.2*	785.52	802.38	806.22	812.50	821.39	862.0
296.2*	423.2	428.40	480.3	592.1	663.00	785.59	802.39	806.23	812.51	822.0*	862.1
296.3*	423.3	428.41	480.8	592.9	666.0*	786.00	802.4	806.24	812.52	822.1*	862.21
296.4*	423.8	428.43	480.9	633.0*	666.1*	786.01	802.5	806.25	812.53	823.1*	862.22
296.5*	423.9	428.9	481	634.1*	666.2*	786.02	802.6	806.26	812.54	823.3*	862.29
296.6*	424.0	429.2	482.0	634.2	682.2	786.03	802.7	806.27	812.59	824.1	862.31
298.0	424.1	429.4	482.1	634.3*	741.0*	786.1	802.8	806.28	813.10	824.3	862.32
298.1	424.2	429.5	482.2	634.4	746.86	786.50	802.9	806.29	813.11	824.5	862.39
298.2	424.3	429.6	482.30	634.5*	747.9	786.51	803.0*	806.30	813.12	824.7	862.8
298.3	424.90	429.81	482.31	634.6*	762.1	786.52	803.1*	806.31	813.13	824.9	862.9
298.4	424.91	429.82	482.32	634.7	762.2	786.59	803.2*	806.32	813.14	827.1	863.0
298.8	424.99	429.89	482.39	634.8*	762.4	789.0*	803.3*	806.33	813.15	828.1	863.1
322.9	425.0	430	482.4*	635.0	762.5	789.4	803.4*	806.34	813.16	850.0	863.50
345.1*	425.1	431	482.81	635.1*	765.0*	789.51	803.5*	806.35	813.17	850.1	863.51
345.2	425.2	432.0	482.82	635.2	765.1*	789.6	803.6*	806.36	813.18	850.2	863.52
345.3	425.3	432.1	482.83	635.3*	767.0	790.1	803.7*	806.37	813.30	850.3	863.53
345.4*	425.4	432.9	482.89	635.4	767.4	790.2	803.8*	806.38	813.31	850.4	863.54
345.5*	425.5	433.0*	482.9	635.5*	767.8	790.3	803.9*	806.39	813.32	850.5	863.55
410.0*	425.7	433.1*	483*	635.6*	768.2	799.01	804.0*	806.4	813.33	850.9	863.56
410.1*	425.8	433.2*	484.1	635.7	768.3	799.02	804.1*	806.5	813.50	850.11	863.59
410.2*	425.9	433.3*	484.3	636.1*	768.4	799.1	804.2*	806.60	813.51	850.12	863.90
410.3*	426.0	433.8*	484.5	636.2	768.5	800.0*	804.3*	806.61	813.52	851.0*	863.91
410.4*	426.10	433.9*	484.6	636.3*	768.6	800.1*	804.4*	806.62	813.53	851.1*	863.92
410.5*	426.11	434.0*	484.7	636.4	768.9	800.2*	804.5*	806.69	813.54	851.2*	863.93
410.6*	426.12	434.1*	484.8	636.5*	769	800.3*	804.6*	806.7	813.90	851.3*	863.94
410.7*	416.13	434.9*	485	636.6*	770.1	800.4*	804.7*	806.70	813.91	851.4*	863.95
410.8*	426.2	435.0	486	636.7	770.8	800.5*	804.8*	806.71	813.92	851.5*	863.99
410.9*	426.3	435.1	487.0	638.0	770.81	800.6*	804.9*	806.72	813.93	851.6*	864.1*
411.0	426.4	435.2	487.1	638.1	770.82	800.7*	805.0*	806.79	818.1	851.7*	865.0*
411.1	426.50	435.3	487.8	638.2	770.83	800.8*	805.1*	806.8	819.1	851.8*	865.1*
411.81	426.51	435.8	506*	638.3	770.84	800.9*	805.2	806.9	820.0*	851.9*	866.1*
411.89	426.52	435.9	511.0	638.4	770.85	801.0*	805.3	807.0*	820.01	852.0*	867.1
413.1	426.53	436	511.1	638.5	771.8	801.1*	805.4	807.1*	820.02	852.1*	867.3

867.5	874.02	878.3	887.0	897.0	927.01	934.8	944.3*	948.20	952.04	992.1	998.2
867.7	874.10	878.4	887.1	897.1	927.02	940.2	944.4*	948.21	952.05	992.2	998.3
867.9	874.11	878.5	887.2	897.2	927.03	940.3	944.5*	948.22	952.06	992.3	998.31
868.1*	874.12	878.6	887.3	897.3	927.09	940.4	945.3*	948.3*	952.07	992.4	998.32
869.1	874.2	878.7	887.4	897.4	927.10	940.5	945.4*	948.4*	952.08	992.6	999.1
870.3	874.3	879.1	887.5	897.5	927.11	941.2*	945.5*	948.5*	952.09	992.7	999.4
870.4	874.4	879.2	887.6	897.6	927.8	941.3*	946.3	948.6*	952.1*	994.0	E9289
871.0	874.5	879.3	887.7	897.7	928.00	941.4*	946.4	948.7*	952.2	994.1	
871.1	875.0	879.4	890.1	925.1	928.01	941.5*	946.5	948.8*	952.3	994.7	
871.2	875.1	879.5	890.2	925.2	928.10	942.3*	947.1	948.9*	952.4	994.8	
871.3	876.0	880.1*	891.1	926.0	928.11	942.4*	947.2	950*	952.8	995.0	
871.5	876.1	880.2*	891.2	926.11	928.20	942.5*	947.3	951*	958.0	996.73	
871.6	877.1	881.1*	896.0	926.12	928.21	943.2*	947.4	952.00	958.1	997.1	
873.1	878.0	881.2*	896.1	926.19	933.1	943.3*	947.8	952.01	958.4	997.3	
874.00	878.1	882.1	896.2	926.8	934.0	943.4*	948.10	952.02	991.6	998.0	
874.01	878.2	882.2	896.3	927.00	934.1	943.5*	948.11	952.03	992.0	998.1*	

8.6.3 Procedure Codes and Modifiers

Transportation providers use the following procedure codes and modifiers. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Ambulance services billed will be commensurate with services actually performed. Services rendered are independent of the type of call received or the type staff / equipped ambulance service responding.

Procedure Codes for Basic Life Support (BLS) Services

Basic Life Support Service (BLS) is an ambulance service which includes equipment and staff to render basic services such as control of bleeding, splinting fractures, treating shock, performing cardiopulmonary resuscitation (CPR), delivery of babies, use of horizontal immobilizers, restraints for combative recipients, and use of gauze pads/bandages.

Procedure Code	***Description***
A0429	Ambulance Service, basic life support, emergency transport (BLS - Emergency)
A0425	Ground Mileage, per mile (100) miles or more requires prior authorization)

Procedure Codes for Advanced Life Support (ALS) Services

An ALS ambulance has similar equipment, crew, and certification requirements under Medicare as a basic ambulance, except the ALS ambulance has complex specialized life-sustaining equipment. It is ordinarily equipped for radio-telephone contact with a hospital or physician. A typical ALS ambulance may be a mobile coronary care unit or other vehicle appropriately equipped and staffed by personnel authorized to initiate and administer IV fluids, establish and maintain a recipient's airway, defibrillate the heart, relieve pneumothorax conditions, administer cardiopulmonary resuscitation (CPR), provide anti-shock therapy ,administer life sustaining drugs, venous blood draws, cardiac monitoring (EKG), administer pacing nebulizer and perform other advanced life support procedures or services to recipients during the transport. Documentation must support need for ALS services.

Procedure Code	***Description***
A0225	Neonatal Emergency Transport, transport of a critically ill neontate, a level of interfacility service provided beyond the scope of the Paramedic. This service should be billed only for the transport of a neonate.
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ALS1) Must provide medically necessary supplies and services, including the provision of an ALS assessment or at least one ALS intervention.
A0433	Advanced Life Support Level 2 (ALS2). The administration of at least three different medications and the provision of one or more of the following ALS procedures: Manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line.
A0434	Specialty Care Transport (SCT), in a critically injured or ill patient, a level of interfacility service provided beyond the scope of the Paramedic. This service is necessary when a patient’s condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).

Procedure Codes for Non-emergency Services

Procedure Code	*Description*
A0426	Ambulance service, advanced life support, Level 1 (ALS1, Must provide medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention), non-emergency transport, (cannot be billed with A0422)
A0428	Ambulance service, basic life support, (BLS), non-emergency transport
A0425	Ground Mileage, per mile (100) miles or more requires prior authorization)

Miscellaneous Procedure Codes

Procedure Code	*Description*
A0382	BLS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground Mileage, per mile (100) miles or more requires prior authorization)

Services Not Covered by Medicare That Are Covered by Medicaid

- Some non-emergency ambulance services are non-covered by Medicare but are covered by Medicaid if billed in conjunction with the modifiers below. These claims should be filed on a medical claim electronically.
- Modifiers DD, DG, DJ, DN, DP, DR, ED, GD, GP,HD, HP, ND, JP,NP, PD, PE, PG, PH, PJ, PN, PP, PR, RD, or RP
- A0422, A0425, A0426, A0428, A0429

Procedure Codes for Medicare Crossovers Only

Medicaid will reimburse providers for only the coinsurance and deductible for the following procedure codes:

Procedure Code	*Description*
A0432	Paramedic ALS intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers

Procedure Codes for Air Transportation

Procedures not included in this list are not covered by Medicaid.

Procedure Code	*Modifier*	*Description*
A0435		Air mileage, fixed wing, per statute mile
A0436		Air mileage, rotary wing, per statute mile
A0430		Ambulance service, conventional air services, transport, one way (fixed wing)
A0431		Ambulance service, conventional air services, transport, one way (rotary wing)
A0070		Ambulance service, oxygen, administration and supplies, life sustaining situation, limited to 1 unit per trip
A0215		Miscellaneous disposable supplies, limited to 1 unit per claim

First Modifier

The first place alpha code is the origin; the second place alpha code is the destination. **The valid origin/destination modifiers and their explanations are listed below:**

Modifier	*Description*
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.) (Note: Bed-bound recipients only, NET Program prior authorization required)
R	Residence
S	Scene of accident or acute event

For example, when a recipient is picked up at the residence (origin code R) and taken to the hospital (destination code H) for an ALS emergency transport (procedure code A0427), the claim is coded as **A0427RH.**

The following are all of the valid combinations for the first modifier fields:

	DN	EH	GE	HG	HR	JH	NG	RD	RN
DD	DR	EJ	GH	HH	IH	JN	NH	RE	SH
DG	ED	EN	GN	HI	IN	JR	NJ	RG	SI
DH	EE	ER	GR	HJ	JD	ND	NN	RH	I I
DJ	EG	GD	HE	HN	JE	NE	NR	RJ	

NOTE:

For ground ambulance transport from a residence to an airport or helicopter site the ground provider should use the modifier combination “SI” since the reason for transport would be an accident or “acute event”.

Second Modifier **(These are not required by Medicaid)**

Modifier	*Description*
2A	Accidental injury home/nursing home
3A	Accidental injury
4A	Recipient in shock
6A	Transported by stretcher
8A	Hospital lacks facility (recipient admitted to second hospital)
9A	Rectal bleeding
5B	Dead on arrival (DOA) at hospital
6B	Died en route to hospital

Repeat Trip

Modifier TS (Follow up Service) is used in the second modifier position to indicate a repeat trip for the same recipient on the same day.

When a recipient is picked up at a hospital (origin code H), taken to another hospital (destination code H), and returned to the original hospital, bill the procedure code with a TS modifier for Follow-up Service.

8.6.4 Place of Service Codes

The following place of service codes apply when filing claims for transportation services:

POS	*Description*
41	Ambulance – Land
42	Ambulance – Air or Water

8.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

8.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
NET Program	Appendix G

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9

9 Ambulatory Surgical Centers (ASC)

The policy provisions for ASC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 38.

Ambulatory surgical services are procedures typically performed on an inpatient basis that can be performed safely on an outpatient or ambulatory surgical center (ASC) basis.

9.1 Enrollment

HP enrolls ASC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an ASC provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for ASC-related claims.

NOTE:
All ten characters are required when filing a claim effective.

ASC Providers are assigned a provider type of 02 (ASC). Valid specialties for ASC providers include the following:

- Ambulatory Surgical Center (020)
- Lithotripsy (520)

Enrollment Policy for Ambulatory Surgical Center Providers

To participate in the Alabama Medicaid Program ASC providers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authorities
- Possess a copy of a transfer agreement with an acute care facility (refer to the *Alabama Medicaid Agency Administrative Code* rule no. 560-X-38-05 for details)

9.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

ASC services are items and services furnished by an outpatient ambulatory surgical center in connection with a covered surgical procedure.

Rates of reimbursement for ASC services include, but are not limited to:

- Nursing, technician and related services
- Use of an ambulatory surgical center
- Lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administrative, record keeping, and housekeeping items and services
- Materials for anesthesia

NOTE:

Outpatient dental care (procedure code D9420) must be prior approved and is covered only for recipients under the age of 21. The dentist is responsible for obtaining prior approval from the Alabama Medicaid Agency Dental Program at (334) 242-5472. Dental services provided to SOBRA adult females are non-covered.

ASC services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:

- Physician services
- Lab and x-ray not directly related to the surgical procedure
- Diagnostic procedures (other than those directly related to performance of the surgical procedure)
- Prosthetic devices (except intraocular lens implant)
- Ambulance services
- Leg, arm, back, and neck braces
- Artificial limbs
- Durable medical equipment for use in the patient's home

ASC services are reimbursed by means of a predetermined fee established by Medicaid. All ASC procedures will be reimbursed at the lesser of the predetermined rate for the procedure or the provider's submitted charge less the copay amount.

NOTE:

Ambulatory surgical center services are limited to three encounters each calendar year.

Medicaid pays for a surgical procedure performed on an outpatient basis for a Medicaid recipient only if the procedure is on the approved surgical list found in Appendix I.

Covered Surgical Procedures

Covered surgical procedures are procedures that meet the following criteria:

- Surgical procedures commonly performed on an inpatient basis in hospitals but may be safely performed in an ambulatory surgical center setting
- Surgical procedures limited to those requiring a dedicated operating room and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room
- Surgical procedures not otherwise excluded under 42 C.F.R. § 416.65 or other regulatory requirement
- Procedure codes within the range of 10000-69XXX

Medicaid maintains a listing of the covered surgical procedures in Appendix I, ASC Procedures List. This list is reviewed and updated on a quarterly basis. Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Ambulatory Surgical Center Transfer Procedures

The ambulatory surgical centers must have an effective procedure for the immediate transfer to a hospital of recipients requiring emergency medical care beyond the capabilities of the center. The hospital will have a provider contract with Medicaid. The center must have a written transfer agreement with said hospital, and each physician performing surgery in the center must have admitting privileges at said hospital. Changes in this submitted information will be made available to the HP as they occur.

Surgical Procedures Groups

The surgical procedures are classified into separate payment groups. All procedures within the same payment group are reimbursed at a single rate. These rates are subject to adjustment by Medicaid.

If one covered surgical procedure is furnished to a Medicaid recipient in an operative session, Medicaid pays either the submitted charges minus the copayment amount or the predetermined rate for the procedure minus the copayment, whichever is lowest.

If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, Medicaid pays the lesser of either the submitted charges or the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges or at 50 percent of the predetermined rate for each of the other procedures, whichever is lowest.

Payment Adjustment for Provider Preventable Conditions (PPC's)

Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPC's) and Other Provider Preventable Conditions (OPPCs).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

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.

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonable preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the results of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPC's for considerations 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 30 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 internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

OPPCs must be reported via encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Providers that do not currently have a password for the Adverse Event reporting may require one by contacting Patricia Williamson at patricia.williamson@medicaid.alabama.gov or via phone at 334-353-4142.

Reportable OPPCs include but are not limited to:

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

The following information is required for reporting:

- Recipient first and last name
- Date of Birth
- Medicaid number
- Date event occurred
- Event type

A sample form is on the Alabama Medicaid Agency website at http://medicaid.alabama.gov/ under Programs/Medical Services/Hospital Services. Providers may submit their own form as long as it contains all of the required information.

9.3 Prior Authorization and Referral Requirements

Certain procedures require prior authorization. Please refer to the ASC Procedures List in Appendix I. A "Y" in the PA column on the list indicates surgical procedures that require prior approval. Payment will not be made for these procedures unless authorized prior to the service being rendered.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

All requests for prior approval must document medical necessity and be signed by the physician. Requests should be sent to HP, Attention Prior Authorization, P.O. Box 244032, Montgomery, Alabama 36124-4032.

The prior authorization number issued must be listed on the UB-04 claim form when billing for the prior authorization service.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center.

9.3.1 Patient 1st Referrals

By verifying eligibility, providers can get information regarding whether a recipient is enrolled in the Patient 1st program. If the recipient is enrolled in Patient 1st, the provider must document information regarding the recipient's primary medical provider (PMP) and obtain a referral for services prior to rendering services. A Patient 1st referral form is available; however, any method of documenting the required information is acceptable. The referral form must identify the PMP, the reason for the referral, authorized dates of service, and name of staff member giving referral.

As a specialty provider, ASCs are required to obtain a referral from the recipient's PMP before rendering services. Without a referral from the PMP, reimbursement cannot be made. Refer to Chapter 5, Filing Claims, for specifics on completing the UB-04 claim form with this referral information.

9.3.2 EPSDT Referrals

Children under 21 years of age can receive medically necessary health care diagnosis, treatment and/or other services to correct or improve conditions identified during or as a result of an EPSDT screening. Refer to Appendix A, EPSDT, for more specifics on obtaining these referrals.

9.4 Cost Sharing (Copayment)

Deleted: ~~$3.00~~
Added: $3.90

The copayment amount for an ASC encounter is **$3.90** per encounter. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, family planning, and crossovers. Native American Indians that present an “active user letter” issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

9.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

ASC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

For straight Medicaid claims, ASCs should bill Medicaid on the UB-04 claim form. Medicare-related claims should be filed using the Medical Medicaid/Medicare Related Claim Form.

9.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ambulatory surgical center providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

9.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits).

9.5.3 Procedure Codes and Modifiers

ASC providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four procedure code modifiers.

Only procedures listed in the ASC Procedures List are reimbursable in the ambulatory surgical setting. The list of covered outpatient procedures is located in Appendix I.

NOTE:

Procedures not listed on the ASC Procedures List may be covered under special circumstances. Approval must be obtained prior to the surgery. Refer to Section 9.3, Prior Authorization and Referral Requirements, for more information. Prior to providing services, providers should inform recipients of their responsibilities for payment of services not covered by Medicaid.

9.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

9.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

9.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
ASC Procedures List	Appendix I

10

10 Audiology/Hearing Services

Audiological function tests and hearing aids are limited to Medicaid recipients who are eligible for treatment under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. These services do not require an EPSDT referral. See chapter 39 for Patient 1st referral requirements. Hearing aids are provided through hearing aid dealers who are contracted to participate in the Alabama Medicaid Hearing Aid Program.

An eligible recipient with hearing problems may be referred to a private physician or to a Children's Specialty Clinic for medical evaluation.

The policy provisions for audiology and hearing services providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 19.

10.1 Enrollment

HP enrolls hearing services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Only in-state and bordering out-of-state (within 30 miles of the Alabama state line) audiology and hearing aid providers who meet enrollment requirements are eligible to participate in the Alabama Medicaid program.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an Audiology/hearing provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hearing-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Hearing service providers are assigned a provider type of 22 (Hearing Aid Dealer) and/or 20 (Audiologist). The valid specialty for Hearing Aid providers is Hearing Aid Dealer (220). The valid specialty for Audiology is 200.

Enrollment Policy for Audiology Providers

Audiologists must hold a valid State license issued by the state in which they practice.

HP is responsible for enrollment of audiologists. Licensed audiologists desiring to participate in the Alabama Medicaid Program must furnish the following information to HP as part of the required enrollment application:

- Name
- Address
- Specialty provider type
- Social Security Number
- Tax ID Number
- Copy of current State license

Hearing Aid Dealers

Dealers must hold a valid license issued by the Alabama Board of Hearing Aid Dealers, as issued by the state in which the business is located.

10.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

10.3 Prior Authorization and Referral Requirements

Hearing services procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP). When an EPSDT referral is required for treatment of medically necessary services, the Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

10.4 Cost Sharing (Copayment)

Copayment does not apply to hearing services.

10.5 Completing the Claim Form

NOTE:

An audiologist employed by a physician cannot file a claim for the same services billed by that physician for the same patient, on the same date of service.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hearing services providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

10.5.1 Time Limit for Filing Claims

Medicaid requires all claims for hearing services to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

10.5.2 Diagnosis Codes

Hearing aid dealers must bill diagnosis code V729 on all claims.

Audiologists are required to use a valid ICD-9 diagnosis code. The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

10.5.3 Cochlear, Auditory Brain Stem and Osseointegrated Implants

Cochlear Implants

Cochlear Implants are covered on an inpatient basis only. Prior authorization for the preoperative evaluation and the implantation must be requested by a Medicaid-approved *cochlear implant team surgeon,* using the Authorization for Cochlear Implants Form (PHY-96-11).

Specialty Code 740 is needed to enroll for Cochlear Implants.

The Criteria for the Team members is as follows;

1. Surgeon Board certified otolaryngologist
   Completion of Nucleus Pediatric Cochlear Implant Surgeons' Course or show evidence of training during residency.
   Successfully performed previous Pediatric Cochlear Implantations

2. Audiologist Master's degree from an accredited institution
   Certificate of Clinical competence in audiology
   Alabama License in audiology
   Completion of the Cochlear Implant Workshop

3. Speech/Language Pathologist
   Master's degree from an accredited institution
   Certificate of Clinical Competence in Speech/Language Pathology
   Alabama License in Speech/Language Pathology
   Experience in auditory-verbal and total communications methodologies

4. Rehabilitation Specialist-not required as part of the team, but must have available for consultation the following professionals:
   Psychologists
   Social Workers
   Physical Therapists
   Occupational Therapist

Medicaid may reimburse for cochlear implant services for recipients who meet the following criteria:

1. EPSDT referral
2. Chronological age 1 through 20 years of age
3. Profound (>90 dBHL) sensorineural hearing loss bilaterally and minimal speech perception under best aided conditions
4. Minimal or no benefit obtained from a hearing (a vibrotacile) aid as demonstrated by failure to improve on age appropriate closed-set work identification task. Appropriate amplification and rehabilitation for a minimum six-month trial period is required to assess the potential for aided benefit. Benefits may be extended to candidates with severe hearing impairment and open-set sentence discrimination that is less than or equal to 30 percent in the best aided conditions.
5. No medical or radiological contraindications, and otologically stable and free of active middle ear disease prior to cochlear implantation.
6. Families/caregivers and possible candidates well-motivated. Education must be conducted to ensure parental understanding of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the child's therapeutic program and the ability to adequately care for the external equipment.

Effective June 1, 2002, Medicaid will reimburse for a personal FM system for use by a cochlear implant recipient when prior authorized by Medicaid and not available by any other source. The replacement of lost or damaged external components (when not covered under the manufacturer's warranty) will be a covered service when prior authorized by Medicaid.

Reimbursements for manufacturer's upgrades will not be made within the first three years following initial implantation.

Prior Authorization Procedures are as follows:

1. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

2. The prior authorization number issued for the cochlear implant must be indicated in the clinical statement section of form 342.

3. Additional medical documentation supporting medical necessity for FM system (V5273) or replacement external components should be attached.

Auditory Brain Stem Implants (ABI)

An ABI is covered on an inpatient basis only and requires prior authorization. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for ABI services for recipients who meet the following criteria:

1. Must be 12-20 years of age
2. Physician notes must indicate the diagnosis of Neurofibromatosis Type II
3. Medical assessment to ensure candidate is able to tolerate surgery
4. Documentation of anticipatory guidance to child/parents concerning expected outcomes, complications, and possible aural rehabilitation

Osseointegrated Implant (BAHA)

An Osseointegrated Implant (BAHA) is covered on an inpatient basis only and requires prior authorization. The Alabama Prior Review and Authorization request (Form 342) must be completed, signed and mailed to the address indicated on the form.

Medicaid may reimburse for osseointegrated implant services for recipients who meet the following criteria:

1. Must be 5-20 years of age; and
2. Congenital or surgically induced malformations of the external ear canal or middle ear; or
3. Chronic external otitis or otitis media when a conventional hearing aid cannot be worn; or
4. Tumors of the external canal.
5. Must all meet audiologic criteria of: pure tone average bone conduction threshold of up to 70 dB and speech discrimination score better than 60%.

For Single Sided Deafness (SSD), criteria are as follows:

1. Must be 5-20 years of age; and
2. Bone conduction of 35-40 dB or better in the contralateral ear.

10.5.4 Procedure Codes and Modifiers

Audiological function tests must be referred by the attending physician before testing begins. The (837) Professional electronic claim has been modified to accept up to four Procedure Code Modifiers.

Audiology Tests

The following CPT codes represent comprehensive audiological tests that may be performed each calendar year. Additional exams may be performed as needed when medically necessary to diagnose and test hearing defects.

Procedure Code	*Description*
92531	Spontaneous nystagmus, including gaze
92532	Positional nystagmus
92533	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)
92534	Optokinetic nystagmus
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording
92542	Positional nystagmus test, minimum of 4 positions with recording
92543	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording
92544	Optokinetic nystagmus test, bi-directional, foreal or peripheral stimulation, with recording
92545	Oscillating tracking test, with recording
92546	Torsion swing test, with recording
92547	Use of vertical electrodes in any or all of above vestibular function tests counts as one additional test
92557	Basic comprehensive audiometry (92553 & 92556 combined)
92582	Conditioning play audiometry (for children up to 5 years old)
92585	Brainstem evoked response recording (evoked response (EEG) audiometry)

NOTE:

Procedure codes 92531-92547 are normally performed on adults; however, children are occasionally tested.

The following procedure codes are not included in the annual limitations.

Procedure Code	*Description*
92551	Screening test, pure tone, air only
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry; threshold only
92556	Speech audiometry; threshold and discrimination
92558	Evoked otoacoustic emissions; screening, automated analysis.
92560	Bekesy audiometry; screening
92561	Bekesy audiometry; diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry
92568	Acoustic reflex testing

Procedure Code	Description
92569	Acoustic reflex decay test
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test (Deleted 1/1/07)
92575	Sensorineural activity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92583	Select picture audiometry
92584	Electrocochleography
92585	Brainstem evoked response recording
92587	Evoked otoacoustic emissions
92588	Comprehensive/diagnostic evaluation
92590	Hearing aid examination and selection; monaural
92591	Hearing aid examination and selection; binaural
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic evaluation for hearing aid; monaural
92595	Electroacoustic evaluation for hearing aid; binaural
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630	Auditory Rehabilitation; pre-lingual hearing loss
92633	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour

Cochlear & Auditory Brain Stem Implants (ABI) and BAHA System

Procedure Code	Description
69930	Cochlear Device Implantation (See NOTE below)
L8619*	Processor repair/replacement- Will be reimbursed at invoice price
S2235**	Implantation of Auditory Brain Stem Implant
V5299	Hearing service, miscellaneous (for non lithium processor batteries, cords, etc)
92601	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; with programming.
92602	Diagnostic analysis of Cochlear Implant, patient under 7 years of age; subsequent reprogramming.
92603	Diagnostic analysis of Cochlear Implant, age 7 years or older, with programming.
92604	Diagnostic analysis of Cochlear Implant, age 7 years of age or older; subsequent reprogramming.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Group, two or more individuals
92626	Evaluation of Auditory Rehabilitation Status; first hour
92627	Evaluation of Auditory Rehabilitation Status; each additional 15 mins
92630*	Auditory Rehabilitation; pre-lingual hearing loss
92633*	Auditory Rehabilitation; post-lingual hearing loss
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour
V5273	Assistive listening device, includes FM receiver and transmitter for use with Cochlear Implant
V5299	Hearing service, miscellaneous code for repair done for V5273
69714**	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69715**	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy

Procedure Code	Description
69717**	Replacement, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy
69718**	Replacement, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy
L8691	Auditory osseointegrated device, external sound processor, replacement – Will be reimbursed at invoice price
L8627	Cochlear Implant, external speech processor, component, replacement –will be reimbursed at invoice price
L8628	Cochlear Implant, external controller component, replacement-will be reimbursed at invoice price

*Cannot bill 92507 on the same day as 92630 or 92633
**Requires Prior Authorization

NOTE:

The Cochlear, ABI and BAHA Device is purchased at contract price established by hospital and supplier and covered through the hospital per diem.

Hearing Aid Monaural

Procedure Code	Description
V5030	Hearing aid, monaural, body worn, air conduction
V5040	Hearing aid, monaural, body worn, bone conduction
V5050	Hearing aid, monaural, in the ear
V5060	Hearing aid, monaural, behind the ear
V5070	Glasses, air conduction
V5080	Glasses, bone conduction
V5244	Hearing aid, digitally programmable analog, monaural, completely in the ear canal
V5245	Hearing aid, digitally programmable analog, monaural, in the canal
V5246	Hearing aid, digitally programmable analog, monaural, in the ear
V5247	Hearing aid, digitally programmable analog, monaural, behind the ear
V5254	Hearing aid, digital, monaural, completely in the ear canal
V5255	Hearing aid, digital, monaural, in the canal
V5256	Hearing aid, digital, monaural, in the ear
V5257	Hearing aid, digital, monaural, behind the ear

Hearing Aid Binaural

Binaural aids should be billed with one unit.

Procedure Code	Description
V5100	Hearing Aid, bilateral, body worn
V5120	Binaural, body
V5130	Binaural, in the Ear
V5140	Binaural, behind the Ear
V5150	Binaural, glasses
V5210	Hearing aid, bicros, in the Ear
V5220	Hearing aid, bicros, behind the Ear
V5250	Hearing aid, digitally programmable analog, binaural, completely in the ear canal

Procedure Code	Description
V5251	Hearing aid, digitally programmable analog, binaural, in the canal
V5252	Hearing aid, digitally programmable analog, binaural, in the ear
V5253	Hearing aid, digitally programmable analog, binaural, behind the ear
V5258	Hearing aid, digital, binaural, completely in the ear canal
V5259	Hearing aid, digital, binaural, in the canal
V5260	Hearing aid, digital, binaural, in the ear
V5261	Hearing aid, digital, binaural, behind the ear

(Extra ear mold is a billable expense in connection with binaural aids.)

Hearing Aid Accessories

Procedure Code	Description
V5298	Stethoscope (1 every 2 years)
V5298	Harness (Huggies)
V5266	Batteries (1 package every 2 months for use with monaural aid)
V5298	Battery Cover
V5266	Batteries (2 packages every 2 months for use with binaural aids)
V5298	Receiver
V5264	Ear mold (1 every 4 months for use with monaural aid)
V5298	Garment Bag
V5298	Cords
V5298	Ear Hook
V5014	Factory Repair of Aid (out of warranty) (1 every 6 months for use with monaural aid)
V5264	Ear Mold (2 every 4 months for use with binaural aids)
V5014	Factory Repair of Aids (out of warranty) (2 every 6 months for use with binaural aids)
V5267	Hearing aid supplies/accessories

When billing for hearing services, replacement items and supplies, providers should bill the actual acquisition cost.

Place of Service Codes

The following place of service codes apply when filing claims for hearing services:

POS Code	Description
11	Office

10.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

10.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

11

11 Chiropractor

Chiropractors are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

The policy provisions for chiropractors can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

11.1 Enrollment

HP enrolls chiropractors and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a Chiropractor is added to the Alabama Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for chiropractic-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Chiropractors are assigned a provider type of 18 (Chiropractor). Valid specialties for chiropractors include the following:

- Chiropractor (150)
- QMB/EPSDT (600)

Enrollment Policy for Chiropractors

To participate in the Medicaid program, chiropractors must have a current certification and/or be licensed to practice and operate within the scope of practice established by the state's Board of Chiropractic Examiners.

11.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Chiropractic services are only covered for QMB recipients or for recipients referred directly as a result of an EPSDT screening.

For more information about the EPSDT program, refer to Appendix A, EPSDT.

11.3 Prior Authorization and Referral Requirements

Chiropractic services generally do not require prior authorization since services are limited to QMB recipients and EPSDT referrals. Some codes may require prior authorization before services are rendered. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines on determining if a prior authorization is needed and how to obtain the information.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 to determine whether your services require a referral from the Primary Medical Provider (PMP).When an EPSDT referral is required for treatment of medically necessary services, the Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

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.

11.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

Deleted: ~~is $1.00~~

Added: is:

Added: $3.90 for procedure…99348, 99349, 99350

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

Added: If any of…then copay applies.

If one of these CPT codes is applicable for your practice, then copay applies.

Added: Native American Indians…Medicaid required copayment.

Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

11.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Chiropractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

11.5.1 Time Limit for Filing Claims

Medicaid requires all claims for chiropractors to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

11.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

11.5.3 Procedure Codes and Modifiers

Chiropractors use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

11.5.4 Place of Service Codes

The following place of service codes apply when filing claims for chiropractic services:

POS Code	*Description*
11	Office

11.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

11.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

12

12 Comprehensive Outpatient Rehabilitation Facility (CORF)

Rehabilitative services are specialized services for the restoration of people with chronic physical or disabling conditions to useful activity. These services will be provided to recipients on the basis of medical necessity.

12.1 Enrollment

CORFs are enrolled only for services provided to QMB eligible recipients (crossover claims).

HP enrolls CORF providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a CORF provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for rehabilitation-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

CORF providers are assigned a provider type of 012 (Rehabilitation Center). The valid specialty for CORF providers is Rehabilitation Hospital (012).

12.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

CORF providers are limited to Medicare-related claims billed on the UB-04 claim form.

12.3 Prior Authorization and Referral Requirements

CORF procedures do not require prior authorization or referrals since they are limited to Medicare crossovers only.

12.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by CORF providers.

12.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

CORF providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

12.5.1 Time Limit for Filing Claims

Medicaid requires all claims for CORF to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

12.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

12.5.3 Revenue Codes

CORF providers use the revenue codes identified by Medicare.

12.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

12.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy Institutional Medicaid/Medicare-related claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

12.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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13 Dentist

Certain dental health care services are available for eligible children as part of the Early and Periodic Screening, Diagnosis, and Treatment up to age 21 as long as the child remains eligible for Medicaid **with the exception of SOBRA children** who cease to be eligible upon reaching their 19th birthday.

Dental services are any diagnostic, preventive, or corrective procedures administered by or under the direct supervision of a licensed dentist. Such services include treatment of the teeth and the associated structures of the oral cavity, and of disease, injury, or impairment, which may affect the oral or general health of the individual.

As defined in the Rules of The Board of Dental Examiners of Alabama, Rule 270-X3.06, "Direct supervision is defined as supervision by a dentist who authorizes the intraoral procedure to be performed, is physically present in the dental facility, and available during the performance of the procedure, and takes full professional responsibility for the completed procedure".

Any facility that utilizes unlicensed graduate dentists to treat Medicaid Recipients must meet the requirements set forth in Section 270-X-4.02 of the Dental Practice Act.

Deleted: ~~forward~~

Added: forth

NOTE:

A dental consultant is available for clinical consultation regarding coverage for unusual services and may be contacted through the Dental Program Manager at (334) 242-5472.

The policy provisions for dental providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 15.

NOTE:

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyrighted by the American Dental Association. All rights reserved. Applicable FARS/DFARS Apply.

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13.1 Enrollment

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Added: HPES

HPES enrolls dental providers who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a Dental provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for dental-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Dental providers are assigned a provider type of 27 (Dentist). Valid specialties for dental providers include the following:

- General Dentistry (271)
- Oral and Maxillofacial Surgery (272)
- Endodontist (275)
- Pediatric Dentistry (276)
- Orthodontist (277)
- Periodontist (278)
- Mobile Provider (299)
- Anesthesiologist (311)

Oral Surgeons are assigned a provider type of 62, depending on the source of the licensure information sent to the HP provider enrollment unit. The valid specialty for Oral Surgeons is Oral and Maxillofacial Surgery (272).

Oral Surgeons billing medical procedures or CPT procedure codes should refer to Chapter 28, Physician and Chapter 5, Filing Claims. Dental procedures (current CDT procedure codes) should always be billed on the ADA dental claim form—Version ADA 2006.

Enrollment Policy for Dental Providers

To participate in the Alabama Medicaid Program, dental providers must be licensed to practice in the state where care is provided. Each dental provider **must** enroll with a NPI that will follow them to each office location (a Service Location Provider Number will be assigned for each office location to assist in identifying where the service was provided). This also applies for reimbursement for preventive services and must be performed at a fixed physical office location. Each claim filed constitutes a contract with the Alabama Medicaid Agency. Dental providers are required to complete and sign a coding sheet (often referred to as a “super bill”) listing all procedure codes/ descriptions performed on each date of service for each Medicaid recipient. For audit purposes, these coding sheets are required to be maintained on file for a period of three (3) years from the date of service.

Dentists who perform anesthesia (general) or IV sedation services must submit a copy of their GA/IV certification to HP with their provider enrollment application.

Out of state providers must follow the enrollment procedures of the Alabama Medicaid Agency, please refer to Chapter 2 - Becoming a Medicaid Provider. All program policies apply regardless of where care is provided.

Enrollment of Mobile Dental Clinics

A mobile dental facility or portable dental operation (Mobile Dental Clinic) is any self-contained facility in which dentistry or dental hygiene is practiced which may be moved, towed, or transported from one location to another.

Mobile Dental Clinics shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, Code of Federal Regulations and applicable Medicaid billing manuals.

In order to enroll as a Mobile Dental Clinic, an operator shall:
(a) obtain a certificate of registration issued by the Board of Dental Examiners (the Board); and
(b) complete an Alabama Medicaid Provider Enrollment application.

Mobile Dental Clinics shall comply with the following consent requirements:
(a) The operator of a Mobile Dental Clinic shall not perform services on a minor without the signed consent from the parent or guardian. The consent form shall be established by the Board.
(b) The consent form shall inquire whether the prospective patient has received dental care from a licensed dentist within one year and if so, the consent form shall request the name, address, and phone number of the dental home. If the information provided to the operator does not identify a dental home for the prospective patient, the operator shall contact the Alabama Medicaid Agency for assistance in identifying a dental home for Medicaid eligible patients. If this information is provided to the operator, the operator shall contact the designated dental home by phone, facsimile, or electronic mail and notify the dental home of the prospective patient's interest in receiving dental care from the operator. If the dental home confirms that an appointment for the prospective patient is scheduled with the dentist, the operator shall encourage the prospective patient or his or her guardian to seek care from the dental home.
(c) The consent form shall document that the patient, or legal guardian, understands the prospective patient has an option to receive dental care from either the Mobile Dental Clinic or his or her designated dental home if applicable.
(d) The consent form shall require the signature of a parent or legal guardian.

Each Mobile Dental Clinic shall maintain a written or electronic record detailing all of the following information for each location where services are performed:

(a) The street address of the service location.
(b) The dates of each session.
(c) The number of patients served.
(d) The types of dental services provided and the quantity of each service provided.

(e) Any other information requested by rule of the Board or Medicaid.

At the conclusion of each patient's visit to the Mobile Dental Clinic, the patient shall be provided with a patient information sheet which shall also be provided to any individual or entity to whom the patient has consented or authorized to receive or access the patient's records. The information sheet shall include at a minimum the following information:

(a) The name of the dentist or dental hygienist, or both, who performed the services.
(b) A description of the treatment rendered, including billing service codes and fees associated with treatment and tooth numbers when appropriate.
(c) If applicable, the name, address, and telephone number of any dentist to whom the patient was referred for follow-up care and the reason for such referral.
(d) The name, address, and telephone number, if applicable, of a parent or guardian of the patient.

Mobile Dental Clinics shall comply with the following requirements for Emergency Follow-up Care:

(a) The operator shall maintain a written procedure for emergency follow-up care for patients treated in a Mobile Dental Clinic, which includes arrangements for treatment and follow-up care by a qualified dentist in a dental facility that is permanently established within a 50-mile radius of where mobile services are provided.

(b) An operator who either is unable to identify a qualified dentist in the area or is unable to arrange for emergency follow-up care for patients otherwise shall be obligated to provide the necessary follow up via the Mobile Dental Clinic or the operator may choose to provide the follow-up care at his or her established dental practice location in the state or at any other established dental practice in the state which agrees to accept the patient.

(c) An operator who fails to arrange or provide follow-up care as required herein shall be considered to have abandoned the patient, and will subject the operator and any dentist or dental hygienist, or both, who fail to provide the referenced follow-up treatment to termination as a Medicaid provider.

The provider shall not charge Medicaid for services rendered on a no-charge basis to the general public.

A Mobile Dental Clinic that accepts or treats a patient but does not refer patients for follow-up treatment when such follow-up treatment is clearly necessary, shall be considered to have abandoned the patient and will subject the operator and any dentist or dental hygienist, or both, who fails to provide the referenced follow-up treatment to termination as a Medicaid provider.

Mobile Dental Clinics shall comply with the following requirements for sale or cessation of operation:

(a) In the event a Mobile Dental Clinic is to be sold, the current provider shall inform the Board and Medicaid, at least 10 days prior to the sale being completed and shall disclose the purchaser to the Board and Medicaid, via certified mail within 10 days after the date the sale is finalized.

(b) The provider shall notify the Board and Medicaid, at least 30 days prior to cessation of operation. Such notification shall include the final day of operation, and a copy of the notification shall be sent to all patients and shall include the manner and procedure by which patients may obtain their records or transfer those records to another dentist.

(c) It is the responsibility of the provider to take all necessary action to ensure that the patient records are available to the patient, a duly authorized representative of the patient, or a subsequent treating dentist. For purposes of this subsection, a patient shall mean any individual who has received any treatment or consultation of any kind within two years of the last date of operation of the Mobile Dental Clinic.

NOTE:

If you are already a Medicaid Provider, you do not have to re-enroll with Medicaid to be a Mobile Dental Provider. As a mobile dental provider you will need to submit a request to HPES Provider Enrollment, P.O. 241685, Montgomery, AL 36124, to add the mobile provider specialty (299) to your existing provider file along with a copy of your certification received from the Alabama Dental Board. **When filing claims for mobile dental services please indicate your place of service as 15.**

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Added: HPES

Added: P.O. 241685, Montgomery, AL 36124

13.2 1st Look – The Oral Health Risk Assessment and Dental Varnishing Program

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Added: covers

Medicaid covers the application of fluoride varnishes for children 6 months through 35 months of age who have a high caries risk based on the risk assessment by **Patient 1st medical providers or their clinical staff (RNs, PAs, Nurse Practitioners, LPNs) that have received the 1st Look Training.** This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals**, a specialty indicator (274)** will be added to the provider file in order for the provider to receive reimbursement.

NOTE:

The trained Patient 1st provider does include the nurse practitioner under his/her Patient 1st practice. An enrolled nurse practitioner that has been trained in the 1st Look program can bill for the 1st Look services provided.

Once training is completed, a list is sent to the Medicaid Agency for the new specialty to be added to the provider's file. The effective date of the specialty is the same as the date of certification.

Dental Home as defined by the American Dental Association – The ongoing relationship between the dentist who is the Primary Dental Care Provider and the patient, which includes comprehensive oral health care, beginning no later than age one, pursuant to ADA policy.

A list of Medicaid Dental Providers is available on the Medicaid website at: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.2.6_Locate_Participating_Dentist.aspx .

Deleted: ~~www.medicaid.alabama.gov under the Programs/… on InsureKidsNow.gov~~

Added: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.2.6_Locate_Participating_Dentist.aspx .

Patient 1st medical providers will be able to bill in accordance with Medicaid reimbursement policies for the oral assessment (D0145) and the applications of the fluoride varnish (D1206).

Procedure D0145 may be billed **once by the pediatric medical provider and once by the dental provider for children age 6 months through 35 months of age.** Records must document the content of anticipatory guidance counseling given to parents/caregivers, the results of the Caries Assessment Tool (CAT) and that a referral has been made to the Patient 1st Care Coordinators for all high-risk children. Documentation must also include where referral to a dental home has been made.

NOTE:

At least two high risk indicators must be present in the high risk category to classify a child as being high risk.

Procedure D1206 will be **limited to three per calendar year**, regardless of the provider and cannot exceed a maximum of six fluoride varnish applications **between 6 months through 35 months of age.** Once a recipient is referred to a dental home, D1206 (application of fluoride varnish) is no longer a covered service when performed by the 1st Look Medical Provider.

13.3 Patient Record

The patient record shall include the following:

1. Patient's full name, address and treatment date;
2. Patient's nearest relative or responsible party;
3. Current health history, including chief complaint, if applicable, and a listing of all current medications;
4. Diagnosis of condition
5. Specific treatment rendered and by whom; (e.g. Tooth #04 DO resin 1.8 cc of Lidocaine by Dr. Smith)
6. After each date of service, the Rendering Provider's **SIGNATURE** must be present after the written documentation of the service in the Patient's Operative Notes. Reimbursement for services **without** the Rendering Provider's SIGNATURE in the Patient's Operative Notes is subject to **recoupment**.
7. Name and strength of any medications prescribed, dispensed or administered along with the quantity, date provided and authorized refills;
8. Treatment plan;
9. Applicable radiographs; and
10. Informed consent.

13.4 Informed Consent

Informed consent shall be documented in the record for all patients for whom treatment is to be provided. The consent form should be procedure specific and include the following:

Deleted: ~~Effective July 1, 2003, informed~~

Added: Informed

- Name and date of birth of patient;
- Name and relationship to the patient/legal basis on which the person is consenting on behalf of the patient;
- Description of the procedure in simple terms;
- Disclosure of known adverse risk(s) of the proposed treatment specific to that procedure;
- Professionally-recognized or evidence-based alternative treatment(s) to recommended therapy and risk(s);
- Place for custodial parent or legal guardian to indicate that all questions have been asked and adequately answered;
- Places for signatures of the custodial parent or legal guardian, dentist, and office staff member as a witness.

Consistent violation of the informed consent requirement can result in further investigation and appropriate action.

13.5 Benefits and Limitations

Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT Program.

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of recipients needs.
- The services cannot be experimental or investigational:
- The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Covered procedures are located in section 13.8.2

13.5.1 Orthodontic Services

Medicaid provides medically necessary orthodontic services for eligible and qualified recipients. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service at 1(800) 441-7607or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. All medically necessary orthodontic treatment must be prior authorized by Medicaid before services are provided.

Requests for orthodontic services must include the recommendations of the multidisciplinary team, photos and x-rays.

Criteria for coverage include the following diagnoses when medical necessity exists:

- Cleft palate or cleft lip deformities
- Cleft lip with alveolar process involvement
- Velopharyngeal incompetence
- Short palate
- Submucous cleft
- Alveolar notch
- Craniofacial anomalies included but not limited to
- Hemifacial microsomia
- Craniosynostosis syndromes
- Cleidocranial dysplasia
- Arthrogryposis
- Marfan's syndrome
- Apert's syndrome
- Crouzon's Syndrome
- Other syndromes by review

- Trauma, diseases, or dysplasias resulting in significant facial growth impact or jaw deformity.

NOTE:

Extractions for orthodontic purposes are not covered unless there is a Medicaid approved orthodontia case.

Specific **non-covered services** include the following diagnoses:

- Dento-facial Anomaly, NOS (not otherwise specified)
- Orofacial Anomaly, NOS
- Severe Malocclusion

NOTE:

Procedures billable only by Alabama Children's Rehabilitation Service providers:

D8080 – Comprehensive orthodontic treatment of the adolescent dentition

D8680 – Orthodontic retention (removal of appliances, construction and placement of retainer(s))

D9310 – Consultation – diagnostic service provided by dentist or physician other than requesting dental or physician.

13.5.2 Non-Covered Services

The following dental services are non-covered except where noted. Non-covered dental services include but are not limited to the following:

- Procedures which are not necessary or do not meet accepted standards of dental practice based on scientific literature. This will be determined thru review of submitted radiographs and written documentation which must support the medical necessity of the service rendered.
- Surgical periodontal treatment (Exceptions require prior authorization: Pharmaceutically induced hyperplasia and idiopathic juvenile periodontosis).
- Orthodontic treatment (Exception: medically necessary orthodontic services after evaluation by CRS and referral to the Alabama Medicaid Agency for prior authorization. See section 13.5.1 for additional information).
- Prosthetic treatment, such as fixed or removable bridgework (D6240 and D6750), or full or partial dentures (Exceptions require prior authorization: prosthesis for closure of a space created by the removal of a lesion or due to congenital defects (permanent tooth congenitally missing).
- Panoramic films on recipients under age 5.
- Dental transplants
- Dental implants
- Prosthetic implants
- Esthetic veneers
- Silicate restorations

- Pulp caps on primary teeth
- Pulpotomies on permanent teeth
- Space maintainers for premature loss of primary incisors or as “pedo bridges”
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- Space maintainers placed where the extracted tooth was a restorable tooth
- Space maintainers for teeth A, J, K, T, M and R for recipients greater than 14 years of age
- Space maintainers for teeth B, I, L and S age eight years and older
- Bilateral space maintainer for teeth C and H
- Repair of a damaged space maintainer or replacement of a lost space maintainer
- D2940 for teeth A-T for recipients greater than 6 years of age and older
- D2951 for teeth A-T
- D3220 and D3230 for teeth N, O, P and Q
- D4355 for recipients under age 6
- D1120 for recipients less than 3 years of age
- Non-diagnostic radiographs
- Extraction of exfoliating primary teeth without a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the record
- Acrylic, plastic restorations (class III or V)
- Acrylic, plastic restorations (class IV)
- Plastic crowns (acrylic)
- Porcelain/ceramic substrate crowns
- Permanent crowns, core buildups, and post & cores on recipients under the age of 15
- Adult Dental Care
- Temporomandibular joint disorder

Palliative (emergency) treatment (D9110) is not covered when billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures.

13.6 Prior Authorization (PA) and Referral Requirements

Prior authorization from Medicaid is required for the following services:

- Periodontal treatment (scaling and root planing, periodontal maintenance procedures)
- Excision of hyperplastic tissue

- Inpatient and Outpatient hospitalizations for dental care for children 5 years and older (not required for any out-of state hospitalizations).
- Inpatient and outpatient hospitalization and anesthesia charges for adults when hospitalization is required because (1) the individual's underlying medical condition and status is currently exacerbated by the dental condition, or (2) the dental condition is so severe that it has caused a medical condition (for example, acute infection has caused an increased white blood count, sepsis, or bacterial endocarditis in a susceptible patient)
- Space maintainers (after the first two)
- Apicoectomy/periradicular surgery
- Removal of completely bony impactions
- Home visits or treatment of any recipient under age 21 in a licensed medical institution (nursing facility)
- Diagnostic models (when requested by Medicaid)
- Oral/Facial Images (e.g., photographs or slides when requested by Medicaid)
- Therapeutic drug injection (by report)

Added: years, older

Deleted: ~~above on date(s) of Alabama hospital service~~

NOTE:

Prior authorization does not guarantee eligibility. Providers are responsible for verifying eligibility prior to rendering services.

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

13.6.1 Obtaining Prior Authorization for Dental Services

Emergency Prior Authorizations

In an emergency situation where the delay for written request of prior authorization would endanger the health of the recipient, initiate prior authorization by contacting HPES/Dental PA Unit at (334) 215-4144, please be sure to include all the information listed below. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message will be accepted. The voice mail message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- NPI of dentist
- Phone number of dentist, including area code
- Nature of emergency
- Contact person, if other than dentist for follow-up

Added: HPES/Dental PA Unit

Deleted: ~~the Alabama Medicaid Agency's Dental Program~~

Deleted: ~~242-5472~~

Added: 215-4144

Deleted: ~~or you may e-mail Dental Program at Dental@medicaid.alabama.gov~~

Added: A paper or electronic

Deleted: ~~Alabama Prior Review and Authorization Dental Request (form 343)~~

Added: PA
Deleted: ~~the fiscal agent~~
Added: HPES
Deleted: ~~calendar~~
Added: business, call and or
Deleted: ~~calendar~~
Added: business

Added: **Paper PA Request**

Added: revised 5/13

Added: e.g. D7241 removal of…center call, etc)

Added: If the form…will be denied.

Added: and required documentation

Added: HPES/Dental PA Unit

Added: **Electronic PA Requests** section

A paper or electronic PA request must be received by HPES within ten business days of the telephone call and or~~/~~voice message request. If the request is not received within ten business days of the telephone call, the authorization will be denied. The request must meet established guidelines and criteria.

Paper PA Request

Providers must use the Prior Review and Authorization Dental Request Form (form 343, revised 5/28/13) to request prior authorization for those procedures requiring a prior authorization (e.g., D7241 removal of impacted tooth; D9420 (hospital or ambulatory surgical center call, etc.) as noted in section 13.6. All sections of this 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 completed form must be submitted with the required legible documentation. If the required documents are not received with the paper PA request, the PA will be denied. The form and required documentation should be forwarded to HPES/Dental PA Unit, P.O. Box 244032, Montgomery, AL 36124-4032 or 301 Technacenter Drive, Montgomery, AL 36117.

Electronic PA Requests

Providers may use Medicaid's web portal of PES software to submit an electronic PA for those procedures requiring a prior authorization (e.g., D7241 removal of impacted tooth; D9420 (hospital or ambulatory surgical center call, etc.) When submitting an electronic request, select "Dental" if the service is being performed in the dental office. Select "Surgical" if the service is being performed in hospital setting**.**

Following submission of an Electronic PA request the legible documentation must be mailed to HPES/Dental PA Unit, P.O. Box 244032, Montgomery, AL 36124-4032 or 301 Technacenter Drive, Montgomery, AL 36117. The documents must have the PA number written legibly in the upper right hand corner of each page (e.g. clinical notes, radiographs, etc.) so that documentation can be matched to the electronic PA request.

PA requests will be held for up to 10 business days to allow sufficient time for providers to mail required supporting documents. If legible documents are not received in this time period, the PA will be denied. For reconsideration of the PA, a new **paper** PA request must be submitted with all the required documents attached.

Additional Instructions for Completing PA Request:

- For treatment in the dental office:

  When completing the Alabama Prior Review and Authorization Dental Request (Paper or Electronic), **ONLY** list those procedures that require prior authorization.

- For treatment in outpatient/inpatient hospital or nursing facility:

  When completing the Alabama Prior Review and Authorization Dental Request (Paper or Electronic), list **ALL** procedures planned even if they do not normally require prior authorization.

- Providers cannot charge or collect money from the recipient to schedule a service or guarantee patient compliance

Refer to Chapter 4, Section 4.4, Obtaining Prior Authorization, for instructions on obtaining prior authorization and completion of the form. PA request may be submitted via paper, web portal of PES**.**

Added: Refer to Chapter 4…portal of PES

Prior authorization requests take approximately two to three weeks for processing. Providers should call the Provider Assistance Center (PAC) at 1(800) 688-7989 to verify request is in the system if approval/denial is not received within this time frame.

Deleted: ~~**Emergency Prior Authorizations section**~~

13.6.2 Criteria for Prior Authorization

This section discusses specific criteria for prior authorization for certain periodontal, preventive anesthetic and inpatient/outpatient procedures. There are additional dental procedures that require prior authorization as indicated in Section 13.8.2, Procedure Codes.

Deleted: ~~Dental prior authorizations…they become available.~~

Documentation Necessary for Hospital Cases Requiring Dental Prior Authorization (For recipients age 5 or older)

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Prior authorization for patients **5** years through 20 years of age, at least one of the following criteria justifying use of general anesthesia in the hospital must be met:

Added: Prior, **5**

1. Child or adolescent who requires dental treatment has a physical or mentally compromising condition
2. Patient has extensive orofacial and dental trauma
3. Procedure is of sufficient complexity or scope to necessitate hospitalization; the mere extent of caries or large quantity of teeth to be treated, or preference to provide all treatment in one appointment, or need for premedication, are not, by themselves, qualifying reasons for hospitalization.
4. Child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder (requires an additional report described in a. – k. below)

Approval is typically given for a specified time frame not to exceed six months. Treatment must be dentally necessary and supported by a treatment plan and appropriate radiographs. Requests for treatment in a hospital setting based on lack of cooperation, anxiety, attention deficit disorder, or emotional disorder are not typically approved when the dental history shows treatment was rendered in the office in the past.

Documentation from the medical record justifying one or more of the above four criteria is required to be submitted with the Prior Authorization request along with a completed Informed Consent. **On children under age 5, documentation in the record will be required to support the necessity of the treatment performed in a hospital setting.**

If Criteria number 4 above (without a physical or mental disability) is cited as the justification for treatment in a hospital setting, it additionally requires a report of at least one active failed attempt to treat in the office. This report must include (if applicable):

a. recipient's behavior preoperatively
b. type(s) of behavior management techniques used that are approved by the American Academy of Pediatric Dentistry
c. recipient's behavior during the procedure
d. the use, amount, and type of local anesthetic agent
e. use and dosage of premedication, if attempted
f. use and dosage (%, flow rate and duration) of nitrous oxide analgesia used
g. procedure(s) attempted
h. reason for failed attempt
i. start and end times of the procedure(s) attempted
j. name(s) of dental assistant(s) present in the treatment room
k. presence or absence of parents or guardians in the treatment room

If requirements d, e, or f above were attempted but not successfully accomplished, the report must state the reason(s) for not carrying out or accomplishing these requirements.

If above criteria is met the provider should submit a Prior Authorization request (paper or electronic) listing the CDT code D9420. If the Prior Authorization is approved, the approval letter will generally reflect the approval of **only one procedure code** (usually the hospital code) and the other requested procedure codes will show as pending. The letter will also contain a statement to the effect: "Outpatient/Inpatient Hospital Approved; all other procedures **CONTINGENT UPON**: preoperative radiographs *(type will be specified)* being taken at the hospital and submitted with list of actual treatment procedures directly to Medicaid Agency for review and treatment meeting criteria."

After treatment is completed radiographs and a claim documenting actual services rendered should be sent to:

HPES Dental PA Unit

P.O. Box 244032

Montgomery, AL 36124-4032

Or

301 Technacenter Drive

Montgomery, AL 36117

Once the prior authorization is reviewed and updated, a letter will be sent to the provider indicating services approved. Upon receipt of the letter, the provider may file their claim for services approved by Medicaid.

Added: If above criteria is met the provider should

Deleted: ~~Submit~~

Added: submit a

Deleted: ~~form 343~~

Added: paper or electronic, CDT

Deleted: ~~Alabama Medicaid Agency~~

Added: HPES Dental PA Unit

Deleted: ~~Dental Program~~

Deleted: ~~5624~~

Added: 244032

Deleted: ~~36103-5624~~

Added: 36124-4032

Added: Or, 301 Technacenter Drive, Montgomery, AL 36117

Deleted: ~~Or provider can…dental@me~~

Outpatient/ASC Admission (D9420, limited to 4 times per recipient per calendar year)

Prior authorization is not required for children under 5 years on date of service (dos), unless the planned procedure code itself requires a Prior Authorization (e.g. scaling and root planing D4341)

Adult Anesthesia and Facility Fees (D9420, limited to 4 times per recipient per calendar year)

- Coverage may be available for facility and anesthesia charges through the prior authorization process for medically compromised adults whose dental problems have exacerbated their underlying medical condition. This code covers Anesthesia and Facility fee only and does not cover any dental procedures.
- Criteria for coverage of adult anesthesia and facility fees include the following conditions:
- Uncontrolled diabetes
- Hemophilia
- Cardiovascular problems (for example, CHF, prosthetic heart valves, acute endocarditis)
- When an existing qualifying medical condition is presently exacerbated by the dental condition or when the dental condition is so severe that it has caused a medical condition (for example, acute dental infection has caused an increased white blood cell count, sepsis, or bacterial endocarditis in a susceptible patient)

Documentation by the patient's primary care physician must be included with the completed Alabama Prior Review and Authorization Dental request form, which confirms the medical compromise indicated.

Additional dental prior authorization criteria will be provided to all Medicaid dental providers, as they become available.

Added: Additional dental prior…they become available.

13.6.3 Referral Requirements

EPSDT Referral

Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Refer to Appendix A for EPSDT services.

Medicaid does support the recommendations of The American Academy of Pediatric Dentistry which recommend children be enrolled and under the care of a dentist by age one.

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Dental	M D O	Dentists & Federally Qualified Health Centers (Claim Type D only), Clinics- Children's Dental/Orthodontia and Orthodontists, Oral, Maxillofacial Surgeons Procedure Codes: D8080 (Comprehensive orthodontia treatment of adolescent dentition), D8680 (Orthodontic retention-removal of appliances, construction/ placement of retainers), D9430 (Office visit for obs services during regular hours) Outpatient facility procedure codes D9420. Note: OP facilities do not require a referral for **DENTAL** procedures.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st to determine whether your services require a referral from the Primary Medical Provider (PMP).

Case Management Care Coordination

Alabama's Patient 1st program requires that Medicaid recipients understand the importance of dental care and how to use the dental health care system. Now, professional case managers in the patient's county of residence can complement the dental services of your practice by working with patients you identify as needing additional assistance.

Referrals should be limited to "special cases" only. These include but are not limited to children with special needs who require follow-up care, children needing assistance with referral for specialty care, and missed appointments for children lost to follow-up during treatments such as root canals.

If you have a child that meets the "special cases" criteria, then refer this patient to the targeted case manager in the patient's county of residence for further screening, support, counseling, monitoring and education. For a list of managers in your area, call the Dental Program at (334) 242-5472 or visit the Alabama Medicaid Agency's website at www.medicaid.alabama.gov.

13.7 Cost Sharing (Copayment)

Dental Providers cannot charge Medicaid Recipients, since copayment does not apply to services provided by dental providers.

13.8 Completing the Claim Form

Effective June 1, 2008, all Medicaid dental providers must use the 2006 version of the American Dental Association Dental claim form. If you experience problems with HP processing your forms, contact HP for resolution, 1-800-688-7989. Refer to Chapter 5, Filing Claims, Section 5.5, Completing the ADA Dental Form, for complete instructions on filling out the ADA Dental Form.

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Dental providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

13.8.1 Time Limit for Filing Claims

Medicaid requires all claims for Dental providers **to be filed within one year of the date of service**. Refer to Chapter 5, Filing Claims, Filing Limits, Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

13.8.2 Procedure Codes

Use the code numbers and procedure descriptions as they appear in this section when filling out the ADA dental form. The listing of a procedure in this section does not imply unlimited coverage. **Certain procedures require prior authorization as noted in the PA Required column.**

Diagnostic Clinical Oral Examinations

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0120	Periodic oral examination is an evaluation a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This examination is limited to once every six months (per calendar month) for eligible Medicaid recipients. A full six month period between oral exams is not required. For example, if a recipient received an oral exam on January 15, 2002, he or she is eligible for another exam any time in July 2002 (the sixth month). Cannot be billed within 6 months of D0150 by same provider for the same recipient. Non-emergency oral examinations (D0120 and D0150) are limited to 2 (two) per calendar year whether it is a comprehensive oral examination and one periodic oral examination or 2 (two) periodic oral examinations in a 12 month period.	No
D0140	Limited oral evaluation – problem focused (emergency treatment) A limited oral examination is an evaluation or re-evaluation limited to specific health problems. This may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same day. Typically, recipients receiving this type of evaluation have been referred for a specific problem or are presented with dental emergencies, such as acute infection. Providers using this procedure code must report the tooth number or area (please refer to page 40 for specific instructions) of the oral cavity, symptom(s), diagnosis, and emergency treatment in the dental record where the specific problem is suspected. This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations. Limited to one per recipient per provider/provider group per calendar year.	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0145	Oral Evaluation for a Patient Under Three Years of Age and Counseling with Primary Caregiver : This code is intended to be for the first visit to a dental and/or *medical office for a patient under three years of age, for evaluation of caries susceptibility, development of an appropriate preventive oral health regimen and communication with and counseling with the child's parent or guardian. This code will only be allowed once per recipient lifetime (only exception is the 1st Look Program). Cannot be billed on the same date of service as procedure codes D0120 (periodic exam); D0140 (limited oral evaluation) or D0150 (comprehensive oral evaluation). Under the 1st Look Program: D0145 will be billable once by a pediatric medical provider and once by a dental provider for children ages 6 months through 35 months.	No
D0150	A comprehensive oral examination used by a general dentist or specialist when evaluating a recipient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. This includes an evaluation for oral cancer where indicated, the evaluation and recording of the patient's dental and medical history and a general health assessment. It includes the evaluation and recording of dental caries, missing or unerupted teeth, restorations, existing prostheses, occlusal relationships, periodontal conditions (including periodontal screening and/or charting), hard and soft tissue anomalies, etc. Documentation of the above findings for hard and soft tissues is required even if each finding is normal. This procedure is limited to once per recipient's lifetime per provider or provider group. Cannot be billed within 6 months of D0120 by same provider for the same recipient. Non-emergency oral examinations (D0120 and D0150) are limited to 2 (two) per calendar year whether it is a comprehensive oral examination and one periodic oral examination or 2 (two) periodic oral examinations in a 12 month period.	No

Radiographs

Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated.

A full series consisting of at least 14 periapical and bitewing films OR a panoramic film are permitted every three years if professional judgment dictates. Effective July 1, 2003, panoramic films are limited to age 5 and above. A full series (D0210) uses the panoramic film (D0330) *once every three years* benefit and vise versa.

If **medically necessary**, posterior bitewing and single anterior films may be taken every six months as part of an examination and, subject to the annual limits. **Documentation must support medical necessity**. All periapical films are limited to a maximum of **five** per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).

In order to be reimbursed, **all films must be of diagnostic quality suitable for interpretation, mounted in proper x-ray mounts marked Right and Left, and identified by type, date taken, recipient's name, and name of dentist.**

Radiographs of non-diagnostic quality are not chargeable to Medicaid or the recipient.

When billing Intraoral - Periapical, first film (D0220), and Periapical, each additional film (D0230) a tooth number/letter is required in tooth number column on electronic or paper claim.

Any combination of periapical films with or without bitewings taken on the same date of service which exceed the maximum allowed, must be billed as a Complete Intraoral Series (D0210). D0330 uses the benefit of D0210.

Periapical and occlusal films **must have a valid indication** documented in the record (e.g. aid in diagnosing an emergency, endodontic obturation evaluation, etc.) **Routine use of periapical radiographs(s)** at periodic/comprehensive evaluations or treatment appointments without valid documented indications **are not allowable**.

Radiology Guidelines (guidelines do not override benefit limits)

A. Radiographic Examination of the New Patient

Child-Primary Dentition: Posterior bitewing radiographs for a new patient, with a primary dentition and closed proximal contacts.

Child-Transitional Dentition: Individualized periapical/occlusal examination with posterior bitewings OR a panoramic X-ray and posterior bitewings, for a new patient with a transitional dentition.

Adolescent – Permanent Dentition Prior to the eruption of the third molars.

B. Radiographic Examination of the Recall Patient

1. Patients with clinical caries or other high-risk factors for caries

   a. Child – Primary and Transitional Dentition: Posterior bitewings performed at a 6-12 month interval for those children with clinical caries or who are at increased risk for the development of caries in either the primary or transitional dentition.

b. Adolescent: Posterior bitewings performed at a 6-12 month interval for adolescents with clinical caries or who are at increased risk for the development of caries.

2. Patients with no clinical caries and no other high risk factors for caries

   a. Child-Primary Dentition: Posterior bitewings performed at an interval of 12-24 months for children with a primary dentition with closed posterior contacts who show no clinical caries and are not at increased risk for the development of caries.

   b. Adolescent: Posterior bitewings performed at intervals of 12-24 months for patients with a transitional dentition who show no clinical caries and are not at an increased risk for the development of caries.

3. Patients with periodontal disease, or a history of periodontal treatment for Child – Primary and Transitional Dentition and Adolescent: Individualized radiographic survey consisted of selected periapicals and/or bitewing radiographs of areas with clinical evidence or a history of periodontal disease, (except nonspecific gingivitis).

4. Growth and Development Assessment

   Child- Primary Dentition: Prior to the eruption of the first permanent tooth, no radiographs should be performed to assess growth and development at recall visits in the absence of clinical signs or symptoms.

   Child – Transitional Dentition: Individualized periapical/occlusal series OR a panoramic x-ray to assess growth and development at the first recall visit for a child after the eruption of the first permanent tooth.

   Adolescent: Age 16-19 year of age recall patient, a single set of periapicals of the wisdom teeth or a panoramic radiograph.

Requests to Override the Panoramic Film Limitation

An override of the 3-year limitation on panoramic films will be considered **only** under the following exceptional circumstances:

a. The provider finds clinical or radiographic evidence of **new** oral disease or a **new** problem that cannot be evaluated adequately using any other type of radiograph, or

b. The recipient's previous provider is unable or unwilling to provide a copy of the previous panoramic film that is of diagnostic quality. (Such cases may result in recoupment of Medicaid's payment for the previous film.)

To request a panoramic override, the provider must submit the following:

a. A properly completed 2006 ADA claim form,

b. Copies of the current and previous panoramic films as well as any other radiographs that support the override request, and

c. A cover letter that clearly describes the circumstances of the case.

These requests should be mailed to:

Alabama Medicaid Agency

Dental Program

P.O. Box 5624

Montgomery, AL 36103-5624

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0210	Intraoral – Complete series, including bitewings, consists of 14 periapicals and bitewings. Limit once every 3 years. A complete series uses the benefit of a panoramic film. Any combination of D0220, D0230, D0240, D0272, or D0274 taken on the same date of service, which exceeds the maximum allowed fee for D0210 must be billed as D0210	No
D0220	Intraoral – Periapical, first film. Not allowed on the same date of service as D0210. All periapical films are limited to a maximum of five per year per recipient. Exceptions: full mouth series, panoramic film, or a periapical necessary to treat an emergency (submitted by report).	No
D0230	Intraoral – Periapical, each additional film This film is taken **after** the initial film (D0220) Not allowed on the same date of service as D0210	No
D0240	Intraoral – Occlusal film Requires tooth number. Should not be reimbursed when a periapical film is the appropriate service (D0220 or D0230**). If billed where periapical is more appropriate, reimbursement will be subject to recoupment** **This code is not to be billed when periapicals are billed (D0220 and D0230) for the same area of the mouth as the occlusal film.** **This procedure is for the maxillary (teeth C-H) and mandibular (teeth N-R) areas only. This code is not to be utilized for single teeth.**	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0250	Extraoral – first film	No
D0260	Extraoral – each additional film	No
D0272	Bitewings – two films Limit 1 every six months Not allowed on same the date of service as D0274	No
D0274	Bitewings - four films Limit 1 every six months Effective July 1, 2003, procedure restricted to age 13 or older. Not allowed on same the date of service as D0272	No
D0330	Panoramic film Cannot be billed in addition to D0210. A panoramic film uses the benefit of a complete series (D0210) Limited to once per recipient every three years (calendar year), Effective July 1, 2003 procedure restricted to age 5 or older)	No
D0350	Oral/facial images (traditional photos and intraoral camera images) *Oral/facial images are authorized only when required by Medicaid*	Yes

Tests and Laboratory Examinations

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D0470	Diagnostic casts, per model. Models must be trimmed and able to be articulated and must include bases. *Diagnostic casts are authorized only when required by Medicaid.*	Yes

Preventive Services

Dental prophylaxis includes scaling and/or polishing utilizing a dental prophy cup. Providers should not bill for a “tooth brush prophy”. When billing for prophylaxis and fluoride treatment provided on the same date of service for a recipient, use D1110 and D1208 for recipients over the age of 12 and D1120 and D1208 for children up to and including 12 years of age.

Topical Fluoride Treatment (Office Procedure) D1203, D1204 & D1206

Prescription strength fluoride product designed solely for use in the dental/medical office, delivered to the dentition under the direct supervision of a dental professional or an approved medical professional under the 1st Look Program. Fluoride must be applied separately from prophylaxis paste.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1110	Prophylaxis - **Recipient (13 years of age and older)** Limited once every 6 months. (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as: D4341, D4355, or D4910	No
D1120	Prophylaxis - **Recipient (covered for age 3 up to and including 12 years of age)** Limited once every 6 months (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as D4341, D4355, or D4910	No
D1208	Topical application of fluoride (excluding prophylaxis) **Recipient (up to and including 0-20 years of age)** **Fluoride must be applied separately from prophylaxis paste. Application does not include fluoride rinses or "swish".** Limited once every 6 months (A full six-month period between oral exams is not required. Example: if a recipient received an oral exam on January 15 2002, the recipient is eligible for another exam any time in July 2002 (the sixth month)). Not allowed on the same date of service as: D1206	No
D1206	Topical Fluoride Varnish, Therapeutic Evaluation for High Risk Caries In order to bill this code the patient must have documented evidence of moderate to high risk caries. This procedure can only be billed once annually beginning age 3**.** Not allowed on the same date of service as D1208 (topical application of fluoride – child) **NOTE:** For the 1st Look Program: D1206 will be limited to 3 per calendar year, regardless of the provider (medical or dental) not to exceed 6 fluoride varnish applications for children ages 6 months through 35 months.	No

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D1351	Sealant, per tooth **Only covered for teeth: 02,03,14,15,18,19,30,31, on children aged 5 through 13 years)** For procedure D1351, teeth to be sealed must be free of caries and restorations. Surface sealed must be noted on the dental claim form. Reimbursement for restorations placed for previously sealed surface by the same provider within a 12 month period will be reduced by the amount of the reimbursement for the sealant. Limit one per tooth per lifetime	No

NOTE:

Multiple visits needed to accomplish an exam, prophy; fluoride and sealants must have documented medical necessity in order for Medicaid payment to be allowable. Payment will be subject to recoupment if documentation does not support the medical necessity for multiple visits to accomplish an exam, prophy; fluoride and sealants.

It is considered fraudulent practice for a provider to intentionally schedule multiple appointments for no medical reason in order to maximize their reimbursement.

Space Maintainers

Effective July 1, 2003, space maintainers are covered on the following missing teeth ONLY:

1. Premature loss of second primary molar (A,J,K,T)
2. Premature loss of first primary molar (B,I,L,S) except in mixed dentition with normal class I occlusion
3. Premature loss of primary canines (C,H,M,R)

Space maintainers are NON-COVERED in the following instances:

- Repair of a damaged space maintainer or the replacement of a lost space maintainer
- For premature loss of primary incisor teeth or as "pedo bridges"
- Space maintainers placed greater than 180 days after the premature loss of a primary tooth
- More than once per recipient's lifetime for a given space(tooth) to be maintained
- Space maintainers for the loss of permanent teeth
- Space maintainers placed where the extracted tooth was a restorable tooth
- Space maintainer for teeth A, J, K, T, M, R for recipients greater than 14 years of age
- Space maintainers for teeth B, I, L, S after age 8
- Bilateral space maintainer for teeth C and H

- Repair of a damaged space maintainer or replacement of a lost space maintainer

NOTE:

Contraindications to Space Maintainers According to the American Academy of Pediatric Dentistry:

A space maintainer is usually not necessary if there is a sufficient amount of space present to allow for eruption of permanent tooth/teeth.

A space maintainer may not be recommended if severe crowding exists, such that space maintenance is of minimal effect and subsequent orthodontic intervention is indicated.

A space maintainer may not be necessary if the succedaneous tooth will be erupting soon.

Space maintainers, when indicated, should be placed as soon as possible after early primary tooth loss, but no later than 180 days after extraction or loss. On the 181st day, the space maintainer procedure will deny. The claim or prior authorization form must indicate the primary tooth letter that has been prematurely lost/extracted. If more than one deciduous tooth is lost, show the letter of the most recent tooth lost, which will be replaced by the space maintainer. The first two space maintainer procedure codes billed regardless of tooth (i.e. two per mouth) do not require prior authorization, but must meet coverage requirements. Prior authorization with justification is required for the billing of each additional space maintainer procedure code after the first two.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D1510	Space maintainer- fixed, unilateral	Yes (See above)
D1515	Space maintainer- fixed, bilateral	Yes (See above)
D1520	Space maintainer – removable, unilateral	Yes (See above)
D1525	Space maintainer- removable, bilateral	Yes (See above)
D1550	Re-cement space maintainer (re-cementing is limited to two times for a given space maintainer (tooth)	Yes (See above)

Restorative Services

Fee for restorative service includes: all adhesives including amalgam or resin bonding agents, lining or base, restoration, and local anesthesia or analgesia, if necessary. **Amalgam or resin restorations are not covered on a tooth receiving any of the following procedures:** stainless steel crowns (D2930, D2931), resin crowns (D2932), core buildups (D2950), post & cores (D2952, D2953, D2954, D2957), or crowns (D2750, D2751, D2752, or D2792).

Amalgam or resin codes (D2140 – D2394) **may not be billed** in substitution for a core buildup (D2950). Primary tooth restorations are not allowed when normal exfoliation is imminent. Effective July 1, 2005 restorations (D2140 – D2394) **on primary teeth are not covered unless there is greater than one-third of the original root length remaining.**

Amalgam Restorations (Including Polishing)

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2140	Amalgam – one surface, primary or permanent	No
D2150	Amalgam – two surfaces, primary or permanent	No
D2160	Amalgam – three surfaces, primary or permanent	No
D2161	Amalgam – four or more surfaces, primary or permanent	No

Composite Restorations

Resins are not allowed for preventive procedures or cosmetic purposes (e.g. diastema closure, discolored teeth, correction of developmental anomaly, etc.). **Resins are used to restore a carious lesion into the dentin or a deeply eroded area into the dentin**. Reimbursement for enamel only resins may be subject to recoupment when used as a non-preventative measure.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2330	Resin – one surface, anterior	No
D2331	Resin – two surfaces, anterior	No
D2332	Resin – three surfaces, anterior	No
D2335	Resin – four or more surfaces or involving incisal (anterior) angle	No
D2391	Resin - one surface, posterior	No
D2392	Resin - two surfaces, posterior	No
D2393	Resin - three surfaces, posterior	No
D2394	Resin - four or more surfaces, posterior	No

NOTE:

For procedure codes D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393 and D2394, the reimbursement determinations are based on the total number of different 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 were placed in a posterior tooth, the correct billing would be BOL D2393 and **not** D2391 times 3.

Crowns, Single Restorations Only

Medicaid covers crowns, post & cores, and core buildups **only** following root canal therapy (D3310, D3320, D3330) which must qualify for Medicaid coverage. Effective July 1, 2003, crowns (**excluding stainless steel or resin crowns**), core buildups and post & cores are limited to the permanent teeth on eligible recipients age 15 years or older following root canal therapy. Limited to one per tooth per lifetime. Crowns, post & cores, and buildups on 3rd molars are not covered, with the exception noted below:

NOTE:

Exception: When the second molar is missing and the third molar has moved into the second molar's space and is a functioning tooth, the provider must submit a radiograph with a prior authorization request for consideration of payment.

Effective April 1, 2006, permanent, stainless steel or resin crowns are limited to 6 per date of service individually or in combination when performed in an office setting. These procedure codes include D2750, D2751, D2752, D2792, D2930, D2931, and D2932.

Amalgam or resin restorations or sedative fillings are not authorized on teeth being crowned with or without a core buildup or post and core.

***No prior authorization is required for crowns, core buildups, or post & cores. If no root canal is in Medicaid's history, send a diagnostic postoperative periapical x-ray after crown is seated showing completed root canal and crown (bitewings are not acceptable) with completed claim form directly to: AL Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36103-5624.**

Effective January 1, 2005 reimbursement fees for crown (D2750 – D2792) procedures include any: crown follow up appointments, pre and post radiographs, equilibration, or recementation within 6 months of insertion.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2750	Crown – porcelain fused to high noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2751	Crown – porcelain fused to predominantly base metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2752	Crown – porcelain fused to noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*
D2791	Crown – full cast predominantly base metal	No*
D2792	Crown – full cast noble metal (limited to age 15 or older, on endodontically treated teeth only)	No*

NOTE:

Providers will be reimbursed for only one code per tooth per lifetime for procedures D2750, D2751, D2160, D2752 and D2792.

Incomplete Procedures

Effective July 1, 2003 for multiple appointment procedures, payment will be made to the provider that started the procedure. **Documentation that several attempts were made to complete the procedure** (i.e. phone calls, certified letters) must be supported in the medical record. If no documentation can be provided to support multiple attempts were made to complete the procedure, the starting provider will not be reimbursed. **Billing should only occur after documentation of failed attempts is complete.** If the recipient is treated by a subsequent provider for the same procedure, same tooth, the services are considered non-covered.

Other Restorative Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D2920	Re-cement crown - Limit 2 per lifetime per tooth None allowed within the first six months of placement	No
D2930	Prefabricated stainless steel crown, primary tooth The following are indications for placement of stainless steel crowns (prefabricated crown forms) for fitting on individual teeth: For the restoration of primary and permanent teeth with caries, cervical decalcification, and/or development defects (hypoplasia and hypocalcification) When the failure of other restorative materials is likely with interproximal caries extended beyond line angles Following pulpotomy or Pulpectomy For restoring a primary tooth being used as an abutment for a space maintainer, or For restoring fractured teeth when the tooth cannot be restored with other restorative materials. Limited to once per tooth per lifetime	No
D2931	Prefabricated stainless steel crown, permanent tooth.	No
D2932	Prefabricated resin crown are authorized on primary or permanent teeth. **Allowable on anterior teeth only.**	No
D2940	Sedative fillings - temporary restoration intended to relieve pain. Not to be used as liners or bases under restorations. Not allowable with: amalgam or resin restoration, endodontically treated teeth, core buildups, posts and cores, done on same tooth, same DOS. Non-covered for teeth A-T age 6 and older. Limit one per tooth.	No
D2950	Core buildup, including any pins. Covered for permanent teeth that have had endodontic treatment.	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
	Not covered on primary teeth. **Limited to age 15 or older** Not allowable on the same tooth with: • Amalgam or resins (D2140 – D2394) • Posts & Cores (D2952, D2953, D2954, D2957) Sedative (temporary) fillings (D2940) Pins (D2951)	
D2951	Pin retention – per tooth in addition to restoration. Not allowable with D2950	No
D2952	Post and core in addition to crown, indirectly fabricated Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2953	Each additional indirectly fabricated post – same tooth - (maximum of 2) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2954	Prefabricated post and core in addition to crown - (maximum of 1) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No
D2957	Each additional prefabricated post – same tooth – (maximum of 1) Not billable with D2950 **Limited to age 15 or older** Posts which extend less than one-half the distance of the root length measured from the cementoenamel junction to the anatomic root apex are not covered.	No

Effective April 1, 2006, core buildups (D2950) and post and cores (D2952, D2954) are limited to 6 per date of service individually or in combination when performed in an office setting.

Effective July 1, 2003, the following codes require at a **minimum a diagnostic pre-treatment periapical radiograph** be taken and maintained on file: D2750, D2751, D2752, D2792, D2952, D2953, D2954, and D2957.

Effective July 1, 2004, to qualify for coverage: posts must be radiographically visible and distinct from the obturation material. "So-called Posts" made in the office solely by flowing or compacting materials into the canal(s), such as resins, polymers, acrylics, amalgams, etc., are not covered. In order to qualify for coverage, posts must be fitted and cemented within the prepared root canal, and be attached to the core in order to retain the core. Posts which do not meet criteria for coverage will not be covered as core buildups. Core buildups and posts & cores are only covered on teeth which are receiving crowns and are limited to once per eligible tooth per lifetime.

Endodontics

Pulp Capping

Bases and sedative fillings do not qualify as pulp caps. Pulp caps without a protective restoration are not covered.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3110	Pulp cap, Direct (excluding final restoration) Covered for permanent teeth only. Pulp cap must cover a documented exposed pulp. **Limit one per tooth**	No
D3120	Pulp cap, Indirect (excluding final restoration) Covered for permanent teeth only. Effective January 1, 2005, indirect pulp caps are only covered for documented treatment of **deep** carious lesions near the dental pulp with a protective dressing over the remaining carious dentin to prevent operative pulp exposure. **Limit one per tooth per lifetime.**	No

Pulpotomy/Pulpectomy

Only the single most appropriate endodontic code should be billed. It is not appropriate to bill pulpotomy/pulpectomy (D3220) and pulpal therapy on primary teeth (D3230 or D3240) for the same tooth. D3220 must not be billed with D3310, D3320, D3330 or D3332 for the same tooth, as these four codes already include a pulpotomy or pulpectomy. **Pulpotomies are not covered for permanent teeth effective July 1, 2003.**

Effective April 1, 2006, the following limitations apply for endodontic procedures when performed in an office setting. Pulpotomies (D3220) and Pulpal Therapy (D3230, D3240) are limited to 6 per date of service individually or in combination.

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D3220	Therapeutic pulpotomy **Covered for primary teeth only, excluding final restoration**	No

Primary Endodontics

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3230	Pulpal therapy, anterior primary tooth	No
D3240	Pulpal therapy, posterior primary tooth	No

D3230 and D3240 would be covered **ONLY** when all of the following documented indications exist: the primary tooth is restorable and must be saved until the permanent tooth erupts, **the pulp is non-vital** with no radiographic signs of internal or external root resorption, is present. **These procedures requiring a complete pulpectomy, require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file.** Radiographs are included as part of the procedure (D3230 & D3240) and are not billable to Medicaid or the recipient. These radiographs must show successful filling of canals with a resorbable filling material without gross overextension or underfilling. Follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Endodontics on Permanent Teeth

Root canal therapy for permanent teeth includes diagnosis, extirpation of the pulp, shaping and enlarging the canals temporary fillings, filling and obliteration of root canals(s), progress radiographs, including a root canal fill radiograph and follow-up care. Endodontics on third molars is not a covered procedure. Effective April 1, 2006, Root canal treatment on anterior (D3310) and premolars (D3320) are limited to 6 per date of service individually or in combination when performed in an office setting. Molar root canals (D3330) are limited to 2 per date of service in an office setting. One molar root canal can be performed with 3 anterior or premolar root canal procedures in an office setting.

The following codes are covered only on permanent teeth and require a diagnostic pre-treatment and post-treatment periapical radiograph be taken and maintained on file: D3310, D3320, D3330, D3351, D3410, and D3430. Endodontics (D3310 – D3430) are **only** covered when there are documented tests performed (electrical pulp tests, thermal, percussion, palpation) in the record consistent with radiographic findings and symptoms which support a documented pulpal pathology diagnosis of an irreversible nature on a specific restorable tooth and one of the following procedures are indicated: D3310, D3320, or D3330. When reviewing a radiograph, canals must be filled at approximately 1mm or less from the apex of the root and have no voids in material. There should be a sealing material between the root canal filling material and restorative material.

Intentional endodontics performed for reasons other than documented irreversible pulpal pathology of a specific restorable tooth, such as, but not limited to: prosthetics, bleaching, orthodontics, non-covered periodontal or oral surgery procedures, pain of undetermined origin, preference of the recipient or provider, etc. are not covered and are subject to recoupment.

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3310	Anterior, excluding final restoration (age 6 or older)	No
D3320	Bicuspid, excluding final restoration (age 9 or older)	No
D3330	Molar, excluding final restoration (age 6 or older)	No
D3332	Incomplete endodontic therapy on permanent teeth due to the tooth becoming inoperable or unrestorable due to a fracture or removal of gross decay must be submitted for an administrative review prior to payment.	No
D3351	Apexification, per treatment visit **(nonvital permanent teeth only)** This procedure is only covered after apical closure is obtained and demonstrated with a postoperative periapical radiograph maintained in the record. This postoperative film must be taken after apexification is completed but before canal obturation is performed. Usually several treatments are required. Treatment performed in less than 180 days after apexification with Calcium Hydroxide is not covered. When using Mineral Trioxide Aggregate (MTA) for apexification, the 180 days does not apply.	No

Periapical Services

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D3410	Apicoectomy - Anterior, per tooth - Limit 1 per tooth per lifetime	Yes
D3430	Retrograde filling - **Limit 1 per tooth per lifetime** Covered only in conjunction with D3410 on anterior teeth	Yes

D3230, D3240, D3310, D3320, D3330, D3410 and D3430: **require diagnostic pre-treatment and post-treatment periapical films be taken and maintained on file**. In addition, follow up evaluations with radiographs to assess condition, including possible breakdown of supporting tissues, must also be documented.

Prior Authorization requests for D3410 and D3430 require a postoperative endodontic periapical film with the history and examination findings to include: symptoms, periodontal probings, palpation, percussion, mobility, presence of swelling or sinus tract, etc. and an **explanation of why re-treatment is not being considered.**

Periodontics

Periodontics requires prior authorization. Prior authorization for periodontal therapy codes, D4341 or D4910 requires the following:

- Complete periodontal charting (including probing depths) and free gingival margins in relation to Cementoenamel Junctions(CEJs)
- Posterior bitewing radiographs and any involved anterior periapical or bitewing radiographs to be submitted with the prior authorization request

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D4341	Periodontal scaling and root planning, per quadrant Prior authorization for scaling and root planning requires documentation of pocket depths as follows: • Patients **over** 12 years old must have a generalized pocket depth **greater than 4 mm**, with demonstrable radiographic evidence of generalized periodontitis. (This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque from these surfaces.) • For patients **under** 12 years old, this procedure is ordinarily not indicated unless some unusual circumstance requires a more in-depth review and documentation (for example, familial juvenile periodontitis.) • This procedure will not be authorized for treatment of pseudopockets. • This procedure requires that radiographs (posterior bitewings and anterior periapicals or bitewings) and complete periodontal charting (including probing depths, free gingival margins in relation to CEJs, etc.) be provided with the request. A limit of no more than **two quadrants** of scaling and root planning will be permitted for each date of service, except for patients treated as inpatient/outpatient hospitalization cases. This procedure not allowed for same quadrant, same date of service with: D1110, D1120, D1201, D1205, D4355, or D4910.	Yes
D4355	Full mouth debridement Covered only when subgingival and/or supragingival plaque and calculus obstruct the ability to perform a comprehensive oral evaluation. This is a preliminary procedure and does not rule out the need for other procedures. This procedure requires that appropriate radiographs (bitewings, periapicals) be sent with the request. Clinical photographs/images may be required upon request. This procedure is not allowed on the same date of service or within 6 months of scaling and root planning. If prior approved, this procedure must be performed before a comprehensive evaluation is done. This procedure is not allowed on same date of service or within 6 months of: D1110, D1120, D4341, or D4910. Difficult prophylaxis should be reported as a “routine” dental prophy (D1120, D1110).	Yes
D4910	Periodontal maintenance procedures Prior authorization for Periodontal/Special Maintenance following active therapy (D4341) requires the following information: • A clinical description of the service • Procedure recommendations • X-rays • Complete periodontal charting (probing depths, free gingival margins in relation to CEJs) • Current CDT procedure code • The number of units or visits This procedure is not allowed on same date of service	Yes

Procedure Code	Description of Procedure	Prior Authorization Required
	with: D1110, D1120, D4341 or D4355	

Oral Surgery

Extractions

Extractions include local anesthesia, (infiltration **and/or** nerve block), aveoloplasty, suturing if needed and routine postoperative care. Extractions of exfoliating primary teeth will not be covered unless there is a valid indication (e.g. pain, eruption interference, abscess, etc.) documented in the dental record.

Procedure Code	Description of Procedure	Prior Authorization Required
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No

NOTE:

Payment for extraction is for the complete removal of tooth (clinical crown and roots). Partial extraction of a tooth is subject to recoupment.

Surgical Extractions

Effective July 1, 2003, surgical extractions include and require documentation of local anesthesia, alveoloplasty, mucoperiosteal flap elevation, osseous removal, sectioning and removal of tooth structure, sutures, and routine postoperative care. Radiographs are required with PA request for procedure codes D7240 and D7241. D7241 requires a report by tooth number of **actual unusual surgical complication(s)**. The following codes are only covered for permanent teeth: D7210, D7220, D7230, D7240, D7241, and D7250. **Exception: Ankylosed or impacted primary teeth may be submitted by report with radiographs.** To be reimbursed, providers must send a diagnostic x-ray of primary tooth, report and completed claim form directly to: AL Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36130-5624.

Extractions due to crowding to facilitate orthodontics are not covered unless the orthodontics is covered meeting Medicaid criteria.

Procedure Code	Description of Procedure	Prior Authorization Required
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. Requires documentation of cutting of both gingival and bone, removal of tooth structure, and closure. **Covered for permanent teeth only**	No
D7220	Removal of impacted tooth – soft tissue occlusal surface must be covered by soft tissue, requires documentation of mucoperiosteal flap elevation. **Covered for permanent teeth only.**	No

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7230	Removal of impacted tooth – partially bony a portion of the crown must be covered by bone, requires documentation of mucoperiosteal flap elevation and bone removal. **Covered for permanent teeth only.**	No
D7240	Removal of impacted tooth – completely bony **most or all of the crown must be covered by bone,** requires documentation of mucoperiosteal flap and bone removal. **Covered for permanent teeth only.**	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications most or all of the crown must be covered by bone, requires documentation of mucoperiosteal flap and bone removal. Covered for **actual** complications only by report. **Covered for permanent teeth only.**	Yes
D7250	Surgical removal of residual tooth roots must require documentation of cutting of both soft tissue and bone and removal of tooth structure. Not covered if a portion or all of crown is present. **Covered for permanent teeth only.**	No

Procedures: D7210, D7220, D7230, D7240, D7250 requirements listed above (i.e. flap, bone removal, sectioning, etc.) must be documented in the dental record to be covered.

Other Surgical Procedures Applied To Teeth

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus. This fee includes any composite or bonding attachment to evulsed or displaced tooth and adjacent teeth as well as any brackets, wire or line used.	No
D7280	Surgical exposure of impacted or unerupted tooth to aid eruption	No
D7285	Biopsy of oral tissue, hard (bone, tooth)	No
D7286	Biopsy of oral tissue, soft (all others)	No

Removal of Tumors, Cysts, and Neoplasms

Procedure Code	**Description of Procedure**	*Prior Authorization Required*
D7410	Excision of benign lesion up to 1.25 cm	No
D7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7451	Removal of odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No
D7460	Removal of non-odontogenic cyst or tumor, lesion diameter up to 1.25 cm	No
D7461	Removal of non-odontogenic cyst or tumor, lesion diameter greater than 1.25 cm	No

Excision of Bone Tissue

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7471	Removal of exostosis – per site	No
D7510	Incision and drainage of abscess, intraoral soft tissue. Requires documentation of incision through mucosa, area of incision, presence of any purulence from the abscess, use of any drain or sutures. Not allowed in same site as a surgical tooth extraction. Incisions through the gingival sulcus are not covered.	No
D7520	Incision and drainage of abscess, extraoral soft tissue. Requires documentation of incision through skin and area of incision, type of drain (if any) and sutures (if closed)	No

Treatment of Fractures - Simple

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7610	Maxilla - open reduction (teeth immobilized if present)	No
D7620	Maxilla - closed reduction (teeth immobilized if present)	No
D7630	Mandible - open reduction (teeth immobilized if present)	No
D7640	Mandible - closed reduction (teeth immobilized if present)	No

Reduction of Dislocation - Management of Other Temporomandibular Joint Dysfunctions

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D7820	Closed reduction of dislocation	No

Other Repair Procedures

Deleted: ~~Complete periodontal charting…relation to CEJs)~~

Excision of hyperplastic tissue (D7970) requires:

- Medical documentation, that the hyperplasia is drug-induced
- Possible oral images/photographs (if required by Medicaid)

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D7911	Complicated suture, up to 5 cm. **Excludes** closure of surgical incision reconstruction requiring delicate handling of tissue and wide undermining for meticulous closure.	No
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	No
D7970	Excision of hyperplastic tissue; per arch (covered for drug-induced cases only)	Yes
D7971	Excision of pericoronal gingival. Covered for partially erupted or impacted teeth only. Use for operculectomy. Not allowed for crown lengthening or gingivectomy.	No

Orthodontics

Orthodontic services require prior authorization. Orthodontic services must be requested through a multidisciplinary clinic administered by Alabama Children's Rehabilitation Service or another qualified clinic enrolled as a contract vendor in the Medicaid Dental Program. See Section 13.5.1 of this chapter entitled *Orthodontic Services* for more details.

Adjunctive General Services

Procedure Code	***Description of Procedure***	***Prior Authorization Required***
D9110	Palliative (emergency) treatment of minor dental pain. This procedure requires documentation in the record of: symptoms, findings, tests (if performed), radiographs if taken, diagnosis, and description of emergency treatment. Cannot be billed with the following definitive or emergency procedures: D0210, D0350, D0470, D1110 through D7970, D7971, D9220 and D9610. This is a specific code and must not be used to bill for any procedure that has its own unique code, even if the most appropriate code is not covered. Always bill the most appropriate and current CDT code **Limit one per visit.**	No

Procedures

The following procedures are limited to one per visit when not covered by separately listed procedures.

Anesthesia

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9220	General anesthesia **Requires current state board GA permit**	No
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide or similar analgesia is authorized for payment in special cases such as mentally retarded, a fearful, extremely nervous/anxious or obstreperous patient, or an extremely uncooperative patient. Effective April 1, 2004, documentation of medical necessity, written informed consent, and nitrous oxide dosage (% nitrous oxide/oxygen and/or flow rate, duration of the procedure, post treatment oxygenation procedure and condition of the patient upon discharge), **must be** in the medical record. The provider or recipient's desire to use this procedure, by itself, does not qualify it as medically necessary.	No
D9241	Intravenous sedation/analgesia **Requires current state board IV or GA permit**	No

Drugs

Procedure Code	*Description of Procedure*	*Prior Authorization Required*
D9610	Therapeutic parental drug, single administration, by report billable only when no definitive treatment rendered in same visit	Yes
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	Yes

Periodicity Schedule

NOTE:

The periodicity schedule below is only a guideline to help practitioners make clinical decisions concerning preventive oral health interventions, including anticipatory guidance and preventive counseling, for infants, children, and adolescents. Please refer to policy and procedures within "Chapter 13 Dental" governing reimbursement for dental procedures.

ALABAMA MEDICAID'S EPSDT PERIODICITY SCHEDULE

	Infancy							Early Childhood						Middle Childhood						Adolescence									
AGE	Newborn[1]	3-5 days[2]	By 1 Mo	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo	18 Mo	24 Mo	30 Mo	3 Yrs	4 Yrs	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs	11 Yrs	12 Yrs	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs
Clinical oral examination[1,2]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assess oral growth and development[3]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Caries-risk assessment[4]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Radiographic assessment[5]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Prophylaxis and topical fluoride treatment[4,5]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	O	O	O	O	O
Fluoride supplementation[6,7]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Anticipatory guidance/counseling[8]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Oral hygiene counseling[9]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dietary counseling[10]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Injury prevention counseling[11]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for nonnutritive habits[12]						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for speech/language development[13]									X	X	X	X	X	X	X														
Alcohol and drug use assessment[13]						↔	↔	↔								X	X	X	X	X	X	X	X	X	X	X	X	X	X
Counseling for intraoral/perioral piercing																X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment and treatment of developing malocclusion						↔	↔	↔	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment for pits and fissure sealants[14]								X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Assessment and/or removal of third molars																						X	X	X	X	X	X	X	X
Transition to adult dental care																					↔	↔	↔	↔	↔	↔	↔	↔	↔

NOTES:

X To be performed
O Perform when necessary
↔ Perform within indicated timeframe

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease.
2 Includes assessment of pathology and injuries.
3 By clinical examination.
4 Must be repeated regularly and frequently to maximize effectiveness.
5 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.
6 Consider when systemic fluoride exposure is suboptimal.
7 Up to at least 16 years of age.
8 Appropriate discussion and counseling should be an integral part of each visit.
9 Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.
10 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.
11 Initially play objects, pacifiers, car seats; then learning to walk, sports and routine playing.
12 At first discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.
13 Referral to a Pediatrician, if necessary.
14 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Tooth Numbers and Letters

- Enter the tooth number or letter for the appropriate tooth. Use the letters and/or numbers shown on the dental chart. Additional tooth designations are listed below. Insert these in the “Tooth # or Letter” block on the claim when indicated.
- Tooth Numbers should include for Permanent dentition: 01 through 32
- Tooth Numbers should include for Primary dentition: A through T
- Supernumerary are as follows:

A supernumerary tooth for Permanent Dentition (Tooth numbers 01-32) would have 50 added to its tooth number. Therefore if a patient had an extra tooth number 30 it would be coded as tooth number '80' (30 + 50 = 80). Valid numbers would be 51 through 82.

A supernumerary tooth for Primary Dentition (Tooth numbers “A” through “T”) would place an 'S' after the tooth code. If a patient had an extra 'A' tooth, it would be coded 'AS'. Valid letters would be ‘AS’ through ‘TS’.

The following codes may be used in conjunction with those listed on the claim form:

Code	***Designation***	***Code***	***Designation***
00	Full mouth	30	Lower Left Quadrant
01	Upper Arch	40	Lower Right Quadrant
02	Lower Arch		
10	Upper Right Quadrant	L	Left
20	Upper Left Quadrant	R	Right

Surface

Please bill the single most appropriate surface involved using the following abbreviations:

Code	***Designation***	***Code***	***Designation***
B	Buccal; Labial	L	Lingual
D	Distal	M	Mesial
I	Incisal	O	Occlusal
F	Facial; Labial		

When more than one surface on the same tooth is affected, use the following combinations:

2 Surfaces			***3 Surfaces***				***4 Surfaces***		***5 Surfaces***	
MO	IF	ML	MOD	IFL	BOL	MID	MODB	MIFL	*MODBL*	*MODFL*
DB	IL	OB	MOB	MIL	DOB	MIF	MODL	DIFL	*MIDBL*	*MIDFL*
MB	DI	DO	MOL	DIL	DOL	DIF	MOBL	MIDL		
DL	MI	OL	MBD	MLD			MIDF			

13.8.3 Place of Service Codes

The following place of service codes apply when filing claims for dental services:

Place of Service Codes	Place of Service
11	Dental office
15	Mobile Clinic
21	Inpatient hospital
22	Outpatient hospital
31	Skilled nursing facility or nursing facility

NOTE:

Place of service codes other than 11 and 15 require prior authorization before delivery of the service, unless recipient is less than 5 years old.

13.8.4 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy claim form must be submitted.

Refer to Chapter 5 Filing Claims, Section 5.8, Required Attachments, for more information on attachments

13.9 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
ADA Dental Claim Form Instructions	Section 5.4
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Dental Prior Authorization Form	Section 5.4

14

14 Durable Medical Equipment (DME)

Medicaid authorizes supplies, appliances, and durable medical equipment (DME) to Medicaid recipients of any age living at home. A provider of these benefits must ensure the following:

- The supplies, appliances, and DME are for medical therapeutic purposes.
- The items will minimize the necessity for hospitalization, nursing facility, or other institutional care.

The attending physician is responsible for ordering the items in connection with his or her plan of treatment. The attending physician must be a licensed, active, Alabama Medicaid provider. The DME provider is responsible for delivering and setting up the equipment as well as educating the recipient in the use of the equipment.

Prior Authorization requests for coverage of durable medical equipment must be received by Medicaid's Fiscal Agent within thirty days after the equipment is dispensed. (See section 14.3.1 Authorization for Durable Medical Equipment)

NOTE:

A recipient does not have to be a Home Health Care recipient in order to receive services of this program.

This DME Provider Manual is not an ALL INCLUSIVE DOCUMENT. Additional documentation may be needed upon request. The policy provisions for DME providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 13.

14.1 Enrollment

HP enrolls supply, appliance, and durable medical equipment providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual. A copy of the approved Medicare enrollment application is required.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Re-Enrollment

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment using Medicaid's Provider Enrollment Web Portal.

Application Changes Process

Providers must notify HP in writing of any changes to the information contained in its application at least 30 days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

National Provider Identifier Type and Specialty

A provider who contracts with Medicaid as a DME provider is added to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursement for DME related items.

NOTE:
The 10-digit NPI is required when filing a claim

DME providers are assigned a provider type of 25 (DME) and DME providers of Durable Medical Equipment/Oxygen are assigned a specialty of 250.

DME Provider Enrollment Requirements

To participate in the Alabama Medicaid Program, DME providers must meet the following requirements:

The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.

Physical Location Requirements

All Alabama Medicaid DME providers must maintain a physical facility on an appropriate site in accordance with all applicable federal and state regulations and/or requirements.

1. The provider's business location must be accessible to the public, Medicaid recipients, recipient's representatives and Alabama Medicaid and its agents. (The location must not be in a gated community or other area where access is restricted.)
    - Location may be a "closed door" business, such as a pharmacy or supplier providing services only to recipients residing in a nursing home that complies with all applicable Federal, State, and local laws and regulations. *"Closed door" businesses must comply with all applicable federal and state regulations and/or requirements.*
2. The provider's business must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. This requirement does not apply to Medicare crossover providers.

a. Providers within a 30-mile radius may serve recipients only in all counties adjoining the county in which he/she has a business license and in the county where his/her business is physically located.

b. Providers located more than 30- miles from the border of Alabama may be enrolled only as follows:

(1) For specialty equipment and supplies such as augmentative communication devices and high frequency chest wall oscillation air pulse generator systems which are not readily available in state;

(2) For supplies and equipment needed as the result of a transplant or unique treatment approved out of state as the result of an EPSDT referral. Suppliers will be enrolled by the Medicaid fiscal agent on a temporary basis for these situations.

(3) Medicare cross over providers **only**

Business Signs

Maintains a permanent visible sign in plain view and posts hours of operation. If the supplier's place of business is located within a building complex, the sign must be visible at the main entrance of the building or the hours can be posted at the entrance of the supplier.

Business Telephone

Maintains a primary business telephone that is operating at the appropriate site listed under the name of the business locally or toll-free for beneficiaries.

a. Cellular phones, beepers, or pagers must not be used as the primary business telephone.

b. Calls must not be exclusively forwarded from the primary business telephone listed under the name of the business to a cellular phone, beeper, or pager during posted business hours.

c. Answering machines, answering services, facsimile machines or combination of these options must not be used exclusively as the primary business telephone during posted operating hours.

d. Answering machines and/or answering services are not acceptable as personal coverage during normal business.

Business Hours/Staffing

Providers must be open to conduct business at least 40 hours per week.

Provider’s business days/hours, Monday through Sunday, 8:00 a.m. to 8:00 p.m., are at the discretion of the provider.

Exemption(s):

A physician DME provider who furnishes items to his/her own patient(s) as part of his/her professional service.

A physical or occupational therapist DME provider who furnishes items to his/her own patient(s) as part of his/her professional service.

Provider’s location must be accessible and staffed during posted business hours of operation.

There must be at least one person present to conduct business at the physical location.

Supplies

DME providers must have durable medical equipment, appliances or supply items stocked in the physical store location that are readily available to Medicaid recipients presenting prescriptions for these items.

DME providers must display, on the location's shelves, all non-custom items for which the provider will be submitting claims to Alabama Medicaid to request reimbursement.

Displayed products must be clearly labeled, usable and readily accessible to a recipient who enters the DME location and presents a prescription for DME products, i.e. no expired products on the shelf, no products stored in bins on shelves.

Displayed items must be in original manufacturer's packaging, when appropriate.

Shelf location for items must be labeled, to include but not limited, item's name.

Satellite Businesses/Multiple Locations

Satellite businesses affiliated with a provider are not covered under the provider contract; therefore, no reimbursement will be made to a provider doing business at a satellite location, however, a satellite could enroll with a separate NPI.

A provider with multiple DME store locations must have completed a provider application for each store location. Each store location enrolled with Alabama Medicaid is assigned a unique Medicaid identification number.

License/Certification Requirements (Documents)

The provider must display, in an area accessible to recipients, customers and/patients, all licenses, certificates and permits to operate.

A copy of the following licenses/certifications must be provided, upon request, with the enrollment and/or re-enrollment processes:

Licenses/Certifications Needed		Provider Exemptions
1	Applicable State and Professional licenses	N/A
2	Valid business license(s)	N/A
3	Medicare Accreditation	Medicare exemptions apply
4	Medicare Surety Bond (when applicable)	Medicare exemptions apply
5	Medicaid Surety Bond (when applicable) Effective October 1, 2010, all DME providers must have a $50,000.00 Medicaid Surety Bond for each store location. A DME supplier who provides Breast Prosthesis, Diabetic Shoes and Diabetic Shoe Inserts is **not** exempted	DME supplier who has been a Medicaid provider for five years or longer with no record of impropriety and whose refund requests have been repaid as requested Government-operated Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) State-licensed orthotic and prosthetic personnel in private practice making

Licenses/Certifications Needed		Provider Exemptions
		custom-made orthotics and prosthetics Physicians and non-physician practitioners, as defined in section 1842(b)(18) of the Social Security Act Physical and Occupational Therapists in private practice Providers who received $100,000 or less Medicaid payment in the past two calendar years and have been operating at this same location for at least two consecutive calendar years Pharmacy providers Phototherapy providers who only provide phototherapy services for infants Federally Qualified Health Centers
6.	Alabama Board of Home and Medical Equipment (HME) Services Providers License (when applicable) For more information: http://www.homemed.alabama.gov	Alabama Board of HME exemptions apply

Pharmacy providers are required to submit copies of their Medicare enrollment letter only. Pharmacy providers are not required to submit copies of their Medicare Surety Bond, Medicare Accreditation nor Medicaid Surety Bond nor Home Medical Equipment (HME) License.

Prosthetic, Orthotic, and Pedorthic Providers

The providers of Prosthetic, Orthotic, and Pedorthic devices for adults age 21 – 64 **must** be:

- licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics
- applicable to In-State DME providers ONLY
- meet the same requirements as Durable Medical Equipment providers

The chart below further clarifies the license requirements for POP providers :

Type of Operation	License/Certification Required
Prosthetic, Orthotic & Pedorthic (POP) Services Only (custom made devices only)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification
POP and Mastectomy (custom made devices only)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification
POP and HME (DME)	Alabama Board of Prosthetists and Orthotists Accredited Facility Certification **and** Alabama Board of Home Medical Equipment (HME)
HME (DME) and Mastectomy	Alabama Board of Prosthetists and Orthotists Certification/License **and** Alabama Board of Home Medical Equipment (HME)
Mastectomy Only (Boutique)	Alabama Board of Prosthetists and Orthotists Certification/License **and** Alabama Board of Home Medical Equipment (HME)

Type of Operation	License/Certification Required
HME(DME) Only	Alabama Board of Home Medical Equipment (HME)

Consignment Closets

Alabama Medicaid does not provide coverage for Consignment Closets. Medicaid supports recipients exercising the freedom of choice option which is to use the DME provider of their choosing.

14.2 Benefits and Limitations

This section defines durable medical equipment, discusses Medicaid policy for supplying medical supplies and appliances as a DME provider, discusses prior authorization for DME, provides a listing of non-covered services, and describes reimbursement policy. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

14.2.1 Supplies, Appliances, and DME

A written order or a signed prescription from the attending physician must be dated prior to or on the delivery date, unless a different effective date is clearly documented on the prescription. Otherwise, the effective date is the date of the physician signature. An effective date that is handwritten on a prescription and differs from the date of the physician's signature must be initialed and dated by the physician to verify the effective date. Verbal orders must be signed within 48 hours of the order being issued. This order/prescription submitted to a participating supplier determines medical necessity for covered items of supplies and appliances. An EPSDT/PT 1st referral may be submitted as an order when written according to practice guidelines and state/federal law and must include the date and signature of the provider, the item(s) ordered and the recipient's name. The EPSDT/PT 1st referral form may be considered the physician's order as long as these guidelines are met. If the prescription is from the recipient's primary medical provider (PMP), a separate PT1st referral is not necessary. However, an EPSDT referral is **still required** as the referral provides the screening date and other additional information. A prescription is considered to be outdated by Medicaid when it is presented to the DME provider/ HP past ninety days from the date it was written. Medicaid considers a prescription to be valid for the dispensing of supplies for a period of twelve months. After the twelve month period of time, the recipient must be reevaluated by the attending physician to determine medical necessity for continued dispensing of medical supplies.

Added: Prior Authorization requests…sufficient medical documentation.

Prior authorization by Medicaid is required for certain supplies such as diapers & enteral supplies). For services such as diabetic supplies (A4253, A4259), phototherapy (E0202), certain wheelchair accessories codes and wheelchair repair code (K0739), a prior authorization is not required. However, for a recipient to receive these services in excess of the Medicaid established limits providers must submit requests for additional units with medical documentation justifying the need to the Clinical Services and Support Division, Medical and Quality Review Unit for review and approval. Prior authorization is not required for appliances such as standard glucose monitors, nebulizers, and heating pads.

Prior authorization requests for supplies, appliances and DME must include medical records to support the medical necessity of the requested item(s). Checklists are not sufficient medical documentation.

NOTE:

Signature Requirements 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.

In the "Reason for Referral" section, the specific item(s) being prescribed must be listed. "DME" will **not** be accepted as an order.

The recipient or their authorized representative is responsible for obtaining the prescription from the attending physician for Medicaid-covered items and taking it to a participating Alabama Medicaid DME provider. (In rural areas where physicians visit clinics twice monthly, Alabama Medicaid accepts prescriptions from the Physician Assistant (PA) when the physician is unavailable.)

Upon receipt of the prescription, the DME provider must:

- Verify Medicaid eligibility by checking the recipient's Medicaid number and verifying that number using AVRS, Medicaid's Web portal (interactive, real time), Provider Electronic Solutions or the Provider Assistance Center at HP. Recipient's eligibility must be verified on a monthly basis. Alabama Medicaid will not reimburse providers for items supplied to recipients in months where recipients have no eligibility.
- Obtain necessary managed care referrals and prior authorization
- Collect the appropriate copayment amount
- Furnish the covered item(s) as prescribed
- Retain the prescriptions and all medical documentation in patient's file
- Submit the proper claim form to Medicaid's Fiscal Agent HP (Electronic Data Systems)

Reimbursement will be made for item(s) covered by the Alabama Medicaid Agency or purchase or rentals as indicated on the DME Fee Schedule, using limits established by Medicaid.

The use of automatic refills is not allowed by the Medicaid Agency. If it is determined through provider audits that Medicaid has reimbursed the provider for excessive amounts of durable medical equipment/supplies, the amount paid for the excessive supply will be recouped.

The contract supplier agrees to accept as payment in full the amount paid by Medicaid for covered services.

The provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted and the patient will be responsible for the bill.

The fact that Medicaid payment will not be accepted would be recorded in the patient's record, if one exists. Refer to Rule No. 560-X-1-.07.

The provider may not bill the recipient for an item for which a prior authorization was denied.

Medicaid recipients may be billed for no covered items and items covered by Non contract providers.

14.2.2 Durable Medical Equipment

Medicaid covers new durable medical equipment items for long-term use; long term use is defined as the use of durable medical equipment that exceeds six months. Standard durable medical equipment items (e.g. wheelchairs/beds) may be rented for up to six months or less.

Durable medical equipment is necessary when it is expected to make a significant contribution to the treatment of the recipient's injury or illness or for the improvement of physical condition.

As defined by Medicaid, durable medical equipment is equipment that meets the following conditions:

- Can stand repeated use
- Serves a purpose for medical reasons
- Is appropriate and suitable for use in the home

The cost of the item must not be disproportionate to the therapeutic benefits or more costly than a reasonable alternative. The item must not serve the same purpose as equipment already available to the recipient.

Providers should be aware of Medicaid policy regulating medical necessity for durable medical equipment. The policy is described below for DME covered by Medicaid.

14.2.3 Warranty, Maintenance, Replacement, and Delivery

Warranty

All standard durable medical equipment must have a provider's warranty of a minimum of one year; this may include the manufacturer's warranty. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, replacements and maintenance for the first year. The warranty begins on the date of delivery (date of service) to the recipient. The original warranty must be given to the recipient and the provider must keep a copy of the original warranty for audit review by Medicaid. Medicaid may request a copy of the warranty.

Maintenance and Replacement

Medicaid covers repair of standard durable medical equipment. These services must be prior approved by Medicaid. Medical documentation submitted must support the need for servicing of the equipment. Providers should submit their usual and customary charges for the service.

Requests for items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the Pharmacy DME Unit for review and consideration. Request for repair/replacement due to extenuating circumstances should be mailed to, Alabama Medicaid Agency, 501 Dexter Ave., Pharmacy DME Unit, Montgomery AL, 36103.

The Alabama Medicaid DME Program covers replacement equipment as needed due to wear, theft, irreparable damage, or loss by disasters. Documentation must accompany prior authorization requests for replacement in these instances.

Replacement equipment for wheelchairs, hospital beds etc. will require an additional prior authorization request. No prior authorization is needed for DME items that did not initially require a prior authorization request such as nebulizers. The request for replacement of equipment and appropriate documentation justifying the need for replacement must be submitted electronically to HP and kept in the recipient's file. However, cases suggesting malicious damage, neglect, or wrongful misuse of the equipment will be investigated. Requests for equipment will be denied if such circumstances are confirmed. Payment for repair/replacement of equipment which has been denied by Medicaid would be the responsibility of the recipient/caregiver.

Effective February 1, 2012, disaster claims related to 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.

Delivery

Upon furnishing durable medical equipment/supplies, the supplier should:

1. Obtain a signature indicating that the equipment/supplies have been received by the recipient. If the recipient is unable to sign for the equipment/supply items the supplier should verify the identity of the person signing for the items, i.e. relative, home health worker, neighbor. Alabama Medicaid will accept a signed mail tracking system/shipping label as proof of delivery of DME supplies delivered via mail to Alabama Medicaid recipients. If delivered by a package/shipping delivery company, an appropriate signature is required. (Refer to Rule 560-X-1-.18: Provider/Recipient Signature on Claim Forms.)
2. Document that the recipient was provided the necessary information and instructions on how to use Medicaid-covered items safely and effectively.

Custom Made Items Ordered But Not Furnished

If custom made item(s) are ordered but not furnished, contact Alabama Medicaid's DME Program prior to submitting a claim for the item(s). Failure to contact the Agency prior to claim submission may result in no payment and/or recoupment for work relating to item(s), items and/or materials paid to the provider.

NOTE:
For valid procedure codes and modifiers, refer to Appendix P, Procedure Codes and Modifiers.

Extra Wide Heavy Duty Stationary Commode Chair (E0168) Heavy Duty Walkers without wheels rigid or folding, any type each (E0148)

Heavy Duty walkers wheeled, rigid or folding, any type, each (E0149)

Description:

Medicaid will approve heavy duty walker without wheels rigid or folding (E0148), any type for individual's weight capacities greater than 250 pounds. This code requires prior authorization.

Medicaid will approve heavy duty walkers to accommodate weight capacities greater than 250 pounds (E0149) and extra wide and/or heavy duty stationary or mobile commode chairs with or without arms (E0168) for weight capacities greater than 300 pounds. These codes require prior authorization.

The extra wide and/or heavy duty commode chairs and the stationary or mobile with or without arms and/or heavy duty walkers with wheels or without wheels will require prior authorization. Providers must submit recipient's weight, width, and depth for the commode chairs, and weight width and height for the walkers. A physician's prescription and medical documentation must be submitted justifying the need for the equipment.

Limitations:

Extra wide and/or heavy duty commode chairs, stationary or mobile with or without arms and heavy duty walkers with wheels and without wheels are limited to one per recipient every two years.

Suction Pump, Home Model, Portable (E0600)

Description

A portable or stationary home model respiratory suction pump is an electric aspirator designed for oropharyngeal and tracheal suction.

A physician must prescribe a suction pump as medically necessary for the equipment to qualify for Medicaid reimbursement. HP must receive a request for coverage within **thirty calendar days** after the date the pump is dispensed. The recipient must be unable to clear the airway of secretions by coughing secondary to one of the following conditions:

- Cancer or surgery of the throat
- Paralysis of the swallowing muscles
- Tracheostomy
- Comatose or semi-comatose condition

The suction device must be appropriate for home use without technical or professional supervision. Individuals using the suction apparatus must be sufficiently trained to adequately, appropriately, and safely use the device.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above medical criteria.

NOTE:

Purchase of the suction pump will be limited to one per recipient every five years provided the above criteria are met.

Home Blood Glucose Monitor (E0607) and Diabetic Supplies

Home blood glucose monitors, monitor replacement batteries, calibrator solution/chips, and spring powered lancet devices must be prescribed as medically necessary by the primary physician. To be considered for coverage Medicaid beneficiaries must be diagnosed as having either Type 1, Type 2, gestational diabetes, or receiving Total Parenteral Nutrition. Alabama Medicaid will reimburse covered diabetic supplies for Medicaid recipients that were diabetics prior to the pregnancy and for pregnancy related-diabetes. Reimbursement for these diabetic supplies will promote health and safety of mother and baby.

Home Blood Glucose Monitor with integrated Voice Synthesizer (E2100)

Blood glucose monitors with integrated voice synthesizers are covered when the patient meets the same requirements as a regular glucometer. The patient's physician certifies that the patient has a visual impairment (20/200 or worse) severe enough to require use of this special monitoring system. The recipient's optometrist/ophthalmologist must certify the degree and type of visual impairment. Procedure code E2100 does require prior authorization.

For procedure code E2100 to be dispensed, a written statement that the recipient requesting a glucometer with voice synthesizer is capable of using the equipment in the home setting, and is not dependent upon a caregiver for blood glucose testing. (If the recipient is dependent upon a caregiver, the caregiver's need for a glucometer with a voice synthesizer must be justified.

NOTE:

Recipients who were diagnosed with diabetes prior to the pregnancy are eligible to receive diabetic equipment/supplies.

Medical documentation justifying medical necessity must be in the recipient's file. Documentation in the recipient's file must also include certification that the recipient or their caregiver is receiving, or has received, diabetes education and training on the use of the glucose monitor, strips and lancets in the appropriately prescribed manner in the home.

Requests for Medicaid's authorization of a replacement glucose monitor will be accepted for review **every five years.** A request for replacement of the glucose monitor submitted within less than five 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. The request for a replacement glucose monitor must be submitted to the Pharmacy DME Unit with a completed CMS 1500 claim form and a police or fire report or other appropriate medical documentation justifying the need. This information should be mailed to 501 Dexter Avenue, Montgomery, AL 36130.

For Recipients with Diabetes

Effective for dates of service October 1, 2010, and thereafter, Alabama Medicaid changed the current diabetic supply policy as follows:

Non-Insulin Dependent Recipients:

Claims for **non-insulin** dependent recipients **must** be filed **with the procedure code WITHOUT** using a modifier.

A4253 – Blood glucose test or reagent strips for home blood glucose monitor, per box of 50, will be limited to **two** boxes every three months (providers may bill these strips two boxes in a one month period).

A4259 – lancets, per box of 100, will be limited to **one** box every three months.

Insulin Dependent Recipients:

Claims for insulin dependent recipients **must** be filed **WITH the procedure code and MODIFIER U6**
A4253 (U6) - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 will be limited to **three** boxes per month for insulin dependent recipients age **21 and above.**

A4253 (U6) - Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 will be limited to **four** boxes every month for insulin dependent recipients age **0 – 20.**

A4259 (U6) - Lancets, per box of 100 will be limited to two boxes per month for insulin dependent diabetics regardless of age.

Recipients with Gestational Diabetes:

Effective March 1, 2012, DME diabetic testing supplies claims billed for recipients with Gestational Diabetes must contain a diagnosis code in the range of 64880 through 64884.

A4259 – Lancets, per box 100, will be limited to two per calendar month
A4253 – Blood glucose test or regent strips for home blood glucose monitor, per box of 50, will be limited to four 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.

If recipients require additional strips or lancets above the Medicaid established limits, providers must submit peer reviewed literature justifying the need to the Clinical Services & Support Division, Medical and Quality Review Unit at the Alabama Medicaid Agency for review and approval. If approval is granted, the Clinical Services & Support Division, Medical and Quality Review Unit will notify the Pharmacy DME Unit. The providers will also be notified of the approval and instructed to bill for these additional supplies by submitting a clean CMS 1500 claim form with a short memo to the Pharmacy DME Unit of the Alabama Medicaid Agency. The memo should state that this recipient has been approved for additional units and request Medicaid to override the maximum unit requirement and force payment of the claim.

Providers dispensing diabetic supplies must have the recipient's prescription on file from the primary care physician. A valid prescription will contain the frequency for daily blood sugar testing. Providers must ensure that diabetic supplies are dispensed based on the daily frequency of blood sugar testing indicated on the recipient's prescription.

It is the provider's responsibility to ensure that the recipient does not have an excessive supply of strips/lancets. If it is determined through Provider Audits that Medicaid has reimbursed the provider for excessive amounts of strips/lancets, the amount paid for the excessive supply will be recouped.

The following diabetic supplies are also available for recipients who are eligible for the home blood glucose monitor:

Diabetic supplies	Limits
A4233 Replacement battery, Alkaline, other than J cell	2 units/year
A4234 Replacement battery, Alkaline, J cell	2 units/year
A4235 Replacement battery, Lithium	2 units/year
A4236 Replacement battery, Silver Oxide	2 units/year
A4256 Normal, low and high calibrator solution/chips	4 units /year (1/qtr)
A4258 Spring-powered device for lancet, each	1 per year

External Ambulatory Infusion Pump (E0784), and Supplies (A4232, A4221)

An external ambulatory infusion pump is a small portable battery device worn on a belt around the waist and attached to a needle or catheter designed to deliver measured amounts of insulin through injection over a period of time. The ambulatory infusion pump will be limited to one every five years.

The external ambulatory infusion is approved by the Alabama Medicaid Agency for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment, and must be prior authorized.

E0784 - External Ambulatory Infusion Pump will be limited to one every five years based on submitted documentation. This procedure code will be a capped rental item with rental payment of $334.06 per month for twelve months. At the end of the twelve month period the item is considered to be a purchased item for the recipient paid in full by Medicaid. Any maintenance/repair cost would be subject to an EPSDT screening and referral and a prior authorization as addressed under current Medicaid policy.

A4232 - Syringe with needle for External Insulin Pump, sterile 3cc (each) will be supplied in quantities prescribed as medically necessary by the physician.

A4221 - Supplies for maintenance of drug infusion catheter per week, (list drug separately). Includes all necessary supplies for one week for quantity needed by the recipient for that week.

A4230 – Infusion set for external insulin pump, non-needle cannula type, (each) will be supplied in quantities prescribed as medically necessary by the physician.

The following criteria must be met in determining medical necessity for the insulin pump (All seven must be met):

1. Patient must be under 21 years of age and EPSDT eligible.
2. A board certified or eligible endocrinologist must have evaluated the patient and ordered insulin pump.
3. Patient must have been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the CSII pump.
4. Patient has documented frequency of glucose self-testing an average of at least four times per day during the three months prior to initiation of the insulin pump.
5. Patient or caregiver must be capable, physically and intellectually, of operating the pump.
6. Type 1 diabetes must be documented by a C-peptide level < 0.5.
7. Records must have documentation of active and past recipient compliance with medications and diet, appointments and other treatment recommendations.

Two or more of the following criteria must also be met:

1. Copies of lab reports documenting two elevated glycosylated hemoglobin levels (HbA1c>7.0%) within a 120-day span, while on multiple daily injections of insulin.
2. History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements). A history of not less than 3 documented episodes of severe hypoglycemia (<60 mg/dl) or hyperglycemia (>300 mg/dl) in a given year.
3. Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dl).
4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl.

Approved Diagnoses:

Approval will be given for only the following type 1 diabetes mellitus diagnosis codes, if above criteria is met: 250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.41, 250.43, 250.51, 250.53, 250.61, 250.63, 250.71, 250.73, 250.81, 250.83, 250.91, 250.93.

Supplies:

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A4414 or A4415. Procedure code A5063 may not be billed on the same date of service as A5052.

Hospital Bed (E0250, E0255, E0260) (E0303) (E0304)

A physician must prescribe a hospital bed as medically necessary in order for a recipient to qualify for a hospital bed. HP must receive the request for coverage within **thirty calendar days** after the date that the equipment was dispensed. The recipient must meet one of the following conditions:

1. Recipient positioning of the body not feasible on an ordinary bed.
2. Recipient has medical conditions that require head of bed elevation.
3. Recipient requires medical equipment which can only be attached to the hospital bed.

At least one of the criteria listed above must be met as well as any of the following for coverage of variable height hospital bed:

1. Recipient has medical condition or injuries to lower extremities and the variable height feature allows recipient to ambulate by placing feet on the floor while sitting on edge of bed.
2. Recipient's medical condition is such that they are unable to transfer from bed to wheelchair without assistance**.**
3. Severely debilitating diseases and conditions require the need of the variable height bed to allow recipient to ambulate or transfer.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria.

Medicaid covers hospital beds (E0304) extra heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 600 pounds.

Medicaid covers hospital beds (E0303) heavy duty, extra wide, with any type side rails, with mattress to accommodate weight capacities greater than 350 pounds, but less than 600 pounds. Replacement mattresses for the heavy duty, extra wide bed or the extra heavy duty bed can be obtained using procedure code E1399.

Medicaid will use the established prior authorization criteria for these hospital beds, but will add the weight, width and length requirements. DME providers will ensure that accurate/correct weight, height and length measurement are included with these requests. Medicaid will reimburse providers at invoice cost plus 20% for procedure code E0304.

If hospital bed is medically necessary and is needed for six months or less, the equipment will be rented. This policy is applicable for all Medicaid recipients. If the equipment continues to be medically necessary and is needed longer than six months another PA request and prescription must be submitted documenting the need. If approval is granted a capped rental will be established and previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price.

Hospital Bed Accessories

(E0271, E0280, E0310, E0630, E0635, E0910, E0911, E0912, E1399)

Hospital bed accessories must be prescribed as medically necessary, require prior authorization and medical documentation must be submitted justifying the need.

Hospital Bed Accessory procedure codes E0275, E0276 E0621 do not require prior authorization.

Medicaid covers trapeze bar, heavy duty for patent weight capacity greater than 250 pounds, free standing, complete with grab bar (E0912).

Medicaid covers electric patient lifts with seat or sling (E0635) to accommodate weight capacities greater than 450 pounds.

Medicaid will use the established prior authorization criteria for the electric patient lift (E0635) and the trapeze bar, heavy duty (E0912) but will add the weight and width requirements. Individuals approved for the electric lift and the heavy duty trapeze bar must be fitted and measured by the Durable Medical Equipment Company providing these services. Medicaid will reimburse provider's invoice plus 20% for the patient electric lift and heavy duty trapeze bar.

NOTE:
For benefit limits refer to the DME Fee Schedule.

Power Reducing Support Surfaces

Powered Pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty (E0181)

Gel or gel-like pressure pad for mattress, standard mattress length and width (E0185)

Pump for alternating pressure pad, replacement only (E0182)

Replacement pad for use with medically necessary alternating pressure pad owned by patient (A4640)

Powered pressure-reducing air mattress (E0277)

Group 1 pressure reducing support surfaces include powered pressure reducing mattress overlay/pad, alternating with pump includes heavy duty (E0181), a pump for alternating pressure pad, replacement only (E0812), a gel/gel-like pressure pad for mattress (E0185) and replacement pad for use with medically necessary alternating pressure pad owned by patient (A4640) will be considered for Medicaid payment when prescribed as medically necessary by a physician. Medical documentation must be submitted with the prior authorization request justifying the need.

The gel/gel like pad for mattress (E0185), the pump for alternating pressure pad, replacement only (E0182) and the replacement pad for alternating pressure pad owned by the patient (A4640) are purchased items because they are not considered reusable. Group 1 Pressure reducing support surfaces are covered for the entire Medicaid population.

Group 2 pressure reducing support surfaces include powered pressure-reducing air mattress (E0277)). Procedure code E0277 is only covered for children up to the age of 21 through the EPSDT Program.

Initial approval of the powered pressure reducing mattress overlay pad/alternating with pump, includes heavy duty (E0181) and the powered pressure-reducing air mattress (E0277) will consist of up to 90 days. If the primary physician documents that the equipment continues to be medically necessary longer than 6 months, a 10 month capped rental to purchase is established, previous rental payments will be applied towards the total purchase price of the equipment. Rental payments include delivery, in service for caregiver, maintenance, repair and supplies if applicable. Medicaid's reimbursement will not exceed the total purchase price of the equipment.

Group 1 and group 2 power reducing support surfaces require prior authorization.

Continued use of the group 2 support surface is considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that the use of the group 2 support surface is medically necessary for wound management.

NOTE:
For benefit limits refer to the DME Fee Schedule.

Mattress Replacement (E0271)

To qualify for Medicaid reimbursement of a mattress replacement, a physician must prescribe the equipment as medically necessary. Request for coverage must be received by HP within **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria:

- The patient has a safe and adequate hospital bed in his home
- Documentation must be submitted showing the mattress in use is damaged and inadequate to meet the patient's medical needs.

NOTE:
For benefit limits refer to the DME Fee Schedule.

Bed Side Rails (E0310)

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. HP must receive the request for coverage within **thirty calendar days** after the date that the equipment was dispensed. The recipient must be bed confined and have one or more of the following conditions:

- Disorientation
- Positioning problem
- Vertigo

- Seizure disorder

NOTE:

For benefit limits refer to the DME Fee Schedule.

Recipient Hydraulic Lift With Seat or Sling (E0630)

Electric Patient Lifts with Seat or Sling (E0635)

Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. Request for coverage must be received by HP within **thirty calendar days** after the date that the equipment was dispensed. An eligible recipient must meet the following medical criteria:

- Documentation must indicate the recipient has, or is highly susceptible to decubitus ulcers, and/or:
- The recipient must be essentially bed confined and would require the assistance of more than one person to transfer from bed to chair or wheelchair or commode without a lift.

Medicaid covers electric patient lifts with seat or sling (E0635) to accommodate weight capacities greater than 450 pounds.

Medicaid will use the established prior authorization criteria for these electric patient lifts, but will add the weight and width requirements. Individuals approved for these electric lifts must be fitted and measured by the Durable Medical Equipment Company providing these services. Medicaid will reimburse provider at invoice cost plus 20% for these patient electric lifts (E0635).

NOTE:

For benefit limits refer to the DME Fee Schedule.

Trapeze Bar, AKA Recipient Helper, Attached to Bed with Grab Bar (E0910) (E0911)

To qualify for Medicaid reimbursement of a trapeze bar, the physician must prescribe the equipment as medically necessary for the recipient. Request for coverage must be received by HP within **thirty calendar days** after the date that the equipment was dispensed. The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must have positioning problems. Documentation must show that the recipient has physical/mental capability of using the equipment for repositioning.
- The recipient must have difficulty getting in and out of bed independently.

Medicaid covers Trapeze Bar (E0911), heavy duty for patient weight capacity greater than 250 pounds, Attached to Bed with Grab Bar

Medicaid will use the established prior authorization criteria for these trapeze bars, but will add the weight requirements. Individuals approved for these trapeze bars must weigh over 250 pounds. Medicaid will reimburse providers at invoice cost plus 20% for these trapeze bars.

NOTE:

For benefit limits refer to the DME Fee Schedule.

Short Term Rental Policy

Certain Durable Medical Equipment items prescribed as medically necessary will be rented if needed on a short term basis. Short term is described as (6) months or less. These procedure codes will be indicated on the fee schedule with an RR for rental.

Medicaid payment for short term rental will be made under the following conditions:

1. Written order documenting estimated period of time (number of months) medical equipment will be needed
2. Documentation that establishes medical necessity for short term rental

Initial approval will consist of up to 90 days only. If recipient needs the equipment after the initial 90 day period, written documentation must be submitted that demonstrates continued medical necessity.

If equipment continues to be medically necessary longer than six months a capped rental to purchase will be established. Providers must submit a new PA request for the purchase of the DME item with previous rental payments deducted from the total purchase price of the DME item. Providers will submit their claims with the purchase price that Medicaid has showing on the approved PA request for the purchase of the DME item. The requested dates of service on the new PA request for purchase of the DME item must not overlap with the dates of service on the PA request for the rental period of the DME item. Previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price of the equipment.

Nebulizer (E0570)

The nebulizer is a covered service in the DME program for all recipients. The nebulizer can be provided only if it can be used properly and safely in the home. A physician must prescribe it as medically necessary.

This equipment may be purchased for any qualified Medicaid recipient based on the criteria listed below. This equipment may also be rented for any Medicaid recipient. The nebulizer may be rented for a period of no longer than six months. If equipment continues to be medically necessary longer than six months a capped rental will be established and previous rental payments will be applied towards the total purchase price of the equipment. Reimbursement will not exceed the total purchase price of the equipment.

The policy limiting purchase of a nebulizer (E0570) to one every two years was revised. One nebulizer may be purchased every four years for recipients if medically necessary. Medicaid system changes were made to ensure that nebulizer purchases subject to the limitation of one every two years has an end date of December 31, 2002 and purchases subject to the limitation of one every four years has a begin date of January 1, 2003. The system looks at claims from previous years as well as current history to ensure that claims paid in 2002 will not be paid again until the four years are up.

The prior authorization requirement for nebulizer was dropped in June 1999; therefore, nebulizers do not require prior authorization and should not be submitted to HP for prior authorization.

Request (and appropriate documentation) for consideration of payment for replacement of nebulizers due to theft or loss by fire must be submitted

electronically to HP. All documentation must be kept in the recipient's file (police or fire report). These claims will be monitored by Alabama Medicaid on a quarterly basis.

Age Group	*Purchase or Rental Requirements*
Children 6 years of age or under	**Purchases** require documentation of previous episodes of severe respiratory distress associated with one of the following diagnoses: • Asthma • Reactive Airway Disease • Cystic Fibrosis • Bronchiectasis • Bronchospasm Short-term **Rentals** (6 months or less) are allowed for first time episodes associated with one of the above diagnoses. Supporting documentation must accompany the request.
Children 7 through 18 years of age	**Purchases** require documentation of one of the diagnoses listed above. Documentation must also be submitted of one of the following: • The recipient has had a failed trial of at least four weeks of anti-inflammatory drugs (for example, Cromolyn, Nedocromil, and steroids) and bronchodilators (for example, B2 adrenergics, Ipratropium) delivered by metered dose inhaler (MDI) and spacer or dry powder inhalers (DPI). • The recipient's medical condition prevents the coordination necessary to effectively use an MDI and spacer or DPI (i.e. cerebral palsy, mental retardation, neuromuscular weakness, or muscle paralysis).
Recipients 18 years of age and above	**Purchases** require documentation of one of the following diagnoses: • Asthma • Bronchiectasis • Cystic Fibrosis Recipients with a diagnosis of asthma must have documentation of one of the following: • The recipient has had a failed trial of at least four weeks of inhaled or oral anti-inflammatory drugs and inhaled bronchodilators. • The recipient is a moderate or severe asthmatic whose rescue treatment with MDIs is insufficient to prevent hospitalizations or emergency room visits (2 or more ER visits for asthma or 1 or more hospitalizations in the past 12 months). **Rentals** are approved only on a short-term basis (6 months or less) for acute complications of pneumonia.
Children and Adults	**Purchases** may be approved to deliver medications that can be administered only by aerosol (i.e. Pulmozyme for cystic fibrosis). Must be accompanied by supporting documentation. **Rentals** may be approved on a short-term basis (6 months or less) to administer medications as an alternative to intravenous administration of those drugs (for example, nebulized tobramycin, colistin, or gentamicin). Must be accompanied by supporting documentation.

NOTE:

Purchase of the nebulizer is limited to one every four years for recipients who meet the above criteria.

Iron Chelation Therapy Equipment (E0779, A4222, E1399 & K0739)

Iron Chelation Therapy equipment will be considered for Medicaid payment when prescribed as medically necessary by a physician for an eligible recipient who meets the following criteria:

- Documentation must be submitted indicating the recipient has been diagnosed as having Sickle Cell Disease.
- HP must receive a prior authorization request after obtaining the above information within **thirty calendar days** after the date that the equipment was dispensed. This includes the Auto-Syringe Infusion Pump for Iron Chelation Therapy (E0779), Supplies for the infusion pump (A4222) and the Auto-Infusion Pump Repair for Iron Chelation Therapy (E1399 & K0739).
- Purchase of the Ambulatory Infusion Pump (E0779) for treatment of sickle cell is limited to one every five years.

Iron Chelation Therapy equipment will be purchased for any qualified Medicaid recipient who meets the above criteria. The information submitted must include documentation that the recipient meets the above criteria.

Augmentative Communication Devices (E2500), (E2502), (E2504), (E2506), (E2508), (E2510), (E2511), (E2512), (E2599)

Augmentative Communication Devices (ACDs) are defined as portable electronic or non-electronic aids, devices, or systems for the purpose of assisting a Medicaid eligible recipient to overcome or improve severe expressive speech-language impairments/limitations due to medical conditions in which speech is not expected to be restored. These devices also enable the recipient to communicate effectively.

These impairments include but are not limited to apraxia of speech, dysarthria, and cognitive communication disabilities. ACDs are reusable equipment items that must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or his family. Medicaid will not provide reimbursement for ACDs prescribed or intended primarily for vocational, social, or academic development/enhancement.

E2500 Speech generating device digitized speech using pre-recorded messages, less than or equal to eight minutes recording time.

E2502 Speech generating device, digitized speech using pre-recorded messages greater than 8 minutes, but less than or equal to 20 minutes recording time.

E2504 Speech generating device, digitized speech using pre-recorded messages greater than 20 minutes, but less than or equal to 40 minutes recording time.

E2506 Speech generating device, digitized speech using pre-recorded messages greater than 40 minutes recording time.

E2508 Speech generating device, synthesized speech requiring message formulation by spelling and access by physical contact with the device.

E2510 Speech generating device, synthesized speech permitting multiple methods of message formulation and access by physical contact with the device.

E2511 Speech generating software program, for personal computer or personal digital assistant.

E2512 Accessory for speech generating device**,** mounting system.

E2599 Accessory for speech generating device not otherwise classified.

V5336 Repair modification of augmentative communication system or device (excludes adaptive hearing aid).

Scope of services includes the following elements:

- Screening and evaluation
- ACD, subject to limitations
- Training on use of equipment

These are inclusive in the allowable charge and may not be billed separately.

NOTE:

This section describes candidacy criteria, evaluation criteria, and prior authorization and limits for ACDs.

Candidacy Criteria

Candidates must meet the following criteria:

Age	***Candidacy Criteria***
Under age 21	• EPSDT referral by Medicaid enrolled EPSDT provider. • Referral must be within one year of application for ACD. The EPSDT provider must obtain a referral from the Patient 1st Primary Medical Provider where applicable • Medical condition which impairs ability to communicate • Evaluation required by qualified, experienced professional • Physician prescription to be obtained after the evaluation and based on documentation contained in evaluation.
Adults, age 21+	• Referral from a primary care physician (Patient 1st PMP where applicable). • Referral must be within one year of application for ACD • Medical condition which impairs ability to communicate Evaluation by required qualified experienced professionals • Physician prescription to be obtained after the evaluation and based on documentation provided in the evaluation.

Evaluation Criteria

Qualified interdisciplinary professionals must evaluate the candidate. Interdisciplinary professionals include a speech-language pathologist and a physician. Qualifications for a speech-language pathologist include:

- Master's degree from accredited institution
- Certificate of Clinical Competence in speech/language pathology from the American Speech, Language, and Hearing Association
- Alabama license in speech/language pathology
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs
- Current continuing education in the area of Augmentative Communication

Interdisciplinary professionals should also include, but may not be limited to, a physical therapist, social worker, and/or occupational therapist.

A physical therapist must possess the following qualifications:

- Bachelor's degree in Physical Therapy from accredited institution
- Alabama license in Physical Therapy
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

A social worker must possess the following qualifications:

- Bachelor's degree from accredited institution
- Alabama license in Social Work
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

An occupational therapist must possess the following qualifications:

- Bachelor's degree in Occupational Therapy from accredited institution
- Alabama license in Occupational Therapy
- No financial or other affiliation with a vendor, manufacturer or manufacturer's representative of ACDs

A Physician must possess the following qualifications:

- Be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; and
- Have no financial or other affiliations with vendors, manufacturers, or other manufacturer's representative of ACDs.

Prior Authorization Process

ACDs and services are available only through the Alabama Medicaid prior authorization process. Requests for authorization must be submitted to Medicaid for review. Documentation must support that the client is mentally, physically and emotionally capable of operating/using an ACD. The request must include documentation regarding the medical evaluation by the physician and recipient information.

Medical examination by a physician is required to assess the need for an ACD to replace or support the recipient's capacity to communicate. The examination should cover:

- Status of respiration
- Hearing
- Vision
- Head control
- Trunk stability
- Arm movement
- Ambulation
- Seating/positioning
- Ability to access the device

The evaluation must be conducted within 90 days of the request for an ACD.

Providers should utilize the Augmentative Communication Device Evaluation Form on the website at this link, http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_FILLABLE_ACD_Eval_Report_Form_3-29-11.pdf.

Medicaid requires the following recipient information with the prior authorization request:

Topic	***Information required for the PA***
Identifying information	• Name • Medicaid recipient number • Date(s) of Assessment • Medical diagnosis (primary, secondary, tertiary) • Relevant medical history
Sensory status (As observed by physician)	• Vision • Hearing • Description of how vision, hearing, tactile and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination)
Postural, Mobility & Motor Status	• Motor status • Optimal positioning • Integration of mobility with ACD • Recipient's access methods (and options) for ACD
Development Status	• Information on the recipient's intellectual/cognitive/development status • Determination of learning style (e.g., behavior, activity level)
Family/Caregiver and Community Support Systems	A detailed description identifying caregivers and support, the extent of their participation in assisting the recipient with use of the ACD, and their understanding of the use and their expectations
Current Speech, Language and Expressive Communication Status	• Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis • Speech skills and prognosis • Communication behaviors and interaction skills (i.e. styles and patterns) • Description of current communication strategies, including use of an ACD, if any • Previous treatment of communication problems
Communication Needs Inventory	• Description of recipient's current and projected (for example, within 5 years) speech-language needs • Communication partners and tasks, including partner's communication abilities and limitations, if any • Communication environments and constraints which affect ACD selection and/or features
Summary of Recipient Limitations	Description of the communication limitations
ACD Assessment Components	Justification for and use to be made of each component and accessory requested
Identification of the ACDs Considered for Recipient-Must Include at Least Three (3)	• Identification of the significant characteristics and features of the ACDs considered for the recipient • Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate) • Identification of manufacturer • Justification stating why a device is the least costly, equally effective alternative form of treatment for recipient • Medical justification of device preference, if any

Topic	*Information required for the PA*
Treatment Plan & Follow Up	• Description of short term and long term therapy goals • Assessment criteria to measure the recipient's progress toward achieving short and long term communication goals • Expected outcomes and description of how device will contribute to these outcomes • Training plan to maximize use of ACD
Additional Documentation	• Documentation of recipient's trial use of equipment including amount of time, location, analysis of ability to use • Documentation of qualifications of speech language pathologists and other professionals submitting portions of evaluation. Physicians are exempt from this requirement. • Signed statement that submitting professionals have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs. One statement signed by all professionals will suffice.

NOTE:

Medicaid reserves the right to request additional information and/or evaluations by appropriate professionals.

Limits

ACDs including components and accessories will be modified or replaced only under the following circumstances:

- Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition that significantly alters the effectiveness of the device.
- Age of Equipment: ACDs outside the manufacturer's or other applicable warranty that do not operate to capacity will be repaired. At such time as repair is no longer cost effective, replacement of identical or comparable component or components will be made upon the request of the recipient. Full documentation of the history of the service, maintenance, and repair of the device must accompany such request.
- Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by present device.

All requests for replacement or modification as outlined above require a new evaluation and complete documentation. If new equipment is approved, old equipment must be returned.

Other Information

Topic	*Required for the PA*
Invoice	The prior authorization request and the manufacturer's invoice must be forwarded to HP Prior Authorization department.
Trial Period	No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. Prior authorization for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request. Prior authorizations for rental of ACD device E2510 may be approved for a four (4) week trial period of usage by the recipient. The manufacturer must agree to this trial period. Medicaid will reimburse the manufacturer for the dollar amount authorized by the Agency for the four (4) week trial period. This amount will be deducted from the total purchase price of the ACD device.
Repair	Repairs are covered only to the extent not covered by manufacturers' warranty. Repairs must be prior approved and billed using procedure code V5336. Battery replacement is not considered repair but does require prior authorization using procedure code E2599.
Loss/Damage	Replacement of identical components due to loss or damage must be prior approved. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.
Component / Accessory Limits	No components or accessories will be approved that are not medically required. Examples of non-covered items include but are not limited to the following: • Printers • Modems • Service contracts • Office/business software • Software intended for academic purposes • Workstations • Any accessory that is not medically required.

The ACD device must be tailored to meet each individual recipient's needs. Therefore, a recipient may need to try more than one device until one is suitable To meet their needs is identified. The Medicaid Agency will allow rental of the device, on a week to week basis for $135.00 per week, for a maximum one month with a maximum rental cap of $540.00. The amount paid for this rental will be deducted from the total purchase price of the ACD device. The procedure code for one month rental of this device is E2510 (R).

Wheelchairs

NOTE:

Wheelchairs are limited to one every **seven** years per recipient.

To qualify for Medicaid reimbursement of a wheelchair, the physician must prescribe the equipment as medically necessary for the recipient. Request for coverage must be received by HP within **thirty calendar days** after the date that the equipment was dispensed. The recipient must be essentially bed confined and must meet the following documented conditions:

- The recipient must be essentially chair confined or bed/chair confined.
- The wheelchair is expected to increase mobility and independence.

A standard wheelchair (procedure code E1130) should be requested unless documentation supports the need for any variation from the standard wheelchair. An example of this variation is an obese recipient who requires the wide heavy-duty wheelchair (E1093). For a list of valid wheelchair procedure codes, refer Appendix P, Procedure Codes and Modifiers.

Medicaid reimburses Durable Medical Equipment providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. Medicaid covers these wheelchairs as a purchase by using HCPC code K0007.

Medicaid covers the ‘Other manual wheelchair/base’ (K0009) to accommodate weight capacity of 600 pounds or greater. The ‘Wheelchair component or accessory not otherwise specified’ for the wheelchair will be covered using procedure code K0108 (an already existing code). The established prior authorization criteria for these specified codes will be used. Medicaid will reimburse for procedure code K0009 at provider’s invoice price plus 20%. Medicaid will require weight, width and depth specification for procedure codes K0007 and K0009.

Effective October 1, 2011, Medicaid’s Motorized/Power Wheelchair Assessment Form 384 must be completed with all prior authorization requests for Manual Wheelchairs with additional accessories for adults.

NOTE:

The provider must ensure that the wheelchair is adequate to meet the recipient’s need. For instance, providers should obtain measurements of obese recipients to ascertain body width for issuance of a properly fitted wheelchair.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any eligible Medicaid recipient. The information submitted must include documentation that the recipient meets the above medical criteria.

Motorized/Power Wheelchairs

The Alabama Medicaid Agency covers motorized/power wheelchairs for the entire Medicaid population. To qualify for motorized/power wheelchairs an individual must meet full Medicaid financial eligibility and established medical criteria. All requests for motorized/power wheelchairs are subject to Medicaid Prior authorization provisions established by the Alabama Medicaid Agency. The patient must meet criteria applicable to manual wheelchairs pursuant to the Alabama Medicaid Agency Administrative Code Rule No. 560-X-13-.17. The attending physician must provide documentation that a manual wheelchair cannot meet the individual's medical needs, and the patient requires the motorized/power wheelchair for six (6) months or longer.

The following are policies related to the coverage of motorized/power wheelchairs:

- HCPC K0813 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, and K0898 will be used as appropriate for related motorized wheelchairs.

  Providers must use an appropriate code for power/custom manual wheelchairs and accessories if one is available. If there is no appropriate code then the provider can use K0108. All prior authorization requests submitted using procedure code K0108 will be reviewed to ensure that there is not another code available.
- Repairs and/or replacement of parts for motorized/power wheelchairs will require prior authorization by the Alabama Medicaid Agency. Prior authorization may be granted for repairs and replacement parts for motorized/power wheelchairs not previously paid for by Medicaid and those prior authorized through the EPSDT program. Wheelchair repairs and replacement parts for motorized/power wheelchairs may be covered using the appropriate HCPC code listed in Section 14.5.3 under Wheelchair Accessories.
- Reimbursement may be made for up to one month for a rental of a wheelchair using procedure code K0462 while patient owned wheelchair is being repaired. When submitting prior authorization (PA) request for loaner wheelchairs providers must submit the appropriate procedure code for the loaner wheelchair dispensed. Alabama Medicaid will then establish the monthly rental at 80% of Medicare's allowable price for the wheelchair code. If loaner wheelchair is not needed for the entire month the wheelchair rental fee will be prorated on a daily basis. When submitting the claim to HP for payment, providers must bill using procedure code K0462 with the Medicaid established rate as it appears on the PA approval form.
- Suppliers providing motorized/power wheelchairs or subsequent repairs/replacement parts to recipients must have at least one employee with certification from Rehabilitation Engineering and assistive Technology Society of North America (RESNA) or registered with the National Registry of Rehab Technology Suppliers (NRRTS). The NRRTS or RESNA certified professional must have direct in person involvement in the wheelchair

selection for the patient. RESNA certifications must be updated every two years. NRRTS certifications must be updated annually. If the NRRTS or RESNA's certification is found not to be current, Alabama Medicaid's Prior Authorization Contractor will deny the PA request for the wheelchair.

- Motor/power wheelchairs are limited to one per recipient every seven years based on medical necessity.
- Home/environmental and vehicle adaption's, equipment and modifications for wheelchair accessibility are not covered.
- Major repairs to wheelchairs require prior authorization.

For information regarding certification through RESNA call (703) 524-6686, extension 311.

The following is the process for obtaining prior approval of a motorized/power wheelchair and accessories:

- The attending physician must provide the patient with a prescription for the motorized/power wheelchair.
- The attending physician must provide medical documentation that describes the medical reason(s) why a motorized/power wheelchair is medically necessary. The medical documentation should also include diagnoses, assessment of medical needs, and a plan of care.
- The patient must choose a Durable Medical Equipment (DME) provider that will provide the wheelchair.
- The DME provider should arrange to have the Alabama Medicaid Agency Motorized/Power Wheelchair Assessment Form 384 completed by an Alabama licensed physical therapist who is employed by a Medicaid enrolled hospital outpatient department. The Form 384 is considered outdated by Medicaid when it is presented to the DME provider/HP past 90 days from the date the PT evaluation was completed. **The physical therapist's evaluation is paid separately and is not the responsibility of the DME provider.** Reimbursement is only available for physical therapists and occupational therapists employed by a Medicaid enrolled hospital through the hospital outpatient department. An occupational therapist (OT) or a physical therapist (PT) not employed by a Medicaid enrolled hospital may perform the wheelchair assessment without any reimbursement from the Alabama Medicaid Agency. The OT/PT performing the wheelchair assessment may not be employed with the DME Company or contracted with the DME Company requesting the physical therapy evaluation. If it is determined that the OT/PT is affiliated with the DME Company and the OT/PT will be penalized and referred to the Medicaid Fraud and Investigation Unit.
- The DME provider must ensure that the prior authorization request for the motorized/power wheelchair includes the product's model number, product name the name of the manufacturer. Providers must submit an itemized list of wheelchair/wheelchair accessory codes and pricing with the prior authorization request.

The DME provider must complete the Alabama Medicaid Agency Prior Authorization Form 342. This form may be submitted electronically or hard copy. If form 342 is submitted electronically all attachments which include medical documentation from the physician and form 384 completed by an Alabama licensed physical therapist employed by an enrolled Medicaid hospital (unless otherwise approved by Alabama Medicaid) must be sent to HP along with a copy of the prior authorization response which providers receive after their initial electronic PA submission. This information may be mailed to HP, Prior Authorization Unit, P.O. Box 244032, Montgomery, Alabama 36124-4032 or faxed to HP at (334) 215-4298 within 48 hours of the electronic PA submission.

Prior authorization requests for wheelchairs received with Julian date July 1, 2009, and thereafter, will no longer require providers to submit signed delivery tickets for wheelchairs to Alabama Medicaid before the prior authorization (PA) request is placed in an approved status in the Alabama Medicaid Interchange PA System. However, a signed delivery ticket must be in the recipient's record for auditing purposes. If a recipient's record is audited and there is no signed delivery ticket showing proof of delivery of the wheelchair, Alabama Medicaid will recoup all monies paid for the wheelchair.

Complex Rehabilitation Technology (CRT) Category

Effective October 1, 2012, Alabama Medicaid provides recognition for individually configured complex rehabilitation technology (CRT) products and services for complex needs patients under the age of 21. These HCPCS codes include complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment such as standing frames and gait trainers. Refer to Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers, for applicable CRT procedure codes.

NOTE:

Purchase of the wheelchair is limited to one every seven years for recipients who meet the above criteria.

Low Pressure and Positioning Equalization Pad for Wheelchair E2603, E2604

(K0108) To be used for wheelchair cushions for obese individuals unable to use codes listed above

To qualify for Medicaid reimbursement of a low pressure equalization pad, the equipment must be prescribed as medically necessary for the recipient by the physician. Requests for coverage must be received by HP within **thirty calendar days** after the date that the equipment was dispensed. To qualify for Medicaid reimbursement or a Low Pressure and Positioning Equalization Pad for a wheelchair, the recipient must meet the following **documented** conditions:

- A licensed physician must prescribe the equipment as medically necessary.
- Recipient must have decubitus ulcer or skin breakdown.
- Recipient must be essentially wheelchair confined.

This equipment may be purchased for any qualified Medicaid recipient who meets the above criteria. This equipment may also be rented for any recipient under the age of 21 who is referred through the EPSDT Program. The information submitted must include documentation that the recipient meets the above medical criteria.

Medicaid also reimburses Durable Medical Equipment providers for the Roho Cushions for the Extra Heavy Duty Wheelchair. This wheelchair cushion is covered as a purchase through Medicaid using Medicare's procedure code K0108. This HCPC code may be used to cover wheelchair cushions for obese individuals who could not use HCPC codes E2603 and E2604.

NOTE:

Medicaid will use the established prior authorization criteria for the Extra Heavy Duty Wheelchair and Roho Cushion, but we will add weight, width and depth specifications. Individuals approved for these items must be fitted and measured for wheelchair and cushion by the Durable Medical Equipment Company providing these services.

NOTE:

Purchase of a Low Pressure and Positioning Equalization Pad will be limited to one every two years for recipients who meet the above criteria.

Oxygen

Oxygen is necessary for life. When we breathe in, oxygen enters the lung and goes into the blood. When the lungs cannot transfer enough oxygen into the blood to sustain life, an oxygen program may be necessary.

Oxygen therapy is a covered service for the entire Medicaid population based on medical necessity and requires prior authorization. Requests for coverage must be received by HP within **thirty calendar days** after the oxygen equipment is dispensed. The 30 days will be calculated from the date the prior authorization request is received by HP. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment) The DME provider will be notified in writing of the assigned effective date and additional justification requirements if applicable.

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form must be filled out, signed and dated by the ordering physician.

In order to receive a prior authorization number, Forms 360 and 342 must be completed and submitted to HP. Oxygen therapy is based on the degree of desaturation and/or hypoxemia. To assess patient's need for oxygen therapy, the following criteria must be met:

a. The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at secretions, bronchospasm and infection) were tried without success, and that continuous oxygen therapy is required.

Oxygen will not be approved for PRN use only.

b. Recipients must meet the following criteria:

i. Adults with a current **ABG** with a **PO2 at or below 59 mm Hg** or an **oxygen saturation at or below 89 percent**, taken at rest, breathing room air. If the attending physician certifies that an ABG procedure is unsafe for a patient, an oximetry for SaO2 may be performed instead. Pulse oximetry readings on adults will be considered only in unusual circumstances. Should pulse oximetry be performed, the prescribing physician must document why oximetry reading is necessary instead of arterial blood gas.

ii. Recipients 20 years old or less with **a SaO2 level:**

- **For ages birth through three years, equal to or less than 94%**
- **For ages four and above equal to or less than 89%**

c. The physician must have seen the recipient and obtained the ABG or SaO2 **within 6 months** of prescribing oxygen therapy. Submission of a copy of a report from inpatient or outpatient hospital or emergency room setting will also meet this requirement. Prescriptions for oxygen therapy must include **all of the following**:

i. type of oxygen equipment

ii. oxygen flow rate or concentration level

iii. frequency and duration of use

iv. estimate of the period of need

v. circumstances under which oxygen is to be used

d. Medical necessity initial approval is an approval for no more than three months. To renew approval, ABG or oximetry is required within the third month of the initial approval period. Approval for up to 12 months will be granted at this time if resulting pO2 values or SaO2 levels continue to meet criteria. If ABG or oximetry is not obtained within the third month of the initial approval period or in the case of a subsequent recertification requests within 6 months prior to the end of the current certification period, approval will be granted beginning with the date of the qualifying ABG or oximetry reading.

e. Criteria for equipment reimbursement

i. Oxygen concentrators will be considered for users requiring one or more tanks per month of compressed gas (stationary unit). Prior approval requests will automatically be subjected to a review to determine if a concentrator will be most cost effective.

ii. Reimbursement will be made for portable O2 only in gaseous form. Medicaid will cover portable oxygen for limited uses such as physician visits or trips to the hospital. This **must** be stated as such on the medical necessity or prior approval request. Portable systems that are used on a standby basis only will not be

approved. **Only one portable system (E0431) consisting of one tank and up to four refills (E0443) per month will be approved based on a review of submitted medical justification.** An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

Medicaid will reimburse for only one stationary system.

iii. **For initial certification for oxygen the DME supplier, and its employees, may not perform the ABG study or oximetry analysis used to determine medical necessity**.

iv. Effective January 1, 2005 for recertification for oxygen only following qualifying sleep study which allows for approval of nocturnal oxygen, the DME supplier may perform the oximetry analysis to determine continued medical necessity for recipients receiving nocturnal oxygen only. A printed download of the oximetry results must be submitted with a prior authorization request. Handwritten results will not be accepted.

NOTE:

There are no restrictions related to oxygen flow rate and eligibility for oxygen coverage. The restriction is related **only** to the procedure codes covered.

Only one portable system consisting of one tank and up to four refills per month will be approved based on a review of submitted medical justification.

At initial certification for continuous oxygen an ABG or O2Sat is acceptable. For initial certification of nocturnal oxygen a sleep study is required. At recertification for continuous oxygen an ABG or O2Sat is acceptable. For recertification of nocturnal oxygen an overnight oximetry, an ABG or an O2Sat is acceptable.

Pulse Oximeter - (E0445)

Pulse oximetry is a non-invasive method of determining blood oxygen saturation levels to assist with determining the amount of supplemental oxygen needed by the patient.

Request for coverage of pulse oximeters must be received by HP within thirty days after the equipment is dispensed. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

Pulse oximeters are a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and whose blood saturation levels fluctuate, thus requiring continuous or intermittent monitoring to adjust oxygen delivery.

To receive prior authorization, submit a written request to include, but not limited to, all the following requirements:

- A completed Form 342 with required supportive documentation
- Copy of EPSDT form/referral
- Copy of prior approval form for home oxygen (Form 360)

The use of home pulse oximetry, for pediatric patients, is considered medically appropriate if one of the following criteria in documentation requirements A is met in addition to the documentation requirements in B:

Documentation Requirements A:

1. Patient is ventilatory dependent with supplemental oxygen required; or
2. Patient has a tracheostomy and is dependent on supplemental oxygen; or
3. Patient requires supplemental oxygen per Alabama Medicaid criteria (see below) and has unstable saturations[1]; or
4. 1Patient is on supplemental oxygen and weaning is in process; or
5. Patient is diagnosed with a serious respiratory diagnosis and requires short term[2] oximetry to rule out hypoxemia and/or to determine the need for supplemental oxygen.

Documentation Requirements B:

The following documentation is required:

1. **Pulse oximetry evaluations**. To qualify, from birth through three years must have a SaO2 equal to or less than 94%. Recipients age four and above must have a SaO2 equal to or less than 89%. Conditions under which lab results were obtained must be specified. When multiple pulse oximetry readings are obtained the qualifying desaturations must occur for five or more minutes (cumulative desatutration time) to qualify. Pulse oximetry evaluations are acceptable when ordered by the attending physician, and performed under his/her supervision, or when performed by a qualified provider or supplier of laboratory services. **A DME supplier is not a qualified provider of lab services.**
2. **Plan of Care.** A plan of care updated within 30 days of request must be submitted to include, at a minimum, plans for training the family or caregiver: The training plan shall provide specific instructions on appropriate responses for different scenarios, i.e., what to do when O2 sats are below 89%.

Initial approval will consist of up to 90 days only. For requests secondary to the need to determine the appropriateness of home oxygen liter flow rates, to rule out hypoxemia and/or to determine the need for supplemental oxygen, approval will be granted for up to 30 days only. Renewal may be requested for patients already approved for oxygen coverage by the Alabama Medicaid Agency. Documentation may also include written or printed results of pulse oximetry readings obtained within the last month with documentation of condition(s) present when readings were obtained. Renewal may be granted for up to a seven-month period for patients receiving oxygen coverage through Alabama Medicaid.

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[1]Unstable saturations are documented desaturations which require adjustments in the supplemental oxygen flow rates to maintain saturation values. This should be documented to have occurred at least once in a 60 day period immediately preceding the request for certification/recertification.

[2]Short-term is defined as monitoring/evaluation for up to 30 days. “Spot oximetry” is not covered under this policy.

Qualifying Diagnoses:

Lung disease, including but not limited to interstitial lung disease, cancer of the lung, cystic fibrosis bronchiectasis.

- Hypoxia related symptoms/conditions, such as pulmonary hypertension
- Recurrent CHF secondary to cor pulmonale
- Erythrocytosis
- Sickle cell disease
- Severe Asthma
- Hypoplastic heart disease
- Suspected sleep apnea or nocturnal hypoxia
- Other diagnoses with medical justification

Medicaid Coverage for Pulse Oximeter

The Pulse Oximeter must be an electric desk top model with battery backup, alarm systems, memory and have the capacity to print downloaded oximeter readings. Downloads for each month of the most current certification period are required for all recertification requests. Recertification is required until the recipient no longer meets criteria or the device is removed from the home. If the pulse oximeter is no longer medically necessary (criteria no longer met), the oximeter will be returned to the supplier and may be rented to another client who meets criteria for pulse oximeter.

This device will be rented for up to three months during the initial certification period. If this device is needed beyond the initial certification period, the equipment will then become a rental to purchase item for an additional seven month period. The monthly payment will include delivery, in-service for the caregiver, maintenance, repair, supplies and 24-hour service calls. After the ten month rental period, the equipment is paid in full and no additional payment will be made by Alabama Medicaid. The pulse oximeter will be considered to be owned by the recipient.

Medicaid will pay for repair of the pulse oximeter after the initial 10 months only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized and the necessary documentation to substantiate the need for repairs must be submitted to HP who will forward this information to Medicaid's Prior Authorization Unit. Replacement of the pulse oximeter requires prior authorization and is considered after three (3) years based upon the review of submitted documentation. If the replacement is due to disaster or damage which is not the result of misuse, neglect or malicious acts by users, then requests for consideration of payment for replacement equipment must be submitted electronically to Medicaid's Fiscal Agent. The 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. In addition, one reusable probe per recipient per year will be allowed after the initial 10 months capped rental period.

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Limitations

Diagnoses not covered:

- Shortness of breath without evidence of hypoxemia
- Peripheral Vascular Disease
- Terminal illnesses not affecting the lungs, such as cancer not affecting the lungs or heart disease with any evidence of heart failure or pulmonary involvement.

Pulse oximeter requests for renewal will not be approved after the initial monitoring/evaluation period for those recipients not meeting criteria for oxygen coverage. Spot oximetry readings are non-covered service under the DME program.

14.2.4 Coverage of supplies for the Pulse Oximeter

Supplies for the Pulse Oximeter will only be paid for by Medicaid after completion of the ten month rental period.

A4606 - non disposable probe is limited to one per year per recipient.

A4606 – disposable probe is limited to two per month per recipient.

NOTE:
When requesting disposable probes medical documentation must be submitted justifying the need for disposable probes. The documentation must show why a non-disposable probe is medically necessary.

Volume Ventilator – Stationary or Portable (E0450, E0461-R) and Pressure Ventilator – E0463 (R)

Volume Ventilators are stationary or portable, with backup rate feature, and used with non-invasive interface or invasive interface (e.g., tracheostomy tube). Non-invasive volume ventilators are laptop sized, designed for homecare and allows maximum mobility. Pressure ventilators weigh about 12.4 pounds which enables the user to be mobile and contain pressure control, pressure support and flow triggering features. These devices decrease the work of breathing while increasing patient comfort.

Request for coverage of ventilators must be received by HP within **thirty calendar days** after the equipment is dispensed. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

Volume ventilator and pressure ventilators are covered for children with an EPSDT screening when prescribed by a physician as medically necessary:

The recipient must meet the following conditions:

- Medically dependent on a ventilator for life support at least 6 hours a day
- Dependent for at least 30 consecutive days (or the maximum number of days authorized under the State Plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;
- Except for the availability of respiratory care services (ventilator equipment) would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the state plan.
- Adequate social support services to be cared for at home are available.
- Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual without continuous technical or professional supervision. (Reference 42 CFR Section 440.185 Respiratory care for ventilator-dependent individuals.)

and

Patient has at least one or more of the following conditions:

a. Chronic respiratory failure

b. Spinal cord injury

c. Chronic pulmonary disorders

d. Neuromuscular disorders, or

e. Other neurological disorders and thoracic restrictive diseases.

Initial approval will be allowed for up to 12 months based on the EPSDT screening.

Subsequent approvals will require documentation from the physician which substantiates that the recipient continues to meet the medical criteria and indicate the recipient's overall condition has not improved sufficiently.

The ventilator will be reimbursed as a monthly rental item. The monthly rental includes delivery, in-service for caregiver, maintenance, a backup ventilator, back up battery, all medically necessary supplies, and repairs and on call service as necessary. Recertification is required until the recipient no longer meets the criteria or the device is removed from the home. If the ventilator is no longer medically necessary (i.e., the criteria is no longer met) it will be returned to the supplier.

Continuous Positive Airway Pressure Device (E0601)

Supplies for CPAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044 and A7046

CPAP therapy is covered through the EPSDT Program for children up to the age of 21. Diagnosis must be documented by a sleep study performed by a registered or approved sleep laboratory. CPAP therapy is considered medically appropriate if the conditions listed below are met and the documentation requirements listed below are submitted:

A physician either specializing in pulmonary, neurology or a board certified sleep specialist must document that the recipient meets the following conditions:

1. Patient is diagnosed with obstructive sleep apnea, upper airway resistance syndrome, or mixed sleep apnea; and

2. The diagnosis is supported by associated signs and syndromes of craniofacial malformations, neuromuscular disorders, cardiopulmonary or metabolic disorders, morbid obesity or adenotonsillar hypertrophy, tracheomalacia, tracheostomy complications or other anomalies of the larynx, trachea and bronchus that can be documented to improve and maintain airway patency and oxygenation through the use of CPAP.

The following documentation must be submitted:

1. A sleep study must be done within six months of prescribing CPAP therapy; and

2. The sleep study results recorded for at least 360 minutes or 6 hours. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or 4 hours.

Medicaid will approve the CPAP based on the EPSDT Screening. To renew approval physician must submit documentation indicating that the recipient's overall condition has not changed and that CPAP is still medically necessary. Documentation of patient compliance with treatment is required and can be substantiated with smart card downloads in order to continue to be covered. The patient must use the device at least four (4) hours per night, 50% of all nights or it will no longer be covered. CPAP may be restarted (by the pulmonologist, or neurologist, or board certified sleep specialist) if indicated. However, if therapy is restarted then the physician must reassess patient compliance again in three months. If patient is still noncompliant, then therapy is no longer covered... In addition, for continued coverage a repeat sleep study is required if the last study was conducted more than 2 years ago.

Effective January 1, 2013, the CPAP will be a capped rental to purchase item. The equipment can be rented for up to 3 months. After 3 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 3 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 until the recipient no longer meets the criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If the CPAP is determined not be medically necessary (i.e., the criteria is no longer met) and if the total rental amount paid is less than the established purchased price the device will be returned to the supplier.

NOTE:
Upon initial approval of the CPAP device, recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

Bilateral Positive Airway Pressure (BI-PAP) Device (E0470) (E4071) (E0472)

Supplies for BI-PAP Device - A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7046, E0550, E0561, and E0565

The Bilateral Positive Airway Pressure (BI-PAP) devices are designed to deliver pressured air to keep the throat open during the night. A mask containing tubing connects to the device and fits over the nose. The machine supplies two levels of pressure through the tube, one for inhaling and one for exhaling. In addition, the machine applies sufficient air pressure to prevent tissues in the airway from collapsing during sleep when a person exhales.

The BI-PAP device is covered for children under the age of 21 through the EPSDT screening, Program and is considered medically appropriate if the following criteria are met in addition to the documentation requirements. Also a sleep study with subsequent failure on CPAP therapy is required for patients prescribed therapy for obstructive sleep apnea syndrome, or mixed sleep apnea unless the patient is 5 years of age or younger. The prescribing physician, either specializing in pulmonary, neurology or board certified sleep specialist, must document that the recipient has one of the following diagnosis:

1. Patient is diagnosed with central or obstructive sleep apnea, (sleep study required) or

2. Patient is diagnosed with upper airway resistance syndrome, (sleep study required) or

3. Patient is diagnosed with mixed sleep apnea, (sleep study required) or

4. Patient is diagnosed with a neuromuscular disease (examples include muscular dystrophies, myopathies, and spinal cord injuries), respiratory insufficiency or restrictive lung disease from wall deformities (sleep study not required)

The following documentation is required if a sleep study was indicated:

1. The sleep study must be done within 6 months of prescribing BIPAP Therapy.

2. The results of a sleep study recorded for at least 360 minutes or 6 hours must be submitted. A sleep study is acceptable for patients less than six months old if the duration of the sleep study is 240 minutes or 4 hours.

Initial approval will consist of 90 days of therapy. To renew approval, a statement is needed from the physician indicating that the recipients overall condition has not changed and that BIPAP is still medically indicated. Documentation of patient compliance with treatment is required. Patient must use the device at least 50% of sleep time. For continued coverage, a repeat sleep study is required if the last study was conducted more than 2 years ago.

The BI-PAP will be a capped rental item. The equipment will be rented for up to 10 months with the total rental payments equal to purchase price. At the end of the 10 month rental period the item is considered to be a purchased item for the recipient paid in full by Medicaid. The monthly rental payment will include delivery, in-service for the caregiver, maintenance, repair and all supplies. Recertification is required until the recipient no longer meets criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If BI-PAP is determined not to be medically necessary and if the total rental amount paid is less than the established purchased price the device will be returned to the supplier. Supplies and repairs for BI-PAP are only covered after the 10 month rent to purchase period. Supplies and repairs for the BI-PAP are

covered through prior authorization. Supplies will be covered up to the maximum allowed units for the specified timeframe as indicated on the DME fee schedule. BI-PAP devices will be limited to one per recipient every eight years.

NOTE:

Upon initial approval of the BI-PAP device recipients may need to try more than one mask to maximize effectiveness of the device. Trial of various masks will be considered as covered in the rent to purchase price and no additional reimbursement is available.

Home Phototherapy (E0202)

Home phototherapy is a covered service in the DME Program for neonatal jaundice, is frequently used for management of physiologic hyperbilirubinemia. The infant is exposed to continuous ultraviolet light via a lamp used in the home for a prescribed period of time. The ultra violet light helps to reduce elevated bilirubin levels which can cause brain damage.

Prior authorization for Home Phototherapy for the first four (4) consecutive days of therapy is no longer a requirement. Prior authorization is no longer required if therapy continues to be medically necessary after four (4) consecutive days.

If more than four (4) consecutive days of therapy are needed, requests for additional days must be submitted with medical documentation justifying the need to the Clinical Services & Support Division Medical Quality and Review Unit at the Alabama Medicaid Agency for review and approval. If approval is granted, the Clinical Services & Support Division Medical Quality and Review Unit will notify the Provider with billing instructions.

The use of Home phototherapy for children under age 21 is considered medically appropriate if all of the following criteria are met:

1. The infant is term (37 weeks of gestation or greater), older than forty-eight hours and otherwise healthy; and
2. The serum bilirubin levels> 12; and
3. The serum bilirubin level is not due to a primary liver disorder; and
4. The diagnostic evaluation (described below) is negative; and
5. The infants' billirubin concentrations as listed below indicate consideration of phototherapy

AGE, HOURS	Consider phototherapy when total serum bilirubin is:
25-48	Greater than 12 (170)
49-72	Greater than 15 (260)
Greater than 72	Greater than 17 (290)

NOTE: These are recommendations for phototherapy for inpatient and outpatient use

NOTE:

An EPSDT screening is not required.

Diagnostic evaluation

Prior to therapy, a diagnostic evaluation should include:

- History and physical examination;
- Hemogobin concentration or hematocrit;
- WBC count and differential count;
- Blood smear for red cell morphology and platelets;
- Reticulocyte count
- Total and direct-reacting bilirubin concentration
- Maternal and infant blood typing and Coombs test; and
- Urinalysis includes a test for reducing substances.

Documentation from the attending physician should indicate the duration of treatment, frequency of use per day and the maximum number of days for home phototherapy. A registered nurse with active license must perform home visits for professional services associated with phototherapy. Providers must submit written verification to the Medicaid agency which includes the nurse's name and license number with an effective date and expiration date for the nurse's license. The provider must assure that the parent or caregiver receives education for the safe and effective use of the home phototherapy equipment. The procedure code (E0202) used for phototherapy includes a global fee per day for equipment, nurse visits, and collection of lab work.

NOTE:

A skilled nursing visit may not be billed in the Home Health program for this service.

High Frequency Chest Wall Oscillation Air Pulse Generator System (E0483) (Includes Hoses and Vest)

A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. Request for the HFCWO must be received by HP within thirty calendar days after the equipment is dispensed. When the request is not received within thirty calendar day time frame the thirty days will be calculated from the date the prior authorization request is received by HP. All prior authorization requests received with a date greater than thirty days from dispensed date will be assigned an effective date based on actual date received by HP if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the

Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

The recipient must meet the following conditions:

The HFCWO is covered for EPSDT referred recipients when prescribed as medically necessary by a physician and all of the following criteria are met:

1. The patient has had two or more hospitalizations or episodes of home intravenous antibiotic therapy for acute pulmonary exacerabations during the previous twelve months; and
2. The FEV1 (forced expiratory flow in one second) is less than 80% of predicted value or FVC (forced vital capacity) is less than 50% of the predicted value; and
3. There is a prescribed need for chest physiotherapy at least twice daily; and
4. There is a well-documented failure of other forms of chest physiotherapy which have been demonstrated in the literature to be efficacious, including hand percussion, mechanical percussion, and Positive Expiratory Pressure (PEP) device. The evidence must show that these have been tried in good faith and been shown to have failed prior to approval of the vest; and
5. The patient does not have a caretaker available or capable of assisting with hand percussion, then a trial of hand percussion would not be a necessary prerequisite, but such patients would still need to in good faith complete a trial of mechanical percussion and the use of the PEP device.

NOTE:

The qualifying diagnosis for the HFCWO system is Cystic Fibrosis (277.00, 277.02).

Medicaid Coverage for the HFCWO (Capped Rental)

The initial rental approval will consist of up to 90 days. A monthly rate of $1,095.00 will be paid to the provider for the first there months totaling $3,285.00. At the end of the 90 days, documentation is required that demonstrates recipients usage and compliance levels. Renewal will be granted up to the capped rental period of 10 months if compliance with prescribed use is documented and documentation is found that respiratory status is stable or improving. The rental period will allow the patient to demonstrate compliance with the device. If patient compliance is shown in the first three month rental period, in the fourth month, the remaining $4,895.00 is paid to the provider. The rental will include all accessories necessary to use the equipment, education on the proper use and care of the equipment as well as routine servicing, necessary repairs and replacements for optimum performance of the equipment. The monthly payment will include delivery, in-service for the caregiver, maintenance and repair. After the device is purchased no additional cost will be incurred by the Medicaid Agency because the device (the inflatable vest, generator and hoses) is covered under lifetime warranty and the responsibility of the manufacturer or supplier to provide maintenance or replace the device.

Recertification is required until the recipient no longer meets the criteria, the device is removed from the home, or the device is purchased. If the HFCWO is determined not to be medically necessary (i.e., the criteria is no longer met) the HFCWO will be returned to the supplier if the total rental amount paid is less than the established purchase price.

Percussor Electric or Pneumatic

Chest percussors, electric or pneumatic, are used to mobilize secretions in the lungs. Chest percussions may be performed by striking the chest with cupped hands or with a mechanical hand held unit. An electric percussor is a vibrator that produces relatively course movements to the chest wall to mobilize respiratory tract secretions and stimulate the cough mechanism.

Requests for coverage of the percussor must be received by HP within thirty days after the equipment is dispensed. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

The percussor is considered medically necessary for patients with excessive mucus production and difficulty clearing secretions if the following criteria are met:

- Must be an EPSDT Medicaid eligible individual; and
- Patient has a chronic lung condition of cystic fibrosis or bronchiectasis; and
- Other means of chest physiotherapy such as hand percussion and postural drainage have been used and failed; and
- No caregiver available or caregiver is not capable of performing manual therapy; and
- Clinical documentation indicates that manual therapy has been used and does not mobilize respiratory tract or the patient cannot tolerate postural drainage

Incontinence Products (Disposable Diapers) T4521, T4522, T4523, T4524, T4529, T4543 and T4530

The procedure codes listed above will be honored for prior authorizations approved for dates of services extending into year 2004. Prior authorizations (for diapers) requested on or after January 1, 2005 will be considered using procedure codes T4521, T4522, T4523, T4524, T4529, T4543 and T4530.

These incontinence products (disposable diapers) require prior authorization.

Medicaid will consider payment of disposable diapers when referred as medically necessary from an EPSDT screen and the criteria below are met:

1. Recipient must be at least 3 years old;
2. Patient must be non-ambulatory or minimally ambulatory;
3. Patient must be medically at risk for skin breakdown, which is defined as meeting at least two of the following:

   a) Unable to control bowel or bladder functions,

   b) Unable to utilize regular toilet facilities due to medical condition

c) Unable to physically turn self or reposition self,

d) Unable to transfer self from bed to chair or wheelchair without assistance.

T4521 Adult-sized incontinence product, diaper, small

T4522 Adult-sized incontinence product, diaper, medium

T4523 Adult-sized incontinence product, diaper, large

T4524 Adult-sized incontinence product, diaper extra large

T4529 Child-sized incontinence product, diaper small/medium

T4530 Child-sized incontinence product, Large

Apnea Monitor (E0619)

The apnea monitor is a covered service with prior authorization in the DME program for EPSDT referred recipients. The apnea monitor can be provided only if it can be used properly and safely in the home and if it has been prescribed as medically necessary by a physician. Request for coverage of **apnea monitors** must be received by HP within **thirty calendar days** after the equipment is dispensed. No payment will be made for the days between the dispensed date and the date assigned by the Prior authorization Unit. (See section 14.3.1 Authorization for Durable Medical Equipment)

To qualify for the placement of an apnea monitor and Medicaid reimbursement for the monitor, the recipient must meet/have documentation of **at least one** of the following (Infants are defined as less than or equal 12 months of age):

- Apnea that lasts 20 or more seconds that is associated with baby's color changing to pale, purplish or blue, bradycardia (heart rate below 80 beats per minute), baby choking or gagging that requires mouth-to-mouth resuscitation or vigorous stimulation documented by medical personnel (documented pathologic apnea).
- Pre-term infants with periods of pathologic apnea
- Sibling of SIDS victim
- Infants with neurological conditions that cause central hypoventilation
- Infants or children less than two years of age with new tracheostomies (tracheostomy within the last 60 days)

The following must also be included:

- Documentation from the physician with a patient specific plan of care, proposed evaluation and intervention to include length of time of use each day, anticipated reevaluation visits/intervals, additional therapeutic interventions appropriate for diagnosis/cause of apnea
- Documentation of counseling to parents must include the understanding that monitoring cannot guarantee survival
- Documentation of parental training and demonstration of proficiency in CPR and resuscitation methods

Approval is for three (3) months only.

Renewal criteria **must** include the following:

- A copy of nightly monitor strips or monthly download is required as documentation of pathologic apnea or bradycardia for the past three months.
- A letter from the physician with patient-specific plan of care to justify the medical necessity for continued use of monitor at **each** recertification period.

Discontinuation Criteria include:

- Apparent Life-Threatening Event (ALTE) infants that have had two to three months free of significant alarms or apnea.
- The provider must check for recipient compliance (i.e. documentation via download monthly or through nightly strips). The monitor will be discontinued with documentation of non-compliance. Non-compliance is defined as failure to use the monitor at least 80% of each certification period.
- Sibling of SIDS victim who is greater than six months of age
- Tracheostomy recipients greater than two years of age

Effective September 2001, before an Apnea Monitor is provided to a Medicaid recipient, it is a Medicaid requirement that the parent/caregiver has documentation showing that they have had CPR training and demonstrated proficiency in CPR and resuscitation methods. The staff providing CPR training must have a license/certification to provide such training. Provider Notice 99-13, reflecting the amended Apnea Monitor policy was mailed to providers in August of 1999. The effective date of this provider notice was September 1, 1999.

The statement listed below is information used to support the revision to the Apnea Monitor coverage policy related to parents/caregivers having CPR training. This information was taken from an article entitled “Infantile Apnea and Home Monitoring.” This article was published in the National Institute of Health Consensus Development Conference Statement.

"All families who have babies with Apnea are encouraged to be trained in infant cardiopulmonary resuscitation (CPR) before the baby is discharged from the hospital. Although it is unlikely that you will ever have to use CPR, it is best that you be prepared." It is the DME provider’s responsibility to ensure that parents provide them with documentation of CPR training. This documentation must show proficiency in CPR and resuscitation methods. It is not the provider’s responsibility to provide CPR training to the parents. However, the provider may direct the parents to agencies such as the Red Cross, Fire Departments, etc., where CPR training is provided.

If a prior authorization request for an Apnea Monitor is submitted to Medicaid without this requested documentation, the request will be denied. The Prior Authorization Unit will request the provider to resubmit the prior authorization request with the needed documentation. No prior authorizations will be approved without this documentation.

NOTE:

A caregiver trained and capable of performing Cardiopulmonary Resuscitation (CPR) must be available in the home. Documentation must be provided.

When submitting a prior approval request for Medicaid's authorization of an apnea monitor for a sibling of a SIDS victim, use the diagnosis code V201. DME providers should use V201 only for a recipient who is a sibling of a SIDS victim. Do not use diagnosis code 7980. The clinical statement on PA Form 342 must include documentation from the physician supporting the recipient's diagnosis of 'Sibling of SIDS victim.'

Enteral Nutrition equipment and supplies

B9002, B4034, B4035, B4036, B9998, B4088 (EPSDT only), B4081, B4082, B4087, A4213 (entire Medicaid population)

Enteral nutrition equipment and supplies are covered for children under the age of 21 with an EPSDT Screening and Referral. Recipients age 21 and above (with noted limitations) qualify based on medical necessity and prior authorization when the following criteria are met:

1. The recipient meets the following criteria for enteral nutrition:
   a. Recipient is < age 21 and record supports that > than 50 % of need is met by specialized nutrition; or
   b. Recipient is > age 21 and record supports 100 % of need is met by specialized nutrition and provided by tube feedings.

3. Prior authorization requests are required for Enteral Nutrition Equipment and Supplies (B9002, B4034, B4035 B4036, and B9998). Prior authorization requests must be submitted with verification that all medical criteria have been met.

4. Enteral nutrition for adults 21 years of age and above is provided through bolus feeds using procedure code A4213

Total Parenteral Nutrition (TPN) Pump and Supplies (B9004, B9006, E0776, B4220 and B4224)

TPN pumps (B9004, B9006) are provided for all Medicaid recipients and require prior authorization. TPN supplies (E0776, B4224, B4220 and B4222) do not require prior authorization. Procedure code B4224 (Parenteral administration kit; per day) is to be used with TPN Therapy. Procedure code B4220 (Parenteral nutrition supply kit; premix, per day) or B4222 (Parenteral nutrition supply kit; homemix, per day) may be used in conjunction with procedure code B4224. However, at no time should procedure code B4220 and B4222 be billed on the same date of service with procedure code B4224. All TPN supplies are provided to Medicaid recipients based on medical necessity when the following criteria are met:

1. The recipient meets the criteria for total parenteral nutrition (TPN)
   a. Recipient < age 21 and record supports that > than 50 % of need is met by specialized nutrition, or
   b. Recipient > age 21 and record supports 100 % of need is met by specialized nutrition.

2. The patient cannot be sustained through oral feedings and must rely on enteral nutrition therapy which is administered by some form of intravenous therapy.

3. Verification that the criteria have been met must accompany the PA request.

If procedure code E0776 (IV Pole) is needed for a period of more than six months this is considered long term and should be billed as a purchased item. Procedure code E0776 may be rented short term for up to six months or less. If medical documentation justifies the need for the IV Pole for additional months of rental, the pole may be rented for four months which would equal the ten month capped rental period. Reimbursement for the IV Pole should at no time exceed the 10 month capped rent to purchase price.

Walker, with Trunk Support, Adjustable or Fixed Height, any Type (Specialty Walkers) E0140

A specialty walker is a tool for disabled children with special needs who may require additional support to maintain balance or stability while walking. Walkers Is height adjustable and should be set at a height that is comfortable for the user, but will allow the user to maintain a slight bend in their arms. The front two legs of the walker may or may not have wheels attached depending on the strength and abilities of the person using it.

Medicaid will cover specialty walkers for children under the age of 21 with an EPSDT referral. The attending physician must prescribe the specialty walker as medically necessary. The medical documentation justifying the need must accompany the prior authorization request. Documentation must also include an evaluation by the recipient's physician or a physical therapist.

Providers must submit the recipient's width and height for specialty walkers (E0140). Individuals approved for these walkers must be fitted and measured by the DME Company providing the service. Providers must submit invoice pricing and Medicaid will reimburse at provider's invoice price plus 20%.

Home Infusion Therapy Services Equipment and Supplies S5498, S5501, S5520, S5521, S9326, S9330, S9336, S9500, S9501, S9502, S9503, S9504, S9351, S9347, S9379, S9490, S9373.

Home Infusion Therapy **(**HIT**)** includes administration of medication and nutrients and the associated supplies, provided to Medicaid recipients residing in a private residence. Infusion therapy is a procedure that involves the insertion of a catheter into a blood vessel providing a painless way of drawing blood, delivering drugs and nutrients into a patient's bloodstream over a period of weeks, months or even years. Common uses for intravenous therapy are intravenous antibiotic treatment, chemotherapy, hydration and pain management therapy.

HIT components can be provided and billed by enrolled DME Pharmacies and Durable Medical Equipment (DME) Infusion providers only as described in the HIT policy. Effective October 1, 2009, DME Home Infusion providers must be accredited by a nationally recognized accrediting body in order to be reimbursed for home infusion therapy services. In addition, if the provider has not submitted sufficient proof for accreditation by October, 1, 2009, their claims will be rejected.

HIT must be prescribed by the attending physician as a medically necessary health care service. The physician's orders must clearly document the starting date for care, expected duration of therapy, the amount and types of services required. If the recipient requires multiple drug therapies, the therapies must be provided by the same agency. The medication administration record and or the nursing documentation should coincide with the billing based on the time of completion and discontinued use of the drug that required the need for durable medical supplies. The recipient's record must have medical documentation justifying medical necessity.

HIT services billed using the S codes include, antibiotic, antiviral or antifungal therapy (S9500; S9501, S9502, S9503 and S9504), hydration therapy (S9373), chemotherapy (S9330), pain management therapy (S9326), specialty infusion therapies such as anti-coagulant (S9336), antiemetic (S9351), catheter care (S5498, S5501), and catheter insertion (S5520 and S5521). These "S" codes include administrative services, professional pharmacy services, care coordination **and all necessary supplies and equipment (including pump)**. Drugs and nursing visits are billed separately. The "S" codes listed in this paragraph **do not** require prior authorization.

Catheter Care

S5498 ($7.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, Catheter Care/ Maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S5501 ($7.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, Catheter Care/ Maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S5520 ($85.00 per day = 1 unit; limited to 5 units per month; must be billed 1 unit per day)

Home Infusion Therapy, **all supplies** (including catheter) necessary for peripherally inserted central venous catheter (PICC) line insertion

S5521 ($85.00 per day = 1 unit; limited to 5 units per month; must be billed 1 unit per day)

Home Infusion Therapy, **all supplies** (including catheter) necessary for a midline catheter insertion

The catheter dressing supplies may be reported separately when used as a stand-alone therapy, or during days not covered under another infusion therapy reimbursement rate. PICC line, Port-A-Cath or MediPort dressing supplies including the anchor device is allowed as a separate charge if there is no other therapy in the last 30 days in the home.

Pain Management

S9326 ($36.00 per day; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous (24 hours or more) pain management infusion, includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Pain management therapy is considered medically necessary when used to administer opiod drugs (e.g., morphine) and/or clonidine intrathecally for treatment of severe chronic intractable pain in persons who have proven unresponsive to less invasive medical therapy. The recipient's record must have medical documentation justifying medical necessity:

Chemotherapy

S9330 ($36.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous (24 hours or more) chemotherapy infusion includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

The recipient's record must have medical documentation justifying medical necessity.

Anticoagulant Therapy

S9336 ($36.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, continuous anticoagulant infusion therapy (e.g., heparin), includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Antibiotic, Antiviral or Antifungal Therapy

S9500 ($45.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately),

S9501 ($50.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral**,** or antifungal therapy; once every 12 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9502 ($55.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral**,** or antifungal therapy; once every 8 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9503 ($60.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

S9504 ($65.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, antibiotic, antiviral, or antifungal therapy; once every 4 hours; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Intravenous Immune Globulin (IVIG) Therapy

Intravenous Immune Globulin (IVIG) therapy may be billed by providers for recipients having the following diagnosis:

- X-linked Agammaglobulinemia;
- Autosomal Recessive Agammaglobulinemia;
- Hyperimmunoglobulin M Syndromes;
- Induced Cytidine Deaminase (AID), and
- Uracil Nucleoside Glycosylase (UNG)
- Hypogammaglobulinemia
- Immunodeficiency

The following procedure codes must be used to bill for Intravenous Immune Globulin (IVIG) therapy:

S9500 ($45.00 per day = 1 unit: limited to 31units per month; billed 1 unit per day)
S9502 ($45.00 per day = 1 unit: limited to 31units per month; billed 1 unit per day)
S9503 ($45.00 per day = 1 unit: limited to 31units per month; billed 1 unit per day)
S9504 ($45.00 per day = 1 unit: limited to 31units per month; billed 1 unit per day)
S9338 ($45.00 per day = 1 unit; limited to 31units per month; billed 1 unit per day)

In addition, the derivative must be administered in the home of the recipient and the physician must determine that it is medically necessary. This service includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment. Drugs and nursing visits are to be coded separately. If the recipient does not have one of the required diagnoses or the units exceed the allowable amount, the provider must obtain prior authorization.

Hydration Therapy

S9373 ($35.00 per day = 1 unit; limited to 31 units per month; must be billed 1 unit per day)

Home Infusion Therapy, hydration therapy includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately), (do not use with hydration therapy codes S9374-S9377 using daily volume scales),

Hydration therapy is considered medically necessary for recipients who become dehydrated due to illness, surgery, or accident. Dehydration occurs when patients are losing necessary fluids at a rate faster than they are retaining fluids. The recipient's record must have medical documentation justifying medical necessity.

Anti-emetic

S9351 ($36.00 per day = 1 unit; limited to 31 per month; must be billed 1 per day)
Home Infusion Therapy, continuous or intermittent anti-emetic infusion therapy; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately)

Anti-emetic therapy is typically used to treat motion sickness and the side effects of opiods analgesics, general anesthetics and chemotherapy directed against cancer. The anti-emetic assists the recipient in preventing or alleviating irretractable nausea and vomiting. The recipient's record must have medical documentation justifying medical necessity.

S9347 ($36.00 per day = 1 unit; limited to 31 per month)
Home Infusion Therapy, uninterrupted, long-term, controlled rate Intravenous or subcutaneous infusion therapy (e.g. epoprostenol); includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately).

S9490 ($32.00 per day = 1 unit; limited to 31 per month)
Home Infusion Therapy, corticosteroid infusion; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipment** (drugs and nursing visits coded separately).

Home Infusion Otherwise Classified (S9379)

Home Infusion Therapy, infusion therapy not otherwise classified; includes administrative services, professional pharmacy services, care coordination, **and all necessary supplies and equipmen**t (drugs and nursing visits coded separately)
Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Clinical Services & Support Division Medical and Quality Review Unit will consider authorization of other therapies on an individual basis.

These special requests will require peer reviewed medical literature documentation and medical review. This procedure code requires prior authorization.

Limitations

Drugs and nursing visits for home infusion are coded separately.

Adult Prosthetic, Orthotic and Perdorthic Devices Covered For Medicaid Recipients age 21-64

Lower Limb Prostheses Codes – L5301, L5321, L5620, L5624, L5629, L5631, L5649, L5650, L5655, L5685, L5695, L5700, L5701, L5704, L5705, L5812, L5850, L5910,L5940, L5950, L5962, L5964, L5974, L5920 Prosthetic related Supplies Codes - L8400, L8410, L8420, L8430, L8470, L8480

Prosthetic related supply codes are covered if a recipient is an amputee, has a prosthetic leg, and these supplies are necessary for the function of the prosthetic.

Orthotic Basic Codes – L1930, L1960, L1970, L1990, L2020, L2405 Ankle-foot orthoses (AFO) codes L1930, L1960, L1970, L1990 and knee-ankle foot orthoses (KAFO) codes L2020 and L2405 are covered for ambulatory recipients with weakness or deformity of the foot and ankle, which requires stabilization for medical reasons, and have the potential to benefit functionally. Knee-ankle foot orthoses (KAFO) are primarily covered for ambulatory recipients that require additional knee stability and would not benefit from the AFO.

Therapeutic Shoe Codes for Diabetes – A5500, A5513, A5501

Addition To Lower Extremity Orthosis: Shoe-Ankle-Shin-Knee- L2220

Additions General: L2795

Additions: Socket Variations - L5651

Additions: Socket Insert and Suspensions – L5671, L5673, L5679

Additions: Endoskeltal Knee-Shin System - L5986

Prosthetic Socks: L8440, L8460

Wrist-Hand-Finger Orthosis – L3807

Orthosis Devices Spinal – L0472, L0458

Transfer or Replacement – L3610

Orthotic Devices-Spinal – L0172

Thoracic – L0486

Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSO) – L0628 must be billed with a CG modifier for age 21-64, L0630, L0640,

Additions To Spinal Orthosis – L0984

A prosthetic device is an artificial substitute that replaces all or part of a body organ, or replaces all or part of the function of a permanently inoperative, absent or malfunctioning body part. Lower limb prostheses may include a number of components, such as prosthetic feet, ankles, knees, endoskeletal knee-shin systems, limb-ankle prostheses, socket insertions and suspensions. Pedorthic is the making and fitting of shoes and other foot support products to alleviate and prevent foot injury and disease. Orthotic devices are fabricated, fitted and/or modified devices to correct or compensate for a neuro-musculoskeletal disorder or acquired condition (in other words braces for the body, excluding teeth). The orthotic device may be custom fabricated and fitted, prefabricated custom fitted or off-the-shelf if prefabricated and fitted.

Basic level prosthetic, orthotics and pedorthic devices prescribed as medically necessary by the primary care physician are provided for adults ages twenty-one through sixty-four in institutional and non-institutional settings. All requests for prosthetic, orthotic and pedorthic devices for adults do not require prior authorization. Prosthetic, orthotic and pedorthic devices are covered for children up to the age of 21 through the EPSDT Program unless specified on the DME Fee schedule DO NOT REQUIRE PRIOR AUTHORIZATION. For items to be covered recipients must meet eligibility requirements, the devices must be reasonable and necessary to improve the functioning of a malformed body member or replace an absent body member, and meet all other applicable Medicaid statutory and regulatory requirements.

Durable Medical Equipment (DME) providers of Prosthetic, Orthotic, and Pedorthic devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics. The provider is required to have a copy of their license available for auditing purposes.

The provider must be practicing as a Prosthetic, Orthotic or Pedorthic Practitioner in the State of Alabama at an accredited facility. Providers must keep a copy of the written prescription from the primary physician for the prosthetic or orthotic device in the recipient's file. The provider must also have in the recipient's file documentation of the education and follow-ups provided to the recipient of the use of the prosthetic and orthotic device.

Durable Medical Equipment (DME) providers of external breast prostheses devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and Mastectomy Fitters must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

For Medicaid to approve lower limb prosthesis medical documentation must be submitted substantiating that prosthesis is essential in order for the recipient to ambulate and that the recipient is motivated to ambulate.

For Medicaid to approve an orthotic device medical documentation must be submitted to show that the device supports or aligns movable parts of the body, prevent or correct deformities, or improve functioning.

For Medicaid to approve Therapeutic Shoes for diabetes medical documentation must be submitted showing that the recipient has diabetes mellitus and other medical conditions justifying the need.

External Breast Prostheses

(1) Effective June 1, 2001, external breast prostheses following mastectomy for breast cancer are covered for all Medicaid-eligible recipients meeting the criteria.

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:

(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses;

(b) The date of the mastectomy and the ICD-9 diagnosis code for which was performed (174.0-174.9, 198.81, 233.0) is provided in the clinical statement section of the appropriate Alabama Prior Review and Authorization Request Form; and

(c) The appropriate procedure codes are billed as indicated below:

Procedure Code	Description	Limits
L8000	Breast prosthesis, mastectomy bra, Maximum of 4 on initial request	6/year
L8015	External breast prosthesis garment, with mastectomy form	2/year
L8020	Breast prosthesis, mastectomy form	**
L8030	Breast prosthesis, silicone or equal	**
*L8035	Custom breast prosthesis, post mastectomy, molded to patient model	
*L8039	Breast prosthesis, not otherwise classified Evaluated on a case-by-case basis with submission of pricing information and medical documentation	

*These codes will be reviewed on a case-by-case basis. Additional documentation may be requested to determine medical necessity for coverage.

**Limited to two of L8020 per year or one L8020 and one L8030 per year or two of L8030 per year or one L8030 and one L8020 per year.

(3) Maximum calendar year limits apply to each of the procedures as indicated above.

(4) Durable Medical Equipment (DME) providers of external breast prostheses devices for adults must be enrolled as an Alabama Medicaid Agency (AMA) provider and Mastectomy Fitters must be licensed by the Alabama Board of Prosthetics, Orthotics and Pedorthics.

Effective January 1, 2013, all Prior Authorization (PA's) for external breast prostheses for artificial breast substitutes covered under the durable medical equipment program will no longer be required for the following procedure codes below.

For reimbursement rates and benefit limits for the Prosthetic, Orthotic and Pedorthic procedure codes, refer to the DME fee schedule.

NOTE:

* Evaluate External Breast Prosthesis on a case-by-case basis with submission of pricing information and medical documentation for procedure codes L8035 and L8039.

Controlled Dose Drug Inhalation System (K0730)

Effective November 1, 2007, Alabama Medicaid began reimbursement for procedure code K0730. Procedure code K0730 will not require prior authorization. K0730 will be reimbursed at $132.92 per month. This code will be a 10 month capped rent to purchase item and at the end of the 10 month rental period the device will be a purchased item for the recipient.

The drug delivery system will only be covered for eligible Medicaid recipients currently receiving the drug Ventavis. Alabama Medicaid must currently be reimbursing for this drug for these recipients. Providers will be required to bill with one of the following diagnosis codes (415.0, 416.0, and 416.8 when submitting claims for the controlled dose inhalation drug delivery system. If it is determined through provider audits that providers are not billing procedure code K0730 in accordance with Medicaid's policy guidelines, Medicaid payments for this service will be recouped.

The drug delivery system will be limited to one per recipient every two years. Repairs for this system will be covered using procedure code E1399. All repair cost must be submitted with itemized provider invoice cost. Repairs will be reimbursed at provider's cost plus 20%.

Tracheostomy Supplies

Alabama Medicaid covers tracheostomy supplies for eligible Medicaid recipients when prescribed as medically necessary by the physician. Procedure code A7509 (Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat moisture exchange system, limited to 1 unit per day). Effective 06/01/2009, the quantity restriction for procedure code A7526 increased from 4 units per month to 31 units per month (1 unit per day).

Effective December 1, 2009, most of the tracheostomy supplies currently billed using procedure code E1399 will be billed with a procedure code corresponding to the tracheostomy supply item. Bill these trach supplies with the appropriate procedure codes as follows:

A4605 (delee), A7012 (drain bag), A7010 (aerosol tubing), A7008 (neb adapters), S8999 (resuscitation bags), A9900 (suction machine bacteria filters). These supplies do not require prior authorization but there are quantity restrictions. See DME Fee Schedule for quantity restrictions.

Procedure code S8189 will be used to bill for the customized/specialty trachs, Peep valves and respiguard filters will be billed using miscellaneous code E1399. Any other trach supply items requested must be submitted using miscellaneous procedure code E1399. These trach supply items requested using E1399 will require prior authorization. Medical documentation and provider's invoice must be submitted for review and approval. Medicaid will reimburse these trach supplies at provider's invoice price plus 20%.

Transfer Boards (E0705)

Medicaid will consider coverage of transfer boards when prescribed as medically necessary by the recipient's primary care physician. Transfer boards will be approved for Medicaid eligible recipients with medical conditions that limit their ability to transfer from a wheelchair to a bed, chair, toilet, etc. Medical documentation should indicate that the recipient is immobile and requires assistance.

Special Ostomy Supplies (A4421)

Request for special ostomy supplies previously submitted with procedure E1399 should
now be submitted using procedure code A4421 with an SC modifier. Special ostomy supplies will require prior authorization (PA). All PA requests will be approved based on the submitted quantity limitations prescribed by the physician and medical documentation justifying the need. Special ostomy supplies will be reimbursed at provider's invoice price plus 20% and will pay from the approved price listed on the PA file.

Adaptive Strollers, Equipment and Accessories (E1035)

Adaptive strollers, equipment and accessories are covered items in the DME program for Medicaid eligible children under the age of 21 through the EPSDT program who meet criteria. Medicaid will reimburse providers at provider's invoice price plus 20%. These Adaptive Strollers, equipment and accessories have previously been covered using procedure code E1220.

Enuresis Alarm (S8270)

The enuresis alarm is covered through the DME Program for recipients age 5 years up to age 21. Providers should submit their claims for the enuresis alarm using procedure code S8270 and should bill their usual and customary charge for reimbursement.

The American Academy of Family Physicians (AAFP) published recommendation for treatment of enuresis stating there are 2 first line therapies, enuresis alarm and demopressin. Providers are encouraged to prescribe the enuresis alarm as a first line and cost effective therapy.

14.2.5 Non-covered Items and Services

Medicaid does not cover the following types of items:

- Items of a deluxe nature
- Replacement of usable equipment
- Items for use in hospitals, nursing facilities, or other institutions
- Items for recipient's/caregiver's comfort or convenience
- Items not listed as covered by Medicaid
- Rental of equipment, with exceptions noted below:
  - For Medicaid recipient's for six months or less.
  - Medicare crossovers

- Certain intravenous therapy equipment
- Short term use due to institutionalization
- Short term use due to death of a recipient
  - DME items may be provided in Nursing Homes or other institutions for children through the EPSDT Program.
  - Medicaid recipients may be billed for items not covered by Medicaid

14.3 Prior Authorization and Referral Requirements

Certain DME requires prior authorization. Please refer to Appendix P, Procedure Codes and Modifiers, for items that require prior authorization from Medicaid. Payment will not be made for these procedures unless the prior authorization request is received within **thirty calendar days** after the service is provided.

NOTE:
Prior authorization is not a guarantee of payment. The authorization number does not guarantee recipient eligibility at the time the equipment is dispensed. The provider is responsible for verifying recipient's eligibility.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 to determine whether your services require a referral from the Primary Medical Provider (PMP).

All requests for prior approval should be initiated and signed by the attending physician and must document medical necessity. Requests may be sent electronically using the HP Provider Electronic Solution software or mailed in hardcopy to the Prior Authorization Unit, P.O. Box 244032, Montgomery, Alabama 36124-4032. The PA Unit at Medicaid will approve, deny, or return the request. HP will return any requests containing missing or invalid information. Please see Chapter 4, Obtaining Prior Authorization, for additional information.

Procedures for changing rendering providers

1. Obtain a written statement from the initial rendering provider indicating that they are aware and agree with the decision of the recipient to change providers and that the approved PA may be cancelled.

2. Confirm this decision with the recipient by having the new provider submit a written statement that they will now be submitting a PA request on the patient's behalf and have the patient sign that they agree and understand.

3. Cancel the approved PA request in the system.

4. Review the new providers request and approve or deny.

14.3.1 Authorization for Durable Medical Equipment

Provider must have a prescription on file from the attending physician that a specific covered item of durable medical equipment is medically necessary for use in the recipient's home prior to completing the Alabama Prior Review and Authorization Request form 342. The physician may also fax the prescription to the provider of the recipient's choice. The provider must submit the appropriate Alabama Medicaid Prior Review and Authorization Request Form 342 and any other pertinent medical information to the Medicaid Fiscal agent. The Fiscal Agent will assign a prior authorization tracking number and transmit the request to Medicaid Agency's Prior Authorization Approval designee for review.

Prior authorization requests for purchase, rental, or re-certification of DME must be received by Medicaid's fiscal agent within **thirty calendar days** of the signature date the equipment was dispensed. Time limits for submitting requests for services and resubmitting additional information are as follows:

- For all prior authorization requests received **greater than thirty days** from dispensed date, the actual date received by the Fiscal Agent will be the effective date assigned to the PA request if the recipient continues to meet medical criteria. No payment will be made for the days between the dispensed date and the date assigned by the Prior Authorization Unit. If additional information is needed to process a prior authorization request is **not received within thirty days** the prior authorization request will be denied.
- All prior authorization requests for the **purchase** of DME received beyond **thirty calendar days** after equipment is provided will be denied.
- All prior authorization requests for re-certifications of DME rental services must be submitted to HP within **thirty calendar days** of the re-certification date. Completed re-certifications received beyond the established time limit will be authorized for reimbursement effective the date of receipt at HP.

Medicaid will review the request and assign a status of approved, denied, or pending. Providers are sent approval letters indicating the ten-digit PA number that should be referenced on the claim form for billing. Providers and recipients will be notified on denied requests. Providers will be notified of approved requests.

All prior requests returned to the DME provider by Medicaid or its designee for additional medical information, if resubmitted, must contain the following:

Prior authorization requests that are lacking necessary information (EPSDT screening, referrals, required attachment) will be denied and the reason(s) noted in the PA letter under, “Analyst Remarks Request for reconsideration of a denied PA must be received by the fiscal agent within 30 days of the date of the denial letter.

All prior requests denied by Medicaid or its designee for additional medical information, if resubmitted for reconsideration, must contain the following:

(a) The PA denial letter

(b) The EPSDT Referral/PMP (Primary Managed Care Provider) Form, if applicable,

(c) All necessary documentation to justify medical necessity,

(d) Current prescription,

(e) Providers are encouraged to write the PA number on each page of documents submitted for reconsideration.

Prior Authorization Forms: For a hardcopy request, the provider or authorized representative must personally sign the form in the appropriate area or place his/her initials next to a typewritten or stamped signature to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of the patient, and that a physician signed order or prescription is on file (if applicable). For electronic requests, provider certification will be made via standardized electronic signature protocol.

DME Review Criteria

Medicaid reviews all DME prior authorization requests for the following:

- Medicaid eligibility
- Medicare eligibility
- Medical necessity
- Therapeutic purpose for use of equipment in the recipient's home
- Referral through the Sickle Cell Foundation, when appropriate

Although equipment prescribed by the physician may be on the list of covered items, Medicaid will determine to what extent it would be reasonable for Medicaid reimbursement. Equipment may be authorized when it is expected to make a significant contribution to the treatment of the recipient's injury or illness or to improve his physical condition. Equipment will be denied if it is disproportionate to the therapeutic benefits or more costly than a reasonable alternative.

In the event Medicaid receives an authorization form from more than one provider prescribing the same item for a recipient, Medicaid will consider the authorization form received first.

NOTE:

For information on submitting Electronic PA Requests Requiring Attachments refer to Chapter 4, section 4.2.1 (Submitting PAs Using Provider Electronic Solutions) of the Alabama Medicaid Provider Manual.

Disposition of Equipment

The recipient or caregiver should contact the Alabama Medicaid Agency, DME Program, when the need for the equipment no longer exists. The DME provider should not take back equipment from recipients or caregivers that were purchased by Medicaid. The provider should have the recipient or caregiver call the DME Program at 1 (800) 362-1504 when the equipment is no longer being used or needed.

14.3.2 Program Referrals

The Omnibus Budget Reconciliation Act of 1989 expanded the scope of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program for Medicaid recipients under age 21. Effective October 1, 1990, Medicaid began prior authorizing certain approved medical supplies, appliances, and durable medical equipment prescribed as a result of an EPSDT screening to treat or improve a defect, an illness, or a condition.

The Alabama Medicaid Agency and any supporting documentation must be sent to HP, Prior Authorization Unit, for review. Complete documentation describing how prescribed items will treat or improve a condition must be included on Form 362. Indicate prescribed items and appropriate procedure codes, and units billed in blank areas on the form.

Requests for EPSDT-referred specialized wheelchair systems

The Alabama Medicaid Agency's Prior Authorization Form 342 must be completed to receive EPSDT-referred specialized wheelchair systems. This form may be submitted electronically or hard copy. If form 342 is submitted electronically all attachments which include medical documentation from the physician and form 384 completed by an Alabama licensed physical therapist employed by an enrolled Medicaid hospital (unless otherwise approved by Alabama Medicaid) must be sent to HP along with a copy of the prior authorization response which providers receive after their initial electronic PA submission. This information may be mailed to HP, Prior Authorization Unit, and P. O. Box 244032, Montgomery, Alabama 36124-4032 or faxed to HP at (334) 215-4140.

Effective October 1, 2011, The Alabama Medicaid Agency's Motorized/Power Wheelchair Assessment Form 384 must be completed with all prior Authorization requests for Custom Manual Wheelchairs requested for children through the EPSDT Program.

Medicaid uses Medicare-based allowables for EPSDT-referred wheelchair systems. If no Medicare price is available, reimbursement rates established by Medicaid for EPSDT-referred wheelchair systems are based on a discount from Manufacturers Suggested Retail Price (MSRP) instead of a "cost-plus" basis.

Providers are required to submit available MSRPs from three manufacturers for wheelchair systems (excluding seating system and add-on products) appropriate for the individual's medical needs.

Requests submitted with fewer than three prices from different manufacturers must contain documentation supporting the appropriateness and reasonableness of requested equipment for a follow-up review by Medicaid professional staff. Provider must document non-availability of required MSRPs to justify not sending in three prices.

The established rate will be based on the MSRP minus the following discounts:

- Manual Wheelchair Systems - 20% discount from MSRP
- Power Wheelchair Systems - 15% discount from MSRP
- Ancillary (add-on) products - 20% discount from MSRP

Suppliers requesting approvals for medical items must provide Medicaid with an expected date of delivery.

For medical items approved based on medical necessity, Medicaid will indicate the time frame allowed for providers to dispense equipment on the approval letter.

When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied in a timely manner. All requests for extensions must be submitted to Medicaid prior to the expiration date indicated on the approval letter. Medicaid will cancel approvals for medical items that are not dispensed in a timely manner when there is no justifiable reason for delay.

The Medicaid screening provider and recipient will be notified when an approved request for equipment is canceled due to provider noncompliance and the recipient will be referred to other Medicaid providers to obtain medical items.

A supplier providing EPSDT referred specialized wheelchair systems to recipients must be registered with the National Registry of Rehab Technology Suppliers (NRRTS) or have certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

Effective May 1, 2011, and thereafter, DME providers will no longer submit PA request for custom wheelchairs and custom wheelchair accessories for children age 0-20 using procedure code E1220. DME providers will be required to use valid procedure codes, from the DME Fee Schedule, when submitting prior authorization requests for custom wheelchairs and custom wheelchair accessories for children age 0-20, whenever possible. DME providers may use procedure code K0108 (wheelchair component or accessory, not otherwise specified), for wheelchair accessories that have no valid procedure code listed on the DME Fee Schedule.

14.4 Patient 1st Referrals

When filing claims for recipients enrolled in the Patient 1st program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

14.5 Cost-Sharing (Copayment)

Medicaid recipients are required to pay and suppliers are required to collect the designated copay amount for the rental/purchase of services, supplies, appliances, and equipment, including crossovers. The copayment does not apply to services provided for pregnant women, recipients less than 18 years of age, emergencies, surgical fees, and family planning. Native American Indians that present an “active user letter” issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

Added: Native American Indians…Medicaid required copayment.

The Medicaid DME Program requires copayment at the following rates:

Item	***Copay Amount***
Durable Medical Equipment, including crossovers	$3.90 for each item
Supplies and Appliances, including crossovers	$3.90 for items costing $50.01 or more $2.60 for items costing $25.01-$50.00 $1.30 for items costing $10.01-$25.00 $0.65 for items costing $10.00 or less
Iron Infusion Pump Repair	$ 3.90 for each Prior Authorization (PA) Number

Durable Medical Equipment, including crossovers
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Supplies and Appliances, including crossovers
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Deleted: ~~2.00~~
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Deleted: ~~1.00~~
Added: 1.30
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Iron Infusion Pump Repair
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The provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost-sharing amount imposed.

14.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

DME providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed on the Medical Medicaid/Medicare-related Claim Form.

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

14.6.1 Time Limit for Filing Claims

Medicaid requires all claims for DME to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

14.6.2 Diagnosis Codes

Effective June 1, 2008 DME providers may no longer bill using diagnosis code V729 on hard copy and electronically submitted claims. Providers will now be required to bill with specific diagnosis codes.

14.6.3 Procedure Codes and Modifiers

The medical supplies and appliances listed in Appendix P are available to eligible Medicaid recipients for use in their homes as prescribed by the attending physician and dispensed by a Medicaid contract provider.

For a complete listing of procedure codes and modifiers refer to Appendix P: Durable Medical Equipment (DME) Procedure Codes and Modifiers.

14.6.4 Place of Service Codes

The following place of service code applies when filing claims for DME:

POS	***Description***
12	Home

14.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

14.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
DME Procedure Codes and Modifiers	Appendix P

14.8 Non Oxygen DME Repairs (K0739, E1399)

K0739 – repair or no routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

Effective February 1, 2012, the allowable units for K0739 are 12.

However, providers must continue to submit justification when billing more than four units. Please include all units over four on the PA request for repairs. The request will be reviewed by Medicaid or its designee. The PA letter, in the Analyst Remarks section, will state the total units approved.

E1399 - durable medical equipment, miscellaneous

Replacement parts are reimbursed based on the procedure code and fee schedule pricing. In situations where there are no procedure codes or fee schedule reimbursement for the repair item(s), the provider must submit an itemized list of the needed repair items with invoice pricing for each item. Alabama Medicaid will reimburse for these repair items based on provider's invoice price plus 20%.

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15

15 Eye Care Services

Medicaid pays for certain eye care services provided by participating Optometrists, Opticians, and Ophthalmologists.

Ophthalmologists may refer to Chapter 28, Physician, for additional information.

Medicaid also contracts with a Central Source contractor who is responsible for providing lenses and frames for Medicaid recipients. At the option of the provider taking the frame measurements, eyeglasses may be obtained from the Central Source or from any other source. Medicaid will pay no more than the contract price charged by the Central Source. Sample kits are available (frames and display containers) which can be purchased by eye care practitioners at the contractor's cost of frames plus mailing. Effective July 1, 2011, the Central Source contractor is Korrect Optical. Korrect Optical began accepting eyeglass orders on Tuesday, September 6, 2011.

Korrect Optical's phone number is 1-800-624-4225 and the website address is www.korrect.com.

NOTE:
Procedure Codes and prices are effective for dates of service 8/1/2011 and thereafter. Please refer to provider manuals prior to the October edition for information on prices for dates of service prior to 8/1/2011.

The policy provisions for eye care providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 17.

15.1 Enrollment

HP enrolls eye care providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as an Eye Care provider is issued a 10-digit National provider Identifier (NPI) that enables the provider to submit requests and receive reimbursements for eye care related claims.

A provider who contracts with Alabama Medicaid as an eye care provider is added to the Medicaid system with the NPI provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for eye care related claims.

NOTE:
All nine digits are required when filing a claim.

Opticians are assigned a provider type of 19. Optometrists are assigned a provider type of 18. Valid specialties for Eye Care providers include the following:

Optician (190)

Optometrist (180)

Ophthalmologists are enrolled with a provider type of 31 (Physician). The valid specialty is Ophthalmologist (330).

Enrollment Policy for Eye Care Providers

To participate in Medicaid, eye care providers must have current certification and be licensed to practice in the state of Alabama, allowed by their licensing board and the laws of State of Alabama.

To prescribe therapeutic agents for the eye, the optometrist must be appropriately licensed by the Alabama Board of Optometry.

Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

(i) Eyeglasses,

(ii) Comprehensive Audiological services,

(iii) Comprehensive Ophthalmological services,

(iv) Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are offered to anyone for free. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

15.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

This section also discusses the types of eye examinations covered by Medicaid and describes the standards and procedures used to provide eyeglasses.

NOTE:

The Agency establishes annual benefit limits on certain covered services. Benefit limits related to eye care services are established every three calendar years for recipients 21 years of age or older. Therefore, it is imperative for Eye Care Providers/Contractors furnishing services to recipients 21 years of age and older, to verify benefit limits for four calendar years (last 3 and current year) to determine if the eye care benefit limits have been exhausted. Providers/Contractors who do not verify benefit limits for four calendar years (last 3 years and current year) for recipients 21 years of age and older risk a denial of reimbursement for those services. When the recipient has exhausted his or her benefit limit for a particular service, providers may bill the recipient.

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Added: 3

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Added: four calendar years (last 3 and current year)

NOTE:

Prior authorized (PA) frames, lenses, exams, and fittings are now posting to the benefit limits screen. It is imperative to verify eligibility and benefit limits prior to rendering services. Please refer to Chapter 3, Verifying Recipient Eligibility for details.

15.2.1 Examinations

Medicaid eye care providers may administer and submit claims for several kinds of examinations, including the following:

- Examination for refractive error
- Optometrist services other than correction of refractive error
- Physician services

Providers may render services to Medicaid recipients confined to bed in a health care facility if the patient's attending physician documents that the patient is unable to leave the facility and that the examination is medically necessary

Examination for Refractive Error

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Medicaid recipients 21 years of age and older are authorized one complete eye examination and work-up for refractive error every three calendar years. Recipients under 21 years of age are authorized the same service each calendar year or more often if documented medical necessity indicates.

Complete Eye Examinations

The appropriate procedure codes to use when filing claims for a complete eye examination and refractive error work-up are codes 92004 and 92014.

A complete eye examination and refractive error work-up includes the following services:

- Case history review
- Eye health examination
- Visual acuity testing
- Visual fields testing (if indicated)
- Tonometry
- Eyeglasses prescription (if indicated)
- Determination of optical characteristics of the lenses (refraction)

Examiners use the appropriate diagnosis code(s) to indicate the diagnosis.

NOTE:

For children, examination of eye tension and visual fields should be performed only if indicated.

NOTE:

Procedure 92002 and 92012 **do not** count against the recipient's eye exam limits. However, these codes **will** count against the 14 annual physician office visit limit.

Please refer to Section 15.5.3 for additional information.

Optometrist Services

Optometrists may provide services other than correction of refractive error as follows:

- During an eye examination, if the optometrist suspects or detects irregularities requiring medical treatment that is not allowed by state law to be provided by an optometrist, the optometrist refers the case to an appropriate doctor of medicine or osteopathy.
- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.

- Orthoptics (eye exercises) require prior authorization.
- Photochromatic lenses require prior authorization.
- Post-operative cataract patients may be referred, with the patient's consent, to an optometrist for follow-up care as permitted by state law. Refer any subsequent abnormal or unusual conditions diagnosed during follow-up care back to the ophthalmologist.
- Artificial Eyes

NOTE:
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.

Physician Services

Physicians may provide the following eye care services when diseases, injuries, or congenital defects are present:

- Contact lenses (when medically necessary for anisometropia, keratoconus, aphakia, and high magnification difference between lenses) require prior authorization.
- Orthoptics (eye exercises) require prior authorization.
- Eyeglass lens changes, within lens specifications authorized by Medicaid, may be supplied when needed because of visual changes due to eye disease, surgery, or injury, require prior authorization.
- Artificial Eyes

15.2.2 Eyeglasses

If a Medicaid recipient requires eyeglasses, services include verification of prescription, dispensing of eyeglasses, frame selection, procurement of eyeglasses, and fitting and adjustment of the eyeglasses to the patient.

Recipients 21 years of age and older are eligible for one pair of eyeglasses every three calendar years. Recipients under 21 years of age are authorized two pair of glasses each year if indicated by an examination, a prior authorization will be required for subsequent pairs requested in calendar year. These limitations also apply to fittings and adjustments.

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Any exception to these benefit limits must be based on medical necessity and the reasons documented in the medical record. Examples of medical necessity could be for treatment of eye injury, disease, significant prescription change, or unrepairable damage to glasses. Additional eyeglasses cannot be authorized for convenience but only for clearly documented medically necessary reasons. An example for convenience may be more than one (1) pair of eyeglasses.

At the option of the provider taking the frame measurements, either the Central Source or any other source may provide eyeglasses that conform to Medicaid standards. Medicaid will pay no more than the contract price charged by the Central Source.

Frame Standards

See Section 15.5.3, Procedure Codes and Modifiers, for frame procedure codes and contract prices.

The authorized frames, or frames of equal quality, are provided for Medicaid recipients at the contract prices shown on the list. Under normal circumstances, the date of service for eyeglasses is the same as the date of examination. All frames must meet American National Standards Index (ANSI) standards.

Lens Standards

Lens specifications are authorized at the specified contract price. See Section 15.5.3, Procedure Codes and Modifiers, for lens procedure codes and contract prices.

Lenses are composed of clear glass, plastic or polycarbonate unless prior authorized by Medicaid because of unusual conditions. All lenses must meet Food and Drug Administration (FDA) impact-resistant regulations and conform to ANSI requirements.

Spherical lenses must have at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (no other error) is 0.50 diopter.

New Lenses Only

Patients who have old frames that meet the above standards may have new lenses installed instead of receiving new eyeglasses. Medicaid will pay for the lens only.

Include the following statement in the patient’s record: "I hereby certify that I used this patient's old frames and that I did not accept any remuneration therefore."

New Frame Only

Patients who have old lenses that meet the above standards may have them installed in a new frame instead of receiving new eyeglasses.

Include the following statement on the patient’s record: "I hereby certify that I used this patient's old lenses and that I did not accept any remuneration therefore."

Patient Requests Other Eyeglasses

If a patient chooses eyeglasses other than those provided by Medicaid, the patient must pay the complete cost of the eyeglasses, including fitting and adjusting; Medicaid will not pay any part of the charge. To prevent possible later misunderstanding, the provider should have the patient sign the following statement for the patient's record: "I hereby certify that I have been offered Medicaid eyeglasses but prefer to purchase the eyeglasses myself."

Additional Eyeglasses and Eye Exams

If medically necessary, Medicaid may prior authorize additional eye exams and eyeglasses for treatment of eye injury, disease, significant prescription change, or other circumstances resulting in unusable glasses/lenses. The provider should forward an electronic PA request or an Alabama Prior Review and Authorization Request (Form 342) with a letter justifying necessity to HP prior to ordering the eyeglasses.

Replacement of Glasses

When a patient presents to your office requesting replacement of glasses for medically necessary reasons or unrepairable damage to glasses within the benefit limit period, the following instructions should be followed. Patients less than 21 years of age are authorized two pair of glasses each year if indicated by an examination. A prior authorization will be required for subsequent pairs requested in calendar year.

If this is a recent replacement and does not necessitate another eye exam, you are not required to perform another eye exam.

If the replacement reason is necessary due to warranty or workmanship reasons and within 90 days of the original issue of eyeglasses, contact Korrect Optical at 1-800-624-4225 for replacement at no cost.

Ordering Frames, Lenses and Eyeglasses

As provided in Section 15.2.2 above, providers may order eyeglasses from the Central Source, Korrect Optical, or any other source that conforms to Medicaid standards.

NOTE:

When the Central Source provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the Central Source may submit claims for these services.

15.3 Prior Authorization and Referral Requirements

The Medicaid program requires that Medicaid give authorization prior to the delivery or payment of certain eye care services. Refer to Chapter 4, Obtaining Prior Authorization, for information about requesting prior authorization.

Prior authorization from Medicaid is required for the following eye care services:

- Lens and frame change in same benefit period
- Orthoptic training (eye exercises)
- Additional comprehensive exams in same benefit period
- Photochromatic lenses
- Low vision aids
- Contact lenses (for anisometropia, keratoconus, aphakia, and high magnification difference between lenses)
- Progressive Lenses

All requests for prior authorization should include the following information:

1. Recipient's name
2. Recipient's Medicaid Number (thirteen-digits)
3. If the PA is requested due to a prescription change, past and current prescription data (complete for both eyes), including diagnosis code(s), is required

4. Exception requested (what is being requested)
5. Reason for exception (explain, e.g., cataract surgery date, etc…), with current justification
6. Signature of practitioner
7. Address of practitioner

Refer to Section 15.5.3, Procedure Codes and Modifiers, for the appropriate procedure codes for services requiring prior authorization.

Other Situations

Providers may render special services for unusual situations upon prior authorization. Medicaid must receive full, written information justifying medical necessity prior to the service being rendered. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

Patient 1st Referral Requirements

The following ranges of procedure codes (including routine vision exams, eyeglasses, fittings, and lenses) **do not require a referral** for Patient 1st recipients:

Procedure Code	***Description***
V0100-V2799	CMS Assignment of Vision Services
V2020	Eyeglasses, Frames
V2025	Eyeglasses, Special Order Frames
92002-92015	Ophthalmological services for new or established patients
92313	Corneoscleral lens
92315-92317	Corneal lens/Corneoscleral lens
92326	Replacement of lens

Refer to Chapter 39, Patient 1st, for more information on Patient 1st requirements.

Eyeglass Contractors

If the Central Source provides eyeglasses, send them a copy of the approval letter from Medicaid bearing the prior authorization number.

15.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

Deleted: ~~The copayment amount…and family planning.~~

Added: The copayment amount…for each procedure:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

Added: 90847, 90849, 90853… Medicaid required copayment.

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

15.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit

Eye care providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

This section explains how to file claims for the following situations:

- Eye examination only
- Eye examination and fitting by one provider, eyeglasses from the Central Source
- Fitting only, eyeglasses from the Central Source
- Post-operative care
- Ophthalmoscopy extended (92225) and subsequent (92226)
- Other situations

NOTE:

Providers who furnish services should only bill for those services provided. Please be aware when filing claims that the claim reflects services actually rendered/provided. Billing for services not provided could be considered fraudulent. Please ensure your billing staff is aware of appropriate billing practices.

Routine Checkups and Medicare

Medicare routinely covers eye care services for medical eye conditions (i.e. glaucoma, cataracts, diabetes, etc.). For dual eligibles (recipients with Medicare and Medicaid), Medicaid is the payer of last resort. For medical eye conditions, Medicare should be billed first for consideration of payment. Upon Medicare payment, the crossover form and information should be forwarded to HP for consideration of Medicaid payment. Should Medicare deny payment for a medical eye condition, seek all corrective Medicare remedies to ensure payment.

Medicare does not cover routine “Examination of Eyes and Vision” for a non medical reason. When non-medical and routine “Examination of Eyes and Vision” services are denied by Medicare, claims should be sent to the Medical Support unit at the Alabama Medicaid Agency within 120 days of the Medicare EOMB date. The claim must have Medicare denial attached. These claims require manual review for appropriateness and will be overridden when indicated.

Eye Examination Only

When the Medicaid recipient undergoes an eye examination only, the examiner completes a claim that specifies "Complete Eye Examinations and Refraction."

If services other than a "complete examination" are provided, the claim should reflect the appropriate optometric procedure code or office visit code. Refer to 15.5.3, Procedure Codes and Modifiers, for a list of possible procedure codes. Send this claim directly to HP.

Eye Examination and Fitting by One Provider, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs an eye examination (including refraction) and fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

1. The examiner completes the CMS-1500 claim form, separately identifying the examination, refraction, and fitting. The examiner does not bill lenses and frames.
2. The examiner forwards the Medicaid job order form reflecting all necessary prescription data, including frame required, to the Central Source.
3. The contractor fills the prescription and returns the eyeglasses to the examiner for delivery to the patient. The Patient or Authorized Signature box must be complete with the appropriate signature or the statement "Signature on file."
4. The Central Source contractor submits claims for payment to HP.

When eyeglasses are NOT procured from the Central Source contractor, the claim should separately specify charges for the examination performed, refraction, fitting, lenses, and frame.

When Opticians provide eyeglasses, the claim should identify only the fitting service, lenses, and frame. The claim is sent directly to HP. Lenses and frames are reimbursed at the Central Source contract prices.

Fitting Only, Eyeglasses from the Central Source Contractor

Use the following procedure when one provider performs a fitting (including frame service, verification, and subsequent service) and the Central Source contractor provides the eyeglasses.

The provider completes a claim that specifies the fitting services only. Send claims for payment directly to HP.

Post-Operative Care

Medicaid will not process post-operative management claims until the referring ophthalmologist has received payment for surgery. The surgeon must first submit a modifier 54 with the appropriate surgical code. The optometrist should then submit a modifier 55 with the appropriate surgical code after the ophthalmologist has been paid in order to be paid for post-operative care.

Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

NOTE:

The date of service for post operative care cannot be greater than 7 days after the global surgical procedure. For example, if the surgery was performed on 12/01, then the follow up must be performed on or before 12/8.

Ophthalmoscopy extended (92225) and subsequent (92226)

Ophthalmoscopy extended (92225) and subsequent (92226) are considered reasonable and necessary services for example, evaluation of tumors, retinal tears, detachments, hemorrhages, exudative detachments, retinal defects without detachment, and other ocular defects for the meticulous evaluation of the eye and detailed documentation of a severe ophthalmologic problem when photography is not adequate or appropriate. A serious retinal condition must exist, or be suspected, based on routine ophthalmoscopy which requires further detailed study. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. Accordingly, medical record documentation should be recorded in the patient's medical record.

15.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

15.5.2 Diagnosis Codes

The International Classification of Diseases Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

15.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed by Medicare

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

This section lists procedure codes for optometric services and equipment arranged by type of service or equipment:

- Common Optometric services
- Special Optometric services
- Contact lenses
- Eyeglasses codes

Services requiring prior authorization are identified in the Prior Authorization column (PA required).

To report intermediate, comprehensive, and special services, use the specific ophthalmological description.

Common Optometric Services

The Optometric Services listed below are those commonly used by Optometrists and Ophthalmologists. Procedure codes 92004 and 92014 should include a complete eye exam and work-up as outlined in Section 15.2.1.

Procedure Code	***Description***
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Comprehensive, established patient, one or more visits
92015	Determination of refractive state (Bill as an add-on charge with complete eye exam when refraction is accomplished)

Procedure Code	*Description*
99201	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A problem-focused history • A problem-focused examination; and • Straightforward medical decision making
99202	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components • An expanded problem-focused history • An expanded problem-focused examination; and • Straightforward medical decision making
99203	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A detailed history • A detailed examination; and • Medical decision making of low complexity
99204	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of moderate complexity
99205	New Patient: Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: • A comprehensive history • A comprehensive examination; and • Medical decision making of high complexity
99211	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A problem-focused history • A problem-focused examination • Straightforward medical decision making
99213	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • An expanded problem-focused history • An expanded problem-focused examination • Medical decision making of low complexity
99214	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A detailed history • A detailed examination • Medical decision making of moderate complexity
99215	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of high complexity

Miscellaneous Procedures

Procedure Code	*Description*
99241	Office consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99242	Office consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making
99251	Inpatient consultation for a new or established patient, which requires these three key components: • A problem focused history • A problem focused examination • Straightforward medical decision making
99252	Inpatient consultation for a new or established patient, which requires these three key components: • An expanded problem focused history • An expanded problem focused examination • Straightforward medical decision making

Special Optometric Services

Procedure Code	*Description*	*PA Required*
92018	Opthalmological examination and evaluation under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic evaluation	No
92019	Limited	No
92020	Gonioscopy (separate procedure)	No
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	No
92065	Orthoptic training and/or pleoptic training, with continuing medical direction and evaluation (requires prior authorization from Medicaid)	Yes
92071	Fitting of contact lenses for treatment of ocular surface disease	No
92072	Fitting of contact lenses for management of keratoconus, initial fitting	No
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent) For children: examination of eye tension and visual fields should be performed only if indicated.	No
92082	Intermediate examination (eg, at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	No
92083	Extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 300	No

Procedure Code	Description	PA Required
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)	No
92136	Opthalmic biometry by partial coherence interferometry with intraocular lens power calculation	No
92140	Provocative tests for glaucoma, with interpretation and report, without tonography	No
92225	Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial	No
92226	Subsequent	No
92230	Florescein angioscopy with interpretation and report	No
92250	Fundus photography with interpretation and report	No
92260	Opthalmolodynamometry	No
92270	Electro-oculography with interpretation and report	No
92275	Electroretinography with interpretation and report	No
92283	Color vision examination extended, e.g., anomaloscope or equivalent	No
92284	Dark adaptation examination with interpretation and report	No
92285	External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)	No
92340	Fitting of spectacles, except aphakia; monofocal	No
92341	Bifocal	No
92342	Multifocal, other than bifocal	No
92352	Fitting of spectacle prosthesis for aphakia; Monofocal	No
92353	Multifocal	No
92354	Fitting of spectacle mounted low vision aid; single element system	No
92355	Telescopic or other compound lens system	No
92358	Prosthesis service for aphakia, temporary (disposable or loan, including materials)	No
92370	Repair and refitting spectacles; except for aphakia	No
92371	Spectacle prosthesis for aphakia	No

Surgical Procedures

Procedure Code	Description
65205*	Removal of foreign body, external eye; conjunctival superficial
65210*	Conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating
65220*	Corneal, without slit lamp
65222*	Corneal, with slit lamp
68801*	Dilation of lacrimal punctum, with or without irrigation
68810*	Probing of nasolacrimal duct, with or without irrigation

* Service Includes Surgical Procedure Only

Post Operative Care Modifiers

Use the appropriate modifier identifying post-operative management when submitting claims.

1st Modifier	***Description***
55	Postoperative Management (Optometrist)
54	Surgical Care (Opthamologist)
2nd Modifier	***Description***
RT	Right Eye
LT	Left Eye

Contact Lenses

Contact lenses may be provided for post-cataract surgery, anisometropia, keratoconus treatment, and high magnification difference between lenses. Fitting services are billed as a separate billed item. Lenses are billed per lens. Prior authorization is required for lenses and fitting services.

Procedure Code	***Modifier, If Applicable***	***Description***	***PA Required***
V2501		Contact lens, PMMA, toric or prism ballast	Yes
V2502		Contact lens, PMMA, bifocal	Yes
V2503		Contact lens, PMMA, color vision deficiency	Yes
V2510		Contact lens, gas permeable, spherical	Yes
V2511		Contact lens, gas permeable, toric	Yes
V2512		Contact lens, gas permeable, bifocal, per lens	Yes
V2513		Contact lens, gas permeable, extended wear	Yes
V2520		Contact lens, hydrophilic, spherical	Yes
V2521		Contact lens, hydrophilic, toric	Yes
V2522		Contact lens, hydrophilic, bifocal	Yes
V2523		Contact lens, hydrophilic, extended wear	Yes
V2530		Contact lens, sclera, gas impermeable	Yes
V2531		Contact lens, gas permeable	Yes
V2599		Contact lens, other type	Yes
92310	52	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	Yes
92311		Corneal lens for aphakia, one eye	Yes
92312		Corneal lens for aphakia, both eyes	Yes
92313		Corneoscleral lens	Yes
92314		Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes except for aphakia	Yes
92315		Corneal lens for aphakia, one eye	Yes
92316		Corneal lens for aphakia, both eyes	Yes
92317		Corneoscleral lens	Yes
92325		Modification of contact lens (separate procedure), with medical supervision of adaptation	No
92326		Replacement of contact lens	Yes

Eyeglasses Codes

NOTE:

Procedure Codes and prices are effective for dates of service 8/1/2011 and thereafter. Please refer to provider manuals prior to the October edition for information on prices for dates of service prior to 8/1/2011.

At the option of the provider making the frame measurements, eyeglasses that conform to Medicaid standards may be procured from either the Central Source or from any other source. However, Medicaid will pay only the contract price charged by the Central Source.

Use the procedure codes and prices listed below for lenses. Add-on lens treatments requiring prior authorization are listed separately.

The lens specifications below are authorized at the specified contract price. Lenses must meet FDA impact-resistant regulations and must be made of glass or clear plastic except when other materials are prior authorized by Medicaid for unusual conditions. Spherical lenses must be at least a plus or minus 0.50 diopter. The minimum initial correction for astigmatism only (with no other error) is 0.50 diopter.

Procedure codes are listed in the following order:
Lens Codes

- Single vision sphere
- Single vision spherocylinder
- Bifocal sphere
- Bifocal spherocylinder
- Trifocal sphere
- Trifocal spherocylinder
- Variable Asphericity Lens
- Other lenses
- Lenses requiring prior authorization from Medicaid before ordering.

Single Vision Sphere (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2100 – Plano +/- 4.00	$11.00
V2101 – +/- 4.12 +/- 7.00d	11.00
V2102 – +/- 7.12 +/- 20.00d	13.00

Single Vision Spherocylinder (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2103 – Plano +/- 4.00d sphere, 0.12 – 2.00d cylinder	11.00
V2104 – Plano +/- 4.00d sphere, 2.12 – 4.00d cylinder	11.00
V2105 – Plano +/- 4.00d sphere, 4.25 – 6.00d cylinder	11.00
V2106 – Plano +/- 4.00d sphere, over 6.00d cylinder	13.00
V2107 – +/- 4.25 +/- 7.00 sphere, 0.12 – 2.00d cylinder	11.00
V2108 – +/- 4.25d +/- 7.00d sphere, 2.12 – 4.00d cylinder	11.00
V2109 – +/- 4.25 +/- 7.00d sphere, 4.25 – 6.00d cylinder	13.00
V2110 – +/- 4. 25– 7.00d sphere, over 6.00d cylinder	13.00
V2111 – +/- 7.25 +/- 12.00d sphere, 0.25 – 2.25d cylinder	13.00
V2112 –+/- 7.25 +/- 12.00d sphere, 2.25d – 4.00d cylinder	13.00
V2113 – +/- 7.25 +/- 12.00d sphere, 4.25 – 6.00d cylinder	13.00
V2114*– over plus or minus 12.00d	13.00

Single Vision (Plus or Minus)	***Price Per Lens***
V2199 – Not otherwise classified	15.00

Bifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	***Price Per Lens***
V2200 – Plano +/- 4.00d	$12.00
V2201 – +/- 4.12 +/- 7.00d	14.00
V2202 – +/- 7.12 +/- 20.00d	7.62

Bifocal Spherocylinder (Plus or Minus)

Bifocal Spherocylinder (Plus or Minus) Cylinder	***Price Per Lens***
V2203 – Plano – +/- 4.00d/0.12 – 2.00d cylinder	$12.00
V2204 – Plano – +/- 4.00/2.12 – 4.00d cylinder	12.00
V2205 – Plano – +/- 4.00 sphere, 4.25 – 6.00d cylinder	14.00
V2206 – Plano – +/- 4.00d sphere over 6.00d cylinder	14.00
V2207 – +/- 4.25 +/- 7.00d sphere, 0.12 – 2.00d cylinder	12.00
V2208 – +/- 4.25 +/- 7.00d sphere, 2.12 – 4.00d cylinder	14.00
V2209 – +/- 4.25 +/- 7.00d sphere, 4.25 – 6.00d cylinder	14.00
V2210 – +/- 4.25 +/- 7.00d sphere over 6.00d cylinder	25.00
V2211 – +/- 7.25 +/- 12.00d sphere, 0.25 – 2.25d cylinder	14.00
V2212 – +/- 7.25 +/- 12.00d sphere, 2.25 – 4.00d cylinder	14.00
V2213 – +/- 7.25 +/- 12.00d sphere, 4.25 – 6.00d cylinder	14.00
V2214* –over plus or minus 12.00d	14.00

Trifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	***Price Per Lens***
V2300 – Sphere Plano- +/- 4.00d	$25.00
V2301 – Sphere- +/- 4.12 - +/- 7.00d	25.00
V2302 – Sphere Plano- +/- 7.12 - +/- 20.00	25.00

Trifocal Spherocylinder (Plus or Minus)

V2303 – Spherocylinder Plano +/- 4.00d sphere 0.12-2.00d cylinder	25.00
V2304 – Spherocylinder Plano +/- 4.00d sphere 2.25 – 4.00d cylinder	25.00
V2305 – Spherocylinder Plano +/- 4.00d sphere 4.25 – 6.00d cylinder	25.00
V2306 – Spherocylinder Plano +/- 4.00d/over 6.00d cylinder	25.00
V2307 – Spherocylinder +/- 4.25 +/- 7.00d sphere 0.12 – 2.00d cylinder	25.00
V2308 – Spherocylinder +/- 4.25 +/- 7.00d sphere 2.12 – 4.00d cylinder	25.00
V2309 – Spherocylinder +/- 4.25 +/- 7.00d sphere 4.25 – 6.00d cylinder	25.00
V2310 – Spherocylinder +/- 4.25 +/- 7.00d sphere over 6.00d cylinder	25.00
V2311 – Spherocylinder +/- 7.25 +/- 12.00d sphere 0.25 – 2.25d cylinder	25.00
V2312 – Spherocylinder +/- 7.25 +/- 12.00d sphere 2.25 – 4.00d cylinder	25.00
V2313 – Spherocylinder +/- 7.25 +/- 12.00d sphere 4.25 – 6.00d cylinder	25.00
V2314 - Spherocylinder trifocal Over +/- 12.00d	25.00

Varible Asphericity Lens

Variable Asphericity Lens	*Price Per Lens*
V2410 – Variable asphericty lens, single vision	$10.00
V2430 – Variable sphericity lens, bifocal	$10.00

Other Lenses

Other	*Price Per Lens*
V2115 – Lenticular (Myodisc)	$14.00
V2118 - Aniseikonic lens, single vision	40.00
V2121 – Lenticular lens, per lens, single	13.00
V2215 - Lenticular (Myodisc) Bifocal	30.00
V2218 – Lens Aniseikonic Bifocal	30.00
V2219 – Lens Bifocal Seg Width Over 28mm	5.00
V2220 – Bifocal add over 3.25d	10.00
V2221 – Lenticular lens, per lens, bifocal	30.00
V2299 –Specialty Bifocals see note box below	14.00
V2315 – Lenticular, (myodisc), per lens, trifocal	35.00
V2318 – Aniseikonic lens, trifocal	35.00
V2319 – Trifocal seg width over 28 mm	5.00
V2320 – Trifocal add over 3.25d	10.00
V2321 – Lenticular lens, per lens, trifocal	35.00
V2399 – Specialty Trifocals see note box below	25.00
V2499 – Variable Asphericity	10.00
V2700 – Balance lens	10.00
V2710 – Slab-off Prism**	30.00
V2715 – Prism**	0.00
V2718 – Press On Fresnell Prism **	30.00
V2745 – Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic**	0.00
V2755 – UV 400 Coating**	0.00
V2784 – Polycarbonate Lenses, or equal**	0.00

NOTE:

1. Effective August 1, 2011 Procedure Code V2784 (Polycarbonate Lens) is an add-on code and should be billed in addition to another lens code for the same eye.
2. Medical record documentation should support the medical appropriateness of billing procedures V2299 and/or V2399. These services are subject to post payment review.

Lenses Requiring Prior Authorization from Medicaid Before Ordering

Lens	*Price per Lens*
V2744 – Tint, Photochromatic **	$25.00
V2781 - Progressive Lens - CR-39** (effective July 1, 2002)	10.00
V2782 - Lens, Index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate **	10.00
V2783 - Lens, Index >1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate **	20.00

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

Frames

The frame specifications below are authorized at the specified contract price.

Effective July 1, 2002, the locally assigned procedure codes for frames are converted to one of two codes (PC), V2020 and V2025.

A special order frame is designated as V2025 and effective for dates of service 8/1/2011 and thereafter should be billed as $100.00.

Procedure code V2020 is designated for all the other frame codes and effective for dates of service 8/1/2011 and thereafter; $0.00 should be billed.

NOTE:

As of 8/1/2011, the price of the frame is included in the cost of the lens. Therefore, frames are zero priced.

For the available selection of frames, please refer to Korrect Optical's website at www.korrect.com.

Special Order Frame (Size, Type) - Providers should bill the price of the frame in this manual and not their usual and customary price for the frame

Frame	*Code Description*	*Price*
V2025	Special Order Frames *(**PA REQUIRED**)*	$100.00

15.5.4 Place of Service Codes

The following place of service codes apply when filing claims for eye care services:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility

15.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances.

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

15.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.7.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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16 Federally Qualified Health Centers (FQHC)

A Federally Qualified Health Center (FQHC) is a health care center that meets one of the following requirements:

- Receives a grant under Section 329, 330, 340, or 340A of the Public Health Services Act
- Meets the requirements for receiving such a grant as determined by the Secretary based on the recommendations of the Health Resources and Services Administration within the Public Health Service
- Qualifies through waivers of the requirements described above as determined by the secretary for good cause
- Functions as outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-determination Act

The policy provisions for FQHC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 48.

16.1 Enrollment

HP enrolls FQHC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a FQHC provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable~~s~~ the provider to submit requests and receive reimbursements for FQHC-related claims.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

NOTE:
The 10-digit NPI is required when filing a claim.

FQHC facilities are assigned a provider type of 56 (FQHC) and the valid specialty is 080 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the rendering NPI (Block 24J) on the CMS-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual NPIs that are linked to the FQHC number. Each of these providers is assigned a provider type of 56 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to specialty table below)
- 095 (Certified Nurse Midwife)
- 093 (Certified Registered Nurse Practitioner)
- 100 (Physician Assistant)

Specialty (Applicable for physicians only)	***Code***
Allergist	310
Anesthesiologist	311
Cardiologist	312
Cardiovascular Disease	313
Cochlear implant team	740
Colon and rectal surgery	750
Dermatologist	314
EENT	760
Emergency medicine Practitioner	315
Endocrinologist	770
EPSDT	560
Family practitioner	316
Gastroenterologist	317
General Dentistry	271
General practitioner	318
General surgeon	319
Geriatric Practitioner	320
Hand Surgeon	321
Hematology	780
Infectious diseases	790
Internal medicine	800
Mammography	292
Neonatologist	323
Nephrologist	324
Neurological surgeon	325
Neurologist	326
Nuclear medicine Practitioner	327
Nutritionist	230
Obstetrician/Gynecologist	328
Oncologist	329
Ophthalmologist	330
Oral Surgeon	272
Orthopedic	810
Orthopedic surgeon	331
Otologist	332
Laryngologist	332
Rhinologist	332
Pathologist	333
General Pediatrician	345
Plastic Surgeon	337

Specialty (Applicable for physicians only)	*Code*
Referring Provider only	820
Proctologist	338
Psychiatrist	339
Pulmonary Disease Specialist	340
Radiology	341
Rheumatology	830
Thoracic surgeon	342
Urologist	343
Vascular surgeon	313

Enrollment Policy for FQHC Providers

To participate in the Alabama Medicaid Program, FQHC providers must meet the following requirements:

- Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter
- Submit a budgeted cost report for its initial cost reporting period
- Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification
- Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites

Provider contracts are valid for the time of the grant award period, and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to Medicaid as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the *Alabama Medicaid Agency Administrative Code* Rule No. 560-X-48-01 have been met.

The effective date of enrollment will be the first day of the month in which the Medicaid enrollment application was received and the termination date will be 60 days beyond the end date of the budget period on the Grant Award Notice.

FQHCs approved for enrollment will be issued a provider agreement for the services for which they agree to provide. This agreement must be signed and returned to Medicaid within 30 days of the date mailed to the provider. Names of satellite center(s) are indicated in the provider agreement.

NOTE:

FQHC's wishing to enroll a Mobile Dental Clinic, you do not have to enroll the clinic with Medicaid. You will need to submit a request to HP Provider Enrollment to add the mobile provider specialty (299) to your existing provider file along with a copy of your certification received from the Alabama Dental Board. **When filing claims for mobile dental services please indicate your place of service as 15.**

Complete guidelines for mobile dental clinics are in Provider Manual Chapter 13 (Dental)

NOTE:

Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants associated with the clinic must also complete enrollment applications.

FQHCs are required to notify HP in writing within five state working days of any of the following changes:

- Losing FQHC status
- Any changes in dates in the FQHC grant budget period
- Opening(s) and/or closing(s) of any satellite center(s)
- Additions or terminations of providers

Patient 1st Requirements for Federally Qualified Health Centers (FQHC)

- The clinic must be a licensed, federally recognized FQHC clinic, enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, patient management, 24 hour coverage, and other program requirements.
- The FQHC clinic (and/or site) must be opened a minimum of 40 hours per week and the physician must practice at that location a minimum of 40 hours per week to be considered a full time equivalent (FTE).
- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of total patient caseload will be allowed, based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension.
- The FQHC clinic must specify what arrangements have been made for hospital admissions. If the physicians within the FQHC clinic do not have admitting privileges, then a designee must be specified. If the FQHC clinic/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees, including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.

Change of Ownership

Medicaid must be notified within 30 calendar days of the date of a FQHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency.

16.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

NOTE:

FQHC physicians should refer to Chapter 28, Physician, for additional information.

16.2.1 Benefits

Services provided by an FQHC include medically necessary diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurses, or clinical social worker; and services and supplies incidental to such services as would otherwise be covered if furnished by a physician. Any other ambulatory services offered by the center that are included in the State Plan are covered except for home health. Home Health services are excluded as an FQHC service because home health services are available on a state wide basis.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP can not make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

16.2.2 Limitations

Home health services are excluded as an FQHC service because home health services are available on a statewide basis.

Reimbursement for other ambulatory services covered by the State Plan includes but is not limited to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals under age 21, family planning, prenatal, and dental for individuals under age 21. These services are subject to policies and routine benefit limitations for the respective program areas. These services do not count against the routine benefit limits for medical encounters.

FQHC clinic visits, outpatient, and inpatient services are subject to the same routine benefit limitations as physician visits. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

16.2.3 Reimbursement

FQHC services and other ambulatory services provided at the FQHC including satellite center(s) will be reimbursed by an all-inclusive encounter rate. Refer to the *Alabama Medicaid Agency Administrative Code*, Chapter 56, for details.

Reimbursement for an enrolled out-of-state FQHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state FQHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

NOTE:

Since FQHC providers are reimbursed by an all inclusive encounter rate, FQHC providers will not receive the case management fee paid to Patient 1st providers nor the capitation fee for lock in recipients.

Costs Reimbursed by Other Than FQHC Encounter Rate

Costs reimbursed by other Medicaid programs are not reimbursed in the FQHC Program. Examples of such reimbursements include, but are not limited to:

- Maternity care, primary contractor
- Prescription drugs by enrolled pharmacy providers
- Surgical procedures performed in place of service 21 (inpatient) or 22 (outpatient) will be reimbursed fee-for-service

NOTE:

For Non-Plan First patients, the dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Plan First recipients who choose to use oral contraceptives (OCPs), the contraceptive patch or vaginal ring and are seeing providers at a Federally Qualified Health Center (FQHC) will have the option of obtaining these supplies from the FQHC or a Medicaid enrolled community/outpatient pharmacy. In order to fill a prescription at a community/outpatient pharmacy, the Plan First-eligible patient must have received the prescription from their Plan First provider. A 30 day supply is the maximum that may be dispensed at one time.

Effective November 1, 2009, the Plan First Contraceptive Order Form was discontinued.

FQHC's will provide and bill for oral contraceptives, the contraceptive patch and the vaginal ring using their NPI. Covered services using this NPI are limited to the following procedure codes with modifier:

- S4993 FP Oral Contraceptives
- J7304 FP Contraceptive Patch
- J7303 FP Contraceptive Ring

These services are limited to 13 units annually and **should be billed for Plan First recipients only.**

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

NOTE:

Effective 5/1/2012, Federally Qualified Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena ® - J7302

Paragard ® – J7300

Implanon ® - J7307

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

1st Look- The Oral Health Risk Assessment and Dental Varnishing Program

Effective January 1, 2009 Medicaid will cover the application of fluoride varnishes for children 6 months through 35 months of age who have a moderate to high caries risk based on the risk assessment by Patient 1st medical providers and their clinical staff (RNs, PAs, Nurse Practitioners, LPNs). This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals, a specialty indicator will be added to the provider file in order for the provider to receive reimbursement.

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

NOTE:

Costs for Maternity Care sub-contractors are not an allowable cost and are shown only in the non-reimbursable section of the cost report.

16.2.4 Encounters

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

This does not apply to dental service, however. Dental services are limited to one dental encounter per date of service. A patient can have one dental encounter and one other encounter on the same day. **Please refer to Dental Provider Manual Chapter 13 for additional Dental guidelines.**

Encounters are classified as billable or non-billable.

Billable encounters are visits for face-to-face contact between a patient and a health professional in order to receive medically necessary services such as lab services, x-ray services (including ultrasound and EKG), dental services, medical services, EPSDT services, family planning services, and prenatal services. Billable encounters are forwarded to HP for payment through the proper filing of claims forms. Billable services must be designated by procedure codes from the Physicians Current Procedure Terminology (CPT) or by special procedure codes designated by Medicaid for its own use.

Non-billable encounters are visits for face-to-face contact between a patient and health professional for services other than those listed above (i.e., visits to social worker, LPN). Such services include, but are not limited to, weight check only or blood pressure check only. Non-billable encounters cannot be forwarded to HP for payment.

16.3 Prior Authorization and Referral Requirements

FQHC procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

16.4 Cost Sharing (Copayment)

Deleted: ~~**$1.00**~~

Added: **$3.90**

Added: Native American Indians…Medicaid required copayment.

The copayment amount is **$3.90** per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an “active user letter” issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible recipient because of the recipient’s inability to pay the cost-sharing (copayment) amount imposed.

16.5 Medicare Co-insurance

For Federally Qualified Health Centers, Medicaid pays the Medicare co-insurance up to the encounter rate established by Medicaid.

16.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

FQHC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

NOTE:

Physicians, Certified Registered Nurse Practitioners, and Physician Assistants bill using their own NPI on Block 24J of the CMS-1500 claim form. Enter the clinic's number in Block 33 in the GRP # portion of the field. Please refer to Section 5.2.2, CMS-1500 Claim Filing Instructions, for more information.

16.6.1 Time Limit for Filing Claims

Medicaid requires all claims for FQHC providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

16.6.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

16.6.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Refer to Appendix H, Alabama Medicaid Injectable Drug Listing.

Claims without procedure codes or with codes that are invalid will be denied. Medicaid recognizes modifiers when applicable. Both CPT and CMS level codes will be recognized. The (837) Professional, Institutional and Dental electronic claims and the paper claims have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Nurse Practitioners/Physician Assistants

Covered services for FQHC-employed nurse practitioners and physician assistants are limited to the following:

- VFC codes, as specified in Appendix A, EPSDT
- Injectable drug codes, as specified in Appendix H, Alabama Medicaid Injectable Drug List
- Laboratory codes for which the clinic is certified to perform
- CPT codes as specified in Appendix O, CRNP and PA Services

Effective January 1, 1998, services provided by Registered Nurses (RNs) employed in a FQHC will be reimbursed only under the FQHC site name and number. Reimbursable services provided by an RN in an FQHC are restricted to the following:

Procedure Codes	***Description***
99205-FP	Family Planning, initial visit
99214-FP	Family Planning, annual visit
99213-FP	Family Planning, periodic revisit
99212-FP	Family Planning, expanded counseling visit

Procedure Codes	Description
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Initial EPSDT, Normal, under 1 year of age Initial EPSDT, Normal, 1-4 years of age Initial EPSDT, Normal, 5-11 years of age Initial EPSDT, Normal, 12-17 years of age Initial EPSDT, Normal, 18-20 years of age
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Initial EPSDT, abnormal, under 1 year of age Initial EPSDT, abnormal, 1-4 years of age Initial EPSDT, abnormal, 5-11 years of age Initial EPSDT, abnormal, 12-17 years of age Initial EPSDT, abnormal, 18-20 years of age
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Periodic EPSDT, normal, under 1 year of age Periodic EPSDT, normal, 1-4 years of age Periodic EPSDT, normal, 5-11 years of age Periodic EPSDT, normal, 12-17 years of age Periodic EPSDT, normal, 18-20 years of age
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Periodic EPSDT, abnormal, under 1 year of age Periodic EPSDT, abnormal, 1-4 years of age Periodic EPSDT, abnormal, 5-11 years of age Periodic EPSDT, abnormal, 12-17 years of age Periodic EPSDT, abnormal, 18-20 years of age
*99391	Interperiodic Screening, Infant age- below 1 year old
*99392	Interperiodic Screening, Early Childhood-age 1 thru 4 years
*99393	Interperiodic Screening, Late Childhood-age 5 thru 11 years
*99394	Interperiodic Screening, Adolescent-age 12 thru 17 years
*99395	Interperiodic Screening-age 18 thru 20 years
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen

* Must be approved by the Alabama Medicaid Agency to provide these services.

Vaccines For Children (VFC)

The Department of Public Health provides vaccines at no charge to Medicaid providers enrolled in the Vaccines For Children (VFC) Program as recommended by the Advisory Committee on Immunization.

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

16.6.4 Place of Service Codes

The following place of service codes apply when filing claims for FQHC services:

POS	Description
11	Office
12	Home
15	Mobile Dental Clinic
21	Inpatient Hospital
22	Outpatient Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
54	Intermediate Care/Facility/Mentally Retarded

NOTE:

Outpatient surgery, outpatient hospital visits, and nursing facility visits should be billed using the FQHC number for the physician rendering services. Do not bill these services on the same claim as other FQHC services.

16.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

16.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Alabama Medicaid Injectable Drug List	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

17

17 Home Health

Medicaid provides home health care services to all Medicaid-eligible persons of any age, who meet the admission criteria, based on a reasonable expectation that a patient's medical, nursing, and social needs can adequately be met in the patient's home.

To be eligible for home health care, a recipient must meet the following criteria:

- The recipient's illness, injury, or disability prevents the recipient from going to a physician's office, clinic, or other outpatient setting for required treatment; as a result, he or she would, in all probability, have to be admitted to the hospital or nursing home because of complications arising from lack of treatment.
- The recipient is unable to function without the aid of supportive devices, such as crutches, a cane, wheelchair or walker; requires the use of special transportation or the assistance of another person.

The patient's attending physician must certify the need for home health services and provide written documentation to the home health provider regarding the recipient's condition which justify that the patient meets home health criteria. The physician must re-certify care every 60 days if home services continue to be necessary. The attending physician must be a licensed, active Medicaid provider.

The policy provisions for home health providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 12.

17.1 Enrollment

HP enrolls home health providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

To become a home health provider, a provider must be a public agency, private non-profit organization, or proprietary agency primarily engaged in providing part-time or intermittent skilled nursing and home health aide services to patients in their homes. Only in-state home health agencies are eligible for participation in Medicaid.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a home health provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for home health-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Home health providers are assigned a provider type of 5 (Home Health). The valid specialty for home health providers is 050 (Home Health).

Enrollment Policy for Home Health Providers

To participate in Medicaid, home health providers must meet the following requirements:

- Be certified to participate as a Medicare provider
- Be certified by the Division of Licensure and Certification of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

17.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

17.2.1 Covered Services

Registered Nurse Services (RN)

If ordered by the patient's attending physician, a registered nurse employed by a certified home health agency can provide part-time or intermittent nursing services to a patient.

- The RN is responsible for a nursing care plan, which is made in accordance with the physician's written plan of care.
- Restorative, preventive, custodial and maintenance, and supportive services are covered.

Licensed Practical Nurse Services (LPN)

If ordered by a patient's attending physician, a licensed practical nurse, supervised by an RN employed by a participating home health agency, can provide intermittent or part-time nursing services to the patient when assigned by the RN.

LPN services are provided in accordance with existing laws governing the State Board of Nursing.

Home Health Aide or Orderly Services

A home health aide or orderly can provide personal care and services as specified in the attending physician’s plan of treatment.

Supervisory visits by the registered nurse must be performed at least every 60 days when services are provided by the LPN, home health aide, or orderly. These services may be provided on a part-time basis only and must be ordered by the attending physician. The RN who is responsible for the care of the patient must supervise the service.

17.2.2 Noncovered Services

There is no coverage under the Medicaid Home Health Care plan for visits by paramedical personnel, physical therapists, speech therapists, occupational therapists, and inhalation therapists for recipients 21 years of age or older.

Medicaid also does not cover sitter service, private duty nursing service, medical social workers, or dietitians except for recipients under 21 years of age.

Supervisory visits made by an RN to evaluate appropriateness of services being rendered to a patient by an LPN, aide, or orderly are considered administrative costs and may not be billed as skilled nursing services. The registered nurse will provide and document in the case record on-site supervision of the LPN, home health aide, or orderly at least every 60 days. The registered nurse will conduct on-site supervision more frequently if warranted by complaints or suspicion of substandard performances by the worker.

17.2.3 Visits

A visit is a personal contact in the place of residence of a patient by a health worker employed by a certified Medicaid home health agency for the purpose of providing a covered service.

Home health care visits to Medicaid recipients must be medically necessary and provided in accordance with a Medicaid Home Health Certification form signed by a licensed physician. Home Health records are subject to on-site audits and desk reviews by the professional staff of Medicaid.

If a Medicaid recipient receiving home health visits is institutionalized and is referred to home health upon discharge from the institution, a new Medicaid Home Health Certification form must be completed and retained by the home health agency.

NOTE:

Home health care visits, including nurse aide visits, are limited to 104 per calendar year. Nurse aide visits are restricted to two visits per week.

17.2.4 Medicare/Medicaid Eligible Recipients

Persons eligible for Medicare and Medicaid are entitled to all services available under both programs, but a claim must be filed with Medicare if Medicare covers the services. A patient may not receive home visits under both programs simultaneously. If Medicare terminates coverage, Medicaid may provide visits.

17.3 Prior Authorization and Referral Requests

Therapy services are limited to EPSDT recipients and must be prior authorized. Additional skilled nursing visits and home health aide visits are limited to EPSDT and must be prior authorized once the recipient has exceeded 104 home health visits in a calendar year. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

17.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by home health providers.

17.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Home health providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

17.5.1 Time Limit for Filing Claims

Medicaid requires all claims for home health to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

17.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

17.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American

Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes apply when filing claims for home health services. Include these procedure codes on bill type 33X (Outpatient):

Physical Therapy - Supervised

Revenue Code	*Procedure Code*	*Description*
420	97001	Physical Therapy evaluation
420	97002	Physical Therapy re-evaluation
420	97010	Application of a modality to one or more areas; hot or cold packs
420	97012	traction, mechanical
420	97014	electrical stimulation (unattended)
420	97016	vasopneumatic devices
420	97018	paraffin bath
420	97022	whirlpool
420	97024	diathermy
420	97026	infrared
420	97028	ultraviolet

Physical Therapy - Constant Attendance

Revenue Code	*Procedure Code*	*Description*
420	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
420	97033	iontophoresis, each 15 minutes
420	97034	contrast baths, each 15 minutes
420	97035	ultrasound, each 15 minutes
420	97036	Hubbard tank, each 15 minutes

Physical Therapy Therapeutic Procedures

Revenue Code	*Procedure Code*	*Description*
420	97110	Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
420	97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
420	97113	aquatic therapy with therapeutic exercises
420	97116	gait training (includes stair climbing)
420	97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
420	97140	Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
420	97150	Therapeutic procedure(s), group (2 or more individuals)
420	97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
420	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
420	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Revenue Code	Procedure Code	Description
420	97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes (requires Prior Authorization)
420	97542	Wheelchair management, propulsion training, each 15 minutes
420	97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

Occupational Therapy - Supervised

Revenue Code	Procedure Code	Description
430	97010	Application of a modality to one or more areas; hot or cold packs
430	97018	paraffin bath
430	97022	whirlpool

Occupational Therapy - Constant Attendance

Revenue Code	Procedure Code	Description
430	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

Occupational Therapy Therapeutic Procedures

Revenue Code	Procedure Code	Description
430	97110	Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
430	97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
430	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
430	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
430	97537	Community/work reintegration training (eg, shopping, transportation, money management, a vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-to-one contact by provider, each 15 minutes

Orthotics

Revenue Code	Procedure Code	Description
420 or 430	L3650 – L3995	Orthotics
420 or 430	L4205 – L4210	Orthotics repair
420 or 430	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or truck, each 15 minutes
420 or 430	97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
420 or 430	97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Speech Therapy

Revenue Code	*Procedure Code*	*Description*
440	92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
440	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
440	92620	Evaluation of central auditory function, with report; initial 60 minutes
440	92621	Evaluation of central auditory function, with report; each additional 15 minutes
440	92626	Evaluation of auditory rehabilitation status; first hour
440	92627	Evaluation of auditory rehabilitation status; each additional 15 minutes (list separately in addition to code for primary procedure)
440	92630	Auditory rehabilitation; pre-lingual hearing loss
440	92633	Auditory rehabilitation; post-lingual hearing loss

Other Home Health Services

Revenue Code	*Procedure Code*	*Description*
551	S9124	Nursing care in the home by LPN; per hour
551	S9123	Nursing care in the home by RN; per hour
571	S9122	Home Health aide or CNA providing care in the home; per hour

NOTE:

Claims for Therapy Services (PT, OT, ST) may be span billed. However, providers must indicate on each detail line the date the procedure was performed instead of noting the total number of units.

Billing for Supplies

Home health providers must enroll as a DME provider to bill for supplies. Supplies may not be billed on a UB-04 claim form.

17.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04claim form.

17.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

17.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

18

18 Hospice

Hospice is an interdisciplinary program of palliative care and supportive services that address the physical, spiritual, psychosocial and economic needs of terminally ill patients and their families. This care may be provided in the patient's home or in a nursing facility, if that is the recipient's place of residence.

The Alabama Medicaid Hospice Care Services Program began October 1, 1990, in order to help people who meet the criteria for hospice services remain in their homes.

Medicaid offers hospice care services to Medicaid-eligible recipients who are terminally ill as certified by the medical director of the hospice, or by the physician member of the hospice inter-disciplinary group and the individual's attending physician, if present. An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Hospice care consists of services necessary to relieve or reduce symptoms of the terminal illness and related conditions.

Medicaid hospice care services are subject to Medicare special election periods applicable to hospice care. Medicaid uses the most recent benefit periods established by the Medicare Program.

Effective June 16, 2005, all Hospice Providers are required to use criteria specific to the Medicaid program to determine medical necessity for recipients electing the hospice benefit when Medicaid is the primary payor. Providers should no longer use the Palmetto GBA Medicare Local Medical Review Policy (LMRP) to determine medical necessity for the hospice program when Medicaid is the primary payor for the hospice services. Providers should continue to use the Palmetto GBA LMRP for dually eligible recipients with Medicare Part A who reside in the community or a nursing facility because Medicare is considered the primary payor for these individuals. The Medicaid hospice criteria should be used to establish eligibility for the following categories of hospice recipients:

- All recipients with full Medicaid benefits
- All recipients with Medicaid and Medicare Part B
- All recipients who are Qualified Medicare Beneficiaries (QMBs) with full Medicaid coverage.

The policy provisions for Hospice providers can be found in Chapter 51 of the *Alabama Medicaid Agency Administrative Code,* and on the agency website *at* www.medicaid.alabama.gov. For diagnoses not found in the Alabama Medicaid Agency Administrative Code for cases with evidence of other co-morbidities and the evidence of rapid decline and for pediatric cases medical necessity review will be conducted on a case-by-case basis.

18.1 Enrollment

HP enrolls hospice providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a hospice provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hospice-related claims.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

NOTE:
The 10-digit NPI is required when filing a claim.

Hospice providers are assigned a provider type of 06(Hospice). Valid specialties for hospice providers include Hospice (060).

Enrollment Policy for Hospice Providers

To participate in Medicaid, hospice providers must meet the following requirements:

Receive certification from the Centers for Medicare and Medicaid Services that the hospice meets the conditions to participate in the Medicare program.

- Possess a letter from the state licensing unit showing the permit number and effective date of the permit
- Possess a document from the licensing unit showing that the hospice meets requirements for the Medicare program
- Possess a signed document indicating that the hospice is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Possess a copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved Medicare reimbursement rate, the fiscal year end, and the NPI
- The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.
- Multiple location means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice who is issued the certification number.
- **A multiple location must meet all of the conditions of participation applicable to hospices.**

18.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Hospice providers must establish and maintain a written plan of care for each individual admitted to a hospice program. All services provided by the hospice must adhere to the plan. When discharging a recipient, hospice providers must follow state and federal guidelines (Code of *Federal Regulations* § 418.26 Discharge from Hospice Care).

Added: When discharging a…from **Hospice Care).**

Added: If the hospice…for auditing purposes.

The hospice must submit required hospice election and physician certification documentation to Medicaid, or its designee, for coverage of hospice care. If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing or incomplete, etc.), the provider will receive a letter requesting the additional information. If the additional information is not received within 30 days, the application will be denied. This information shall be kept on file and shall be made available to the Alabama Medicaid Agency for auditing purposes.

18.2.1 Physician Certification

The hospice provider must obtain physician certification that the individual recipient is terminally ill.

For the first period, the hospice provider must obtain written certification statements signed by the medical director of the hospice or the physician member of the interdisciplinary team and the recipient's attending physician, if present. The hospice must obtain physician certification no later than two calendar days after hospice care begins.

If the hospice provider does not obtain written certification as described, the hospice may obtain verbal certification within the two-day period, but must obtain written certification no later than 30 calendar days after care begins. If every effort is made to secure written certification within 30 calendar days and the hospice provider has not obtained the written certification, then a physician signature obtained by fax will meet the certification requirement. Written certification must be secured and retained in the client record within 30 days of the hospice election.

For each subsequent period, the hospice must obtain a written certification prepared by the medical director of the hospice or the physician member of the interdisciplinary team. The hospice must obtain physician certification no later than two calendar days after the period begins.

Each written certification must indicate that the recipient's medical prognosis is such that his or her life expectancy is six months or less. The hospice must retain these certification statements.

Signature Requirement

Under Alabama's Uniform Electronic Transactions Act, effective January 1, 2002, Alabama law recognizes the validity of electronic signatures. For all Medicaid Hospice Forms, the signature must be an original signature or an approved electronic signature of the recipient's attending physician. Provider certification is made via standardized electronic signature protocol.

18.2.2 Election Procedures

In order to receive hospice care benefits, an individual must qualify for Medicaid and be certified as terminally ill by a doctor of medicine or osteopathy.

An election period is a predetermined timeframe for which an individual may elect to receive medical coverage of hospice care. Individuals may receive hospice care for two 90-day election periods, followed by an unlimited number of subsequent periods of 60 days each.

An individual eligible for hospice care must file an election certification statement with a particular hospice. Beginning April 1, 2005, all Hospice providers must complete the Medicaid Hospice Election and Physician's Certification Form 165 to certify Medicaid recipients for the hospice program. The Medicaid Agency will recognize the Medicare election form as election for both Medicare and Medicaid for dually eligible recipients receiving hospice services. When a dually eligible recipient enters the nursing facility the Hospice Recipient Status Change Form 165B must be completed and returned to the Alabama Medicaid Agency, or its designee. Hospice providers must also use this form to report subsequent changes for all hospice recipients during the hospice certification period. Due to the terminally ill individual's mental or physical incapacity, a representative may be authorized to file an election.

An election to receive hospice care is considered to continue from the initial election period through the subsequent election periods without a break in care as long as the following criteria are met:

- Recipient remains in the care of a hospice
- Recipient does not revoke the election provisions
- Recipient is not discharged from the hospice under the provisions of §418.26.

An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day periods. If an individual revokes the hospice election, any days remaining in that election period are forfeited. An individual or representative may not designate an effective date earlier than the date that hospice care begins. A Medicaid beneficiary who resides in a nursing facility may elect to receive hospice services. The hospice must have a contract with the nursing facility that clearly states which services each has responsibility to provide and details how the nursing facility and hospice will work together.

18.2.3 Medical Records

The hospice has the responsibility to establish and maintain a permanent medical record for each patient that includes the following:

- Physician certifications
- Services provided
- Recipient election statement(s)
- Interdisciplinary treatment plan of care and updates
- Advance directive documentation

The documentation contained in the medical record must be a chronological, complete record of the care provided to the hospice recipient. The medical record must contain the Medicaid Hospice Election and Physician's Certification, Form 165 that is signed and dated by the physician. A Form 165 must be present for each election period. The documentation must contain the physicians' orders that include medication(s) taken by the recipient, an assessment and a plan of care developed prior to providing care by the attending physician, the medical director or physician designee, and the interdisciplinary team. Identification of a specific terminal illness must be

documented and substantiated by labs, x-rays and other medical documentation supporting the terminal illness as set forth by the Medicaid guidelines.

The hospice retains medical records for at least three years after the current year.

Recipients residing in nursing facilities that elect the hospice benefit, but are subsequently determined to be ineligible for hospice care by Medicare or Medicaid, are not automatically approved for Medicaid reimbursement for nursing facility care if hospice payments are denied or recouped. Election of hospice care forfeits other Medicaid benefits.

Added: Recipients residing in…other Medicaid benefits.

Recipients who are denied hospice benefits in the nursing facility who intend to remain in the facility must apply and meet the nursing facility level of care criteria and the financial criteria for nursing home coverage by Medicaid.

Added: Recipients who are…coverage by Medicaid.

18.2.4 Advance Directives

The hospice must document in the patient medical records that each adult recipient has received written information regarding rights to make decisions about his or her medical care, under state law.

The hospice must comply with requirements in the Medicaid contract concerning advance directives.

18.2.5 Waiver of Other Benefits

An individual receiving hospice care waives all rights to Medicaid services covered under Medicaid for the duration of hospice care. Waived services include the following:

- Hospice care provided by any hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice
- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition
- Any Medicaid services that are equivalent to hospice care

Individuals receiving hospice care **do not waive** the following benefits:

- Services provided by the designated hospice
- Services provided by another hospice under arrangements made by the designated hospice
- Services provided by the individual's attending physician if that physician is not an employee of and does not receive compensation from the designated hospice for those services
- Medicaid-covered services that are not related to the hospice recipient's terminal illness

NOTE:
Children under the age of 21 can now receive services related to the treatment of the condition for which a diagnosis of terminal illness was made.

18.2.6 Election Revocation

An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the election to receive hospice care, any days remaining in that election period are forfeited.

The hospice sends the Alabama Medicaid Hospice Care Program the **Hospice Recipient Status Change Form 165B** to revoke the individual's election for Medicaid coverage of hospice care.

Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

NOTE:
An individual should not revoke the hospice benefit when admitted to the hospital for a condition related to the terminal illness for the purpose of pain control or acute or chronic symptom management.

18.2.7 Change of Hospice

An individual or representative may change the designation of the particular hospice that provides hospice care one time per election period. The change of the designated hospice is not a revocation of the election for the period in which it is made.

To change the designated hospice provider, the individual or representative must file a signed statement that includes the following information:

- The name of the hospice from which care has been received
- The name of the hospice from which the individual plans to receive care
- The effective date of the hospice change
- The hospice provider transferring the recipient should submit a Hospice Recipient Status Change Form 165B indicating transfer of the recipient
- The accepting hospice provider should submit documentation to the Alabama Medicaid Agency, or its designee, for review and processing to the LTC file. (Form 165B LTC Hospice Recipient Status Change). The new provider must explain on Form 165B that this is a transfer from another hospice provider
- The approval letter from the previous hospice provider
- If Form 165B from the previous provider indicating the discharge date is available, the new provider should submit that documentation as well

The individual or representative must provide a copy of this statement to the hospice provider and to Medicaid.

The waiver of other benefits remains in effect.

18.2.8 Covered Services

Nursing care, physician services, medical social services, and counseling are core hospice services routinely provided directly by hospice employees.

Appropriately qualified personnel as determined by the nature of the service must perform all covered services.

The following are covered hospice services:

Covered Services	***Description***
Nursing facility care	Provided by or under the supervision of a registered nurse
Medical social services	Provided by a social worker who has at least a bachelor's degree from an approved or accredited school and who works under the direction of a physician
Physician services	Performed by a licensed physician. The medical director and physician member of the interdisciplinary group must be a doctor of medicine or osteopathy.
Counseling services	Provided to the terminally ill individual and the family or other person(s) caring for the patient at home. Counseling includes dietary advice, caregiver training, and counseling for adjustment to approaching death for patients and caregivers.
Short-term inpatient care	Provided in a participating hospice inpatient unit or a hospital or nursing facility that provides services through a contract with the hospice. General inpatient procedures necessary for pain control or acute or chronic symptom management that cannot be provided in another setting; respite inpatient care lasting up to five consecutive days may provide relief for the individual's caregiver at home. Medicaid will not cover respite care when the recipient is a nursing facility resident. These inpatient services must be part of the written plan of care.
Medical appliances and supplies	Includes drugs and biologicals provided to the patient. Drugs must be used primarily for relief of pain and symptom control related to the individual's terminal illness and related conditions. Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care.
Home health aide services	Furnished by qualified aides and homemaker services provided under the general supervision of a registered nurse. These services include personal care and maintenance of a safe and healthy environment as outlined in the plan of care.
Physical Therapy, Occupational Therapy, and Speech Language Pathology	Provided for symptom control or to allow the recipient to maintain basic functional skills and/or activities of daily living

Hospices may contract for supplemental services during periods of peak patient loads and to obtain physician specialty services.

18.2.9 Reimbursement for Levels of Care

With the exception of payment for direct patient care services by physicians, Medicaid pays the hospice for all covered services related to the treatment of the recipient's terminal illness for each day the recipient is Medicaid-eligible and under the care of the hospice, regardless of the services furnished on any given day.

Payment for hospice care shall conform to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid bases hospice payment rates on the same methodology used to set Medicare rates and adjusts rates to disregard offsets due to Medicare co-insurance amounts. Each rate comes from a CMS estimate of the costs generally incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. Medicaid adjusts the rates of reimbursement to reflect local differences in wages.

Medicaid pays reimbursements to the dispensing pharmacy for drugs not related to the recipient's terminal illness through the Medicaid Pharmacy Program.

The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

NOTE:

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website *at www.medicaid.alabama.gov*

With the exception of payment for physician services, Medicaid reimburses hospice care at one of four rates for each day in which a Medicaid recipient receives hospice care. The payment amounts are determined within each of the following categories:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

Routine Home Care

The hospice receives reimbursement for routine home care for each day that the recipient receives hospice care at home but does not receive continuous home care. Medicaid pays this rate without regard to the volume or intensity of routine home care services provided on any given day.

Continuous Home Care

The hospice receives reimbursement for continuous home care when the recipient receives nonstop nursing care at home. Continuous home care is intended only for periods of crisis when skilled nursing care is needed on a continuous basis to manage the recipient's acute medical symptoms, and only as necessary to maintain the recipient at home. Continuous home care consists of a minimum of eight hours per day.

Inpatient Respite Care

The hospice receives reimbursement for inpatient respite care for each day that the recipient receives respite care. Patients admitted for this type of care do not need general inpatient care. Medicaid provides inpatient respite care only on an intermittent, non-routine, and occasional basis and will not

reimburse for more than five consecutive days, including date of admission, but not date of discharge.

General Inpatient Care

The hospice receives reimbursement for general inpatient care for each day that the recipient occupies an approved inpatient facility for the purpose of pain control or acute or chronic symptom management.

NOTE:

Payment for total inpatient care days (general or respite) for Medicaid patients cannot exceed twenty percent of the combined total number of days of hospice care provided to all Medicaid recipients during each 12-month period of November 1 through October 31.

Reimbursement for Physician Services

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians employed by or working under arrangements made with the hospice.

Group activities, which include participation in establishing plans of care, supervising care and services, periodically reviewing and updating plans of care, and establishing governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

- Physicians employed by or working under arrangements made with the hospice may bill for direct patient care services rendered.
- Services provided by the attending physician who is not employed by or receiving compensation from the hospice will be paid to that physician in accordance with the usual billing procedures for physicians. Refer to Chapter 28, Physician, for physician billing procedures.
- Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

Nursing Facility Residents

Medicaid will not restrict hospice services based on a patient's place of residence. A nursing facility resident may elect to receive hospice benefits if he or she meets the requirements for hospice care under the Medicaid program.

If the resident elects to receive hospice benefits, the nursing facility submits discharge information per LTC Admission Notification Software.

A Medicaid hospice recipient residing at home who enters a nursing facility may continue to receive services under the hospice benefit. Any applicable resource liability amount and/or third party liability amount for a nursing facility resident need to be established and applied to the amount paid to the hospice by Medicaid for the nursing facility services. Nursing facility residents are required to use income to offset the cost of nursing facility care. Additionally, if a resident in a nursing facility elects, the hospice income will be applied to offset the cost of hospice care. The Medicaid district office will provide the hospice provider a copy of the Notice of Award or Notice of Change of Liability in order to inform the hospice of the claimant’s liability required amount to be paid from claimant’s income.

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Alabama Medicaid Agency, or its designee, for **dually eligible** institutionalized recipients:

- Initial nursing home admission
- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital after an unrelated hospital stay

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Alabama Medicaid Agency, or its designee, for **Medicaid Only** institutionalized and/or recipients in the community:

- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Discharge, revocation or death
- Expiration in the nursing home
- Readmission to the nursing home or the community from the hospital after an unrelated hospital stay

NOTE:

Medicaid pays the hospice 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing facility for that individual under the State Plan. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. For Nursing Home claims regarding patient days, Medicaid covers the day of admission, but not the day of discharge.

Medicare/Medicaid Eligibility

The Hospice Election and Physicians Certification Form 165 must be completed for all recipients who are Medicaid eligible. However, for dually eligible recipients who have Medicare Part A, Medicare will pay the daily hospice rate for the appropriate level of care – routine, continuous, inpatient respite, or general inpatient.

If the dually eligible hospice recipient with Part A Medicare resides in a nursing facility, Medicare pays the daily hospice rate as usual. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. The number of days of Medicare coverage must equal the number of days requested for nursing facility room and board. Any applicable resource liability amount and/or third party liability amount is deducted from the payment made to the Hospice provider for the facility services.

The Qualified Medicare Beneficiary (QMB) recipient who has **QMB-only** is not eligible for any Medicaid benefits, i.e., home health, hospice, medications, etc. A recipient who has **QMB+** does have full Medicaid benefits and would be eligible for home health, hospice, and medications.

Coinsurance amounts for drugs and biologicals or respite care may be billed to Medicaid as crossover claims for dually eligible recipients for whom Medicare is the primary payer.

Drugs and biologicals furnished by the hospital while the recipient is not an inpatient may be billed at 5 percent of the cost of the drug or biologicals, not to exceed $5.00 per prescription.

Medicaid Waiver Eligibility

A Medicaid-only recipient cannot receive hospice services and waiver services simultaneously; however, a Medicare/Medicaid-eligible recipient may receive the hospice benefit and waiver service if Medicare is the payer for the hospice service. The hospice provider must inform Medicaid recipients receiving Medicaid Waiver Services that they will lose Medicaid Waiver Services when they elect to receive hospice benefits and notify the Waiver Provider of the election of the hospice benefit.

Audits

The provider of hospice care may be asked to furnish the Medicaid Hospice Care Program with information regarding claims submitted to Medicaid. The provider of hospice care must permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

The provider of hospice care must maintain complete and accurate medical and fiscal records that fully disclose the extent of the services and billings. The provider retains these records for the period of time required by state and federal laws.

Inpatient Respite Care

Medicaid pays coinsurance claims for inpatient respite care, drugs, and biologicals for dually eligible recipients. Medicaid pays 5 percent of the Medicare payment for a day of respite care. This payment will not exceed the inpatient hospital deductible applicable for the year in which the hospice co-insurance period began. Medicaid will not pay for more than five consecutive days.

Medicaid pays 5 percent of the cost of each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The cost may not exceed $5.00 for each prescription.

NOTE:

When filing coinsurance claims for inpatient respite care or for drugs and biologicals, the provider must complete the UB-04 claim form.

18.3 Medicaid Approval for Hospice Care

Providers must adhere to all state and federal specific timeframes and documentation requirements under the Medicaid Hospice Program.

Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission; including hospice stays of six months or more. Hospice providers will no longer have the ability to submit dates of service to the LTC file for hospice admission or recertification.

Policies and Procedures for Hospice Admission and Recertification

- Applicants to Medicaid approved hospice providers must be certified, by their attending physician or hospice medical director, to have a terminal illness with a life expectancy of six months or less. The certification for terminal illness is substantiated by specific findings and other medical documentation including, but not limited to, medical records, labs, x-rays, pathology reports, etc.
- The hospice provider will be required to comply with all state and federal rules related to an individual's election of the hospice benefit.
- The hospice provider must establish a permanent medical record for each patient which documents eligibility for the Medicaid Hospice benefit based upon the medical criteria found in the Alabama Medicaid Agency Administrative Code Rule 560-X-51-.04. For cases with evidence of other co-morbidities and the evidence of rapid decline and for pediatric cases, medical necessity review will be conducted on a case-by-case basis.
- All hospice providers certifying patient initial admission, recertification or hospice stays for six months or more must submit medical documentation to the Alabama Medicaid Agency or its designee for review. When approved the Alabama Medicaid Agency or its designee will enter the dates of service through the LTC notification software.
- When submitting records the Hospice Program cover sheet Form 165A and HP coversheet must accompany the medical record. Mail the information to:

HP Enterprise Services

P.O. Box 244032

Montgomery, AL 36124-4032

The Alabama Medicaid Agency or its designee's Nurse Reviewer will review the documentation to ensure the appropriateness of admission based on Medicaid's medical criteria for admission as defined in the Alabama Medicaid Agency Administrative Code Rule No. 560-X-51-.04.

- If there are no established criteria for the admitting hospice diagnosis, the Nurse Reviewer will perform a preliminary review of the documentation for terminality and the normal progression of the terminal disease. The Medicaid Agency's Medical Director will make the final determination of approval or denial of the admission and continued stay in the Hospice Program for those diagnoses which have no established medical criteria.
- When there is both medical and financial approval, the application dates will be entered through the LTC notification software by the Alabama Medicaid Agency or its designee.
- If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing or incomplete, etc.) the provider will receive a letter requesting the additional information. If the additional information is not received within 30 days the application will be denied.

Added: <u>or incomplete</u>

- No hospice segment will be approved by the Alabama Medicaid Agency or its designee for greater than six months. If a recipient remains on hospice beyond six months, the provider must submit documentation which supports continued appropriateness for hospice including documentation of the continued progression of the disease. This information should be forwarded to the Alabama Medicaid Agency or its designee for review two weeks prior to the end of the six month certification period or the case will automatically close. If the documentation demonstrates progression of the terminal illness, then an additional six month certification period will be established and added to the LTC file by the Alabama Medicaid Agency or its designee.
- An approval or denial letter will be faxed or mailed to the provider upon completion of the review. The approval or denial letter notifies the provider of the dates added to the file and may be used for billing of hospice claims.
- All revocations, discharges, deaths and readmissions after an unrelated hospital stay should be faxed to the Alabama Medicaid Agency or its designee using the Hospice Recipient Status Change Form 165B. Readmissions should include the previous six month admission approval letter.

18.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by a Hospice provider.

18.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Hospice providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When filing a claim on paper, a hard copy UB-04 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

18.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Hospice providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

18.5.2 Diagnosis Codes

The International *Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

18.5.3 Procedure Codes, Revenue Codes and Modifiers

Hospice providers are required to use HCPCS procedure codes for each service rendered. Failure to identify each service with a procedure code will result in denial of the service. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Payment of hospice services is limited to the following codes:

Revenue Code	Procedure Code	Description
651	T2042	Routine home care, per day
652	T2042-SC	Continuous home care, per day
655	T2044	Inpatient respite care, per day
656	T2045	General inpatient care, per day
659	T2046 T2046-SC T2046-SE	Nursing facility room and board, Routine care, per day Nursing facility room and board, Continuous care, per day Nursing facility room and board, per dually eligible recipient, per day

NOTE:

For Medicaid recipients with another insurance which pays for routine care in the nursing home, submit T2046. Document the other insurance paid amount for routine care in block 54 of the UB-04, along with the other insurance information in the appropriate blocks of the claim form.

18.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

18.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

18.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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19 Hospital

The Alabama Medicaid Program provides inpatient and outpatient hospital care. The policy provisions for hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* chapter 7.

19.1 Enrollment

HP enrolls hospitals and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a hospital provider is added to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hospital-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Hospitals are assigned a provider type of 01 (Hospital). Valid specialties for hospitals include the following:

- Post-extended care (PEC) hospital (540)
- General hospital (010)
- Inpatient psychiatric hospital under 21 (017)
- Inpatient psychiatric hospital over 65 (011)
- Lithotripsy (520)
- Mammography (292)
- Organ transplants (530)
- Long Term Care Hospital Unit (014)—for crossover claims only

- Psychiatric Unit (011)—for crossover claims only
- Rehabilitation Unit (012)—for crossover claims only

Enrollment Policy for Hospital Providers

In order to participate in the Alabama Medicaid Program and to receive Medicaid payment for inpatient and outpatient hospital services, a hospital provider must meet the following requirements:

- Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the “Hospital/CAH Medicare Database Worksheet” completed by the State Agency Surveyor.
- Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification* Chapter 420-5-7.
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility.
- Submit a written description of an acceptable utilization review plan currently in effect.

The effective date of enrollment cannot be earlier than the Medicare certification dates.

Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line.

Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. Application by nonparticipating hospitals is made to HP Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124-1685.

All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

Enrollment Policy for Lithotripsy

The facility must submit an application to HP Provider Enrollment along with documentation that the lithotripsy machine is FDA approved.

19.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Refer to Appendix A, EPSDT for details on benefit limits for medically necessary services provided as a result of an EPSDT screening referral.

This section includes the following:

Section	Title	Topics Covered
19.2.1	Inpatient Benefits	• Routine Benefits • Extended Hospital Days for Delivery • Other Extended Benefits • Newborn Inpatient Benefits • Bed and Board and Semi-private Accommodations • Nursing and Other Services • Drugs and Biologicals • Supplies, Appliances, and Equipment • Hemodialysis • Organ Transplants • Blood • Sterilization and Hysterectomy • Abortions • Dental Services • Inpatient Noncovered Services • Payment of Inpatient Hospital Services • Utilization Review for Inpatient Hospital Admissions and Concurrent Stays • Adverse Events, Hospital-Acquired Conditions, and Present on Admission Indicators
19.2.2	Post-hospital Extended Care (PEC) Services	• General Information • PEC NPI • Admitting a Recipient to a PEC • Reimbursement for PEC Services
19.2.3	Swing Beds	• General Information • Level of Care for Swing Beds • Benefit Limitations for Swing Beds • Admission and Periodic Review
19.2.4	Billing Medicaid Recipients	Describes conditions under which Medicaid recipients may be billed for services rendered
19.2.5	Outpatient Services	• Outpatient Surgical Services • Injectable Drugs and Administration • Emergency Hospital Services • Outpatient Hemodialysis • Obstetrical Ultrasounds • Inpatient Admission after Outpatient Hospital Services • Outpatient Observation • Outpatient Hyperbaric Oxygen Therapy • Outpatient Lab and Radiology • Outpatient Chemotherapy and Radiation • Outpatient Physical Therapy • Outpatient Sleep Studies • Outpatient Cardiac Rehabilitation • Prior Authorization for Outpatient Service • Payment of Outpatient Hospital Services • Pulse Oximetry Services
19.2.6	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.7	Crossover Reimbursement	Provides crossover reimbursement benefit information for inpatient and outpatient services

19.2.1 Inpatient Benefits

This section describes benefits and policy provisions for the following:

Routine Benefits

An inpatient is a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient with the expectation that he will remain overnight and occupy a bed (even if he is later discharged or is transferred to another hospital and does not use a bed overnight.)

Except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or additional inpatient days that have been authorized for deliveries or children who have been referred for treatment as a result of an EPSDT screening, the first 16 days in a calendar year will be reimbursed on an established per diem rate. Subsequent days will be factored into the establishment of cost as described in the *Alabama Medicaid Agency Administrative Code, Chapter 23, Hospital Reimbursement*. Since subsequent days are factored into the establishment of cost for inpatient hospital stays, the recipient **may not** be billed for services past the 16 day payment. The number of days of care billed to Medicaid for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is used to report days of care for Medicaid recipients even if the hospital uses a different definition of day for statistical or other purposes. When a claim is submitted to Medicaid for inpatient hospital services past the 16 day payment; Medicaid will zero pay the claim.

Medicaid covers the day of admission but not the day of discharge. If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Extended Hospital Days for Delivery

Medicaid authorizes additional inpatient days for delivery for recipients who have exhausted their initial 16 covered days.

When medically necessary, additional days may be approved for deliveries, from onset of active labor to discharge. The number of extended days must meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria in order to be approved. Inpatient days prior to the onset of active labor will not be approved for extended benefits.

Requests for authorization should not be made prior to delivery. QA personnel issue a ten-digit authorization number for the approved stays.

Claims for extended benefit days should be filed separately from all other inpatient stays.

Other Extended Benefits

Medically necessary inpatient days are unlimited for recipients under the age of one in all hospitals.

Medically necessary inpatient days are unlimited for children under the age of six if the services are provided by a hospital that has been designated by Medicaid as a disproportionate share hospital.

Newborn Inpatient Benefits

Newborn well-baby nursery charges will be covered by an eligible mother's claim for up to ten days nursery care for each baby if the mother is in the hospital and is otherwise entitled to such coverage. For well-baby charges, revenue codes 170 and 171 are reflected on the mother's claim in conjunction with her inpatient stay for the delivery. The hospital per diem rate includes charges for the mother and newborn. Newborn well-baby care is not separately billable. Nursery charges for "boarder babies", infants with no identified problems or condition whose mothers have been discharged, were never admitted to the hospital, or are not otherwise eligible for Medicaid are not separately billable.

Criteria for Revenue Codes 170/171 - The infant is considered to have received "well baby" care if any of these criteria are met in the absence of more severe conditions:

1. Premature infants greater than 5.5 lbs. (2500) grams and/or greater than 35 weeks who are not sick;
2. Stable infants receiving phototherapy for less than 48 hours duration or while the mother is an inpatient receiving routine postpartum care, such as physiologic jaundice, breast milk jaundice, etc;
3. Infants on intake and output measurements;
4. Stable infants on intermittent alternative feeding methods, such as gavage, or frequent feedings;
5. Stabilized infants with malformation syndromes that do not require acute intervention;
6. Infants with suspected infection on prophylactic IV antibiotics while the mother is an inpatient;
7. Infants receiving close cardiorespiratory monitoring due to family history of SIDS;
8. Infants in stable condition in isolation;
9. Observation and evaluation of newborns for infectious conditions, neurological conditions, respiratory conditions, etc., and identifying those who require special attention;
10. Oliguria;
11. Stable infants with abnormal skin conditions;
12. Routine screenings, such as blood type, Coombs test, serologic test for syphilis, elevated serum phenylalanine, thyroid function tests, galactosemia, sickle cell, etc.;
13. Complete physical exam of the newborn, including vital signs, observation of skin, head, face, eyes, nose, ears, mouth, neck, vocalization, thorax, lungs, heart and vascular system, abdomen, genitalia, extremities, and back.

Newborns admitted to accommodations other than the well-baby nursery must be eligible for Medicaid benefits in their own right (claim must be billed under the baby's own name and Medicaid number). Example: If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's number even if the mother is still an inpatient.

NOTE:

When billing for multiple births, list each baby's accommodation separately, noting "Baby A," "Baby B," and so on. Also, use the diagnosis codes that indicate multiple live births. For multiple births, nursery days equals the sum of the number of infants times the number of the mother's days.

Unless the newborn infant needs medically necessary, specialized care as defined below, no additional billings for inpatient services are allowed while the mother is an inpatient.

To bill Medicaid utilizing revenue codes 172 (Nursery/Continuing Care), 173 (Nursery/Intermediate Care), 174 (Nursery Intensive Care), and 179 (Nursery/Other), the infant must meet the following criteria established by Medicaid.

Criteria for Revenue Codes 172/173 - The infant must be 36 weeks gestation or less, or 5.5 lbs. (2500 grams) or less, AND have at least one of the following conditions which would cause the infant to be unstable as confirmed by abnormal vital signs or lab values:

1. Respiratory distress requiring significant intervention, including asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc;
2. Any nutritional disturbances, intestinal problems or known necrotizing entercolitis;
3. Cardiac disease requiring acute intervention;
4. Neonatal seizures;
5. Conditions which require IV intervention for reasons other than prophylaxis;
6. Apgar scores of less than six at five minutes of age;
7. Subdural and cerebral hemorrhage or other hemorrhage caused by prematurity or low birthweight;
8. Hyperbilirubinemia requiring exchange transfusion, phototherapy or other treatment for acute conditions present with hyperbilirubinemia, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
9. Pulmonary immaturity and/or without a pliable thorax, causing hypoventilation and hypoxia with respiratory and metabolic acidosis.

Criteria for Revenue Code 174 – Services must be provided in a neonatal intensive care unit due to the infant's unstable condition as confirmed by abnormal vital signs or lab values AND at least one of the following conditions:

1. Confirmed sepsis, pneumonia, meningitis;
2. Respiratory problems requiring significant intervention, such as asphyxia and anoxia, or those requiring oxygen for three or more continuous hours, apnea beds, chest tubes, etc.;
3. Seizures;
4. Cardiac disease requiring acute intervention;
5. Infants of diabetic mothers that require IV glucose therapy;
6. Congenital abnormalities that require acute intervention;

7. Total parental nutrition (TPN) requirements;
8. Specified maternal conditions affecting fetus or newborn, such as noxious substances, alcohol, narcotics, etc., causing life threatening or unstable conditions which require treatment;
9. IV infusions which are not prophylactic, such as dopamine, isoproterenol, epinephrine, nitroglycerine, lidocaine, etc.
10. Dialysis;
11. Umbilical or other arterial line or central venous line insertion;
12. Continuous monitoring due to an identified condition;
13. Cytomegalalovirus, hepatitis, herpes simplex, rubella, toxoplasmosis, syphilis, tuberculosis, or other congenital infections causing life threatening infections of the perinatal period;
14. Fetal or neonatal hemorrhage;
15. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.;
16. Necrotizing enterocolitis, diaphragmatic hernia, omphalocele.

Criteria for Revenue Code 179 – The infant must be unstable as confirmed by abnormal vital signs or lab values AND have one of the following conditions:

1. Close observation after operative procedures;
2. Total parenteral nutrition (TPN);
3. Umbilical or other arterial line or central venous line insertion;
4. Cardiac disease requiring acute intervention;
5. Neonatal seizures;
6. Neonatal sepsis, erythroblastosis, RH sensitization or other causes, or jaundice, requiring an exchange transfusion;
7. Respiratory distress, oxygen requirements for three or more continuous hours, apnea beds, chest tubes, etc.;
8. IV therapy for unstable conditions or known infection;
9. Any critically ill infant requiring 1:1 monitoring or greater may be maintained on a short term basis pending transfer to a Level III nursery;
10. Apgar scores of less than six at five minutes of age;
11. Congenital anomalies requiring special equipment, testing, or evaluation;
12. Bleeding disorders;
13. Hyperbilirubinemia of a level of 12 or greater requiring treatment.
14. Hyperbilirubinemia requiring exchange transfusion or other treatment for acute conditions present, such as acidosis, low albumin levels, kernicterus, erythroblastosis, isoimmunization, etc.

These charges are to be billed on a separate UB-04 claim form. ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care must be on the claim. Medicaid will routinely monitor the coding of neonatal intensive care claims through post-payment review.

Bed and Board in Semi-Private Accommodations

Medicaid pays for semi-private accommodations (two-, three-, or four-bed accommodations). When accommodations more expensive than semi-private are furnished the patient because less expensive accommodations are not available at the time of admission or because the hospital has only private accommodations, Medicaid pays for the semi-private accommodations. In this case, the patient is not required to pay the difference.

When accommodations more expensive than semi-private are furnished the patient at his request, the hospital may charge the patient no more than the difference between the customary charge for semi-private accommodations and the more expensive accommodations at the time of admission. The hospital must have the patient sign a form requesting the more expensive accommodation and agreeing to pay the difference. This form must remain on file for review if questions arise regarding payment of private room charges.

Accommodations other than semi-private are governed by the following rules for private rooms.

Medically Necessary Private Rooms

Payment may be made for a private room or for other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms are considered medically necessary when the patient's condition requires him to be isolated for his own health or for that of others. Isolation may apply when treating a number of physical or mental conditions. Communicable diseases may require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatments are likely to alarm or disturb others in the same room. Medicaid pays for the use of intensive care facilities where medically necessary.

For the private room to be covered by Medicaid, the following conditions must be met:

- The physician must certify the specific medical condition requiring the need for a private room within 48 hours of admission.
- The physician’s written order must appear in the hospital records.
- When the physician certifies the need for continued hospitalization, the private room must also be re-certified as being medically necessary. Medicaid will not cover a private room on the basis of a retroactive statement of medical necessity by the physician.
- When medical necessity for a private room ceases, the patient should be placed in the semi-private accommodation.

Nursing and Other Services

Medicaid covers nursing and other related services, use of hospital facilities, and the medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

Drugs and Biologicals

Medicaid covers drugs and biologicals for use in the hospital that are ordinarily furnished by the hospital for the care and treatment of inpatients.

A patient may, on discharge from the hospital, take home remaining drugs that were supplied by prescription or doctor's order, if continued administration is necessary, since they have already been charged to his account by the hospital.

Medically necessary take-home drugs should be provided by written prescription either through the hospital pharmacy or any other Medicaid-approved pharmacy. Take-home drugs and medical supplies are not covered by Medicaid as inpatient hospital services.

Supplies, Appliances, and Equipment

Medicaid covers supplies, appliances, and equipment furnished by the hospital solely for the care and treatment of the Medicaid recipient during his inpatient stay in the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not generally covered as inpatient hospital services. A temporary or disposable item, however, that is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Medicaid as an inpatient hospital service.

Colostomy bags are provided for inpatients only for use while they are hospital patients. Hospitals cannot supply colostomy bags using Medicaid funds for home or nursing facility use.

Hemodialysis

Medicaid provides hemodialysis for chronic renal cases when the patient is not authorized this care under Medicare.

Organ Transplants

Medicaid-covered organ transplants require prior approval, which will be coordinated by the prime contractor. Medicaid's approved prime contractor is responsible for the coordination and reimbursement of all Medicaid-reimbursed organ transplants with the exception of cornea transplants. The Medicaid Professional Services staff has final approval. Contact the Medicaid Clinic Services Unit at (334) 242-5580 for contractor information.

Letters of approval or denial will be sent to the requesting provider by Medicaid’s coordinating entity upon completion of review by both the appropriate Medicaid Transplant Consultant and Medicaid’s Medical Director.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s). Alabama Medicaid’s Transplant Program must receive the request for appeal within 30 calendar days from the date of the denial letter, or the decision will be final and no further review will be available.

Coordination services begin at initial evaluation and continue through a five-year post-operative period. Medicaid covers the following organ transplants for any age:

- Bone marrow transplants
- Kidney transplants
- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Liver/Small Bowel
- Small Bowel
- Pancreas
- Pancreas/Kidney

For Medicaid-eligible children through the age of 20, EPSDT-referred transplants not listed above will be considered for approval if the transplant is medically necessary, therapeutically proven effective, and considered non-experimental.

Reimbursement for all prior authorized transplants will be an all-inclusive global payment. This global payment includes pre-transplant evaluation; organ procurement; hospital room, board, and all ancillary costs both in and out of the hospital setting; inpatient postoperative care; and all professional fees. All services, room, board, pharmacy, laboratory, and other hospital costs are included under the global payment. All charges for services provided after the discharge, such as patient services, drugs, professional services, and other services will be reimbursed as fee-for-service.

The global payment represents payment in full. Any monies paid outside the global payment will be recouped. The recipient cannot be billed for the difference between the submitted amount and what the contractor pays.

For transplants performed at another in-state facility or at an out-of-state facility, the contractor negotiates the reimbursement rate with the facility and is responsible for global payment of the transplant from evaluation through hospital discharge. Medicaid reimburses the prime contractor for services provided.

The global payment for covered transplants performed out of state will be inclusive of all services provided out of state for the transplant, including all follow-up care, medications, transportation, food and lodging for caretaker/guardian of minor (if applicable), and home health. Once the patient has been discharged back to Alabama after transplant, services will be reimbursed fee for service and will count against applicable benefit limits.

Medicaid reimbursement is available only to the extent that other third party payers do not cover these services.

Blood

Charges for whole blood or equivalent quantities of packed red cells are not allowable since Red Cross provides blood to hospitals; however, blood processing and administration is a covered service.

Sterilization and Hysterectomy

Surgical procedures for male and female recipients as a method of birth control are covered services under the conditions set forth in Appendix C, Family Planning.

Any Medicaid service that relates to sterilization or hysterectomy must have documentation on file with Medicaid that shows consent or an acknowledgement of receipt of hysterectomy and sterilization information. This documentation must be submitted by the attending physician and is required to be on file at HP. This documentation must meet the criteria set forth under the sterilization and hysterectomy regulations. See Chapter 28, Physician and Appendix C, Family Planning, for further details.

NOTE:

Please refer to Section 5.7, Attachments, for information on billing electronic claims with attachments.

Abortions

Payment for abortions under Medicaid is subject to the conditions in the chapter pertaining to Physicians. Refer to Chapter 28, Physician, for further details.

Dental Services

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are covered for those recipients eligible for treatment under the EPSDT Program. See Chapter 13, Dentist, for details.

NOTE:

All inpatient hospital claims for dental services require prior authorization with the exception of children aged five and under.

Payment for Inpatient Hospital Services

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

Repeat Inpatient Admission

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-04's (even if the readmission was for the same diagnosis).

Inpatient Services for Non-Citizens

- Sterilization codes are non-covered for non-citizens.
- Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid must be processed manually. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the SOBRA worker, who determines eligibility; then forwards information to the Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.
- Delivery Services must be billed through HP for Non-Citizens.

Deleted: ~~The Type of…UB-04 inpatient claims.~~

- For UB-04 inpatient claims, the following per diem is covered: Up to 2 days per diem for vaginal delivery and up to 4 days per diem for c-section delivery.
- Allowable diagnosis codes for UB-04 are: V270-V279, V300-V3921, 65100-65993, and 6571-6573.
- Allowable surgical codes for UB-04 are 740-7499.

Inpatient Non-covered Services

Medicaid does not cover the following items and services:

- Free items and services for which there is no legal obligation to pay are excluded from coverage, (for example, chest x-rays provided without charge by health organizations).
- Items and services that are required as a result of an act of war, occurring after the effective date of the patient's current coverage are not covered.
- Personal comfort items that do not contribute meaningfully to the treatment of an illness or injury or to functioning of a malformed body member are not covered. Charges for special items such as radio, telephone, television, and beauty and barber services are not covered.
- Routine physical check-ups required by third parties, such as insurance companies, business establishments or other government agencies are not covered.
- Braces, orthopedic shoes, corrective shoes, or other supportive devices for the feet are not covered.
- Custodial care and sitters are not covered.
- Cosmetic surgery or expenses in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the function of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic service, that coincidentally also serves some cosmetic purpose.

- Items and services to the extent that payment has been made, or can reasonably be expected to be made under a Workman's Compensation Law, a plan of the United States, or a state plan may not be paid for by Medicaid.
- Inpatient hospitalization for routine diagnostic evaluations that could be satisfactorily performed in the outpatient department of the hospital, in a physician's office, or in an appropriate clinic, are not covered.
- Medicaid does not cover psychological evaluations and testing, or psychiatric evaluations, unless actually performed by a psychiatrist in person.
- Medicaid does not cover speech therapy unless actually performed by a physician in person.
- There is no provision under Medicaid for payment of reserved inpatient hospital beds for patients on a pass for a day or more.
- Inpatient services provided specifically for a procedure that requires prior approval is not covered unless prior authorization from Medicaid for the procedure has been obtained by the recipient's attending physician. In the event that the recipient is receiving other services that require inpatient care at the time the procedure is performed, any charges directly related to the procedure will be noncovered and subject to recoupment. Additionally, all admissions must meet Alabama Medicaid Adult and Pediatric (SI/IS) Inpatient Care criteria.

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.

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.

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPC’s).

Healthcare Acquired Conditions include Hospital Acquired Conditions (HAC's).

Other Provider Preventable Conditions refer to OPPCs (sugery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient).

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, these events must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the hospital.
- The PPC 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 PPC must result in significant harm. The OPPCs 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 30 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 OPPCs 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 PPCs.

Reporting Other Provider-Preventable Conditions (OPPS)

The following OPPC policy applies to inpatient and outpatient hospitals.

OPPCs must be reported to Medicaid by encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include, but are not limited to:

- 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.medicaid.alabama.gov under Programs /Medical Services/Hospital Services although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

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

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.

Hospitals should use the POA indicator on claims for these. HACs as identified by Medicare other than Deep Vein Thromboissi (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. 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 . 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.

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	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 940-949.5 991-994.9
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),

Selected HAC	CC/MCC (ICD-9-CM Codes)
	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.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

No reduction in payment for a PPC will be imposed on a hospital provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Hospitals are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

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.

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.

19.2.2 Post Extended Care (PEC) Services

General Information

Inpatient hospital services rendered at a level of care lower than acute are considered post extended care services (PEC). The patient must have received a minimum of three consecutive days of acute care services in the hospital requesting PEC reimbursement. Intra-facility transfers will not be authorized for reimbursement as PEC services. These services include care ordinarily provided by a nursing facility. Refer to Chapter 26, Nursing Facilities, for details.

Medically necessary services include, but are not limited to the following:

- Nursing care provided by or under the supervision of a registered nurse on a 24-hour basis
- Bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay
- Medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician)
- Personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient
- Nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. These include needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W, and normal saline)
- Services ordinarily furnished to an inpatient of a hospital

PEC National Provider Identifier

In order to receive reimbursement for PEC, the hospital must have a NPI. The NPI allows the hospital to designate up to ten beds for these services for hospitals with up to 100 beds, and an additional ten beds per each 100 beds thereafter. **All PEC services must be billed using a 'PEC' NPI.**

Determining the Availability of Nursing Facility Beds

Prior to the hospital admitting a patient to one of these beds, the hospital must first determine that there is no nursing facility bed available within a reasonable proximity and that the recipient requires two of the following medically necessary services on a regular basis:

- Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis
- Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
- Nasopharyngeal aspiration required for the maintenance of a clear airway
- Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, or other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
- Administration of tube feedings by naso-gastric tube
- Care of extensive decubitus ulcers or other widespread skin disorders
- Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
- Use of oxygen on a regular or continuing basis
- Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
- Routine medical treatment for a comatose patient

Admission and Periodic Review for PECs

To establish medical necessity, an application packet must be submitted to Medicaid within 60 days from the date Medicaid coverage is requested. The 60 days are calculated from the date the application is received and date stamped. All applications with a date over 60 days old will be assigned an effective date that is 60 days prior to the date stamp. No payment will be made for the days prior to the assigned effective date. The facility will be informed in writing of the assigned effective date.

The application packet consists of the following:

- A fully completed Medicaid Status Notification form XIX-LTC-4 including documentation certified by the applicant’s attending physician to support the need for nursing home care
- Documentation certifying the patient has received inpatient acute care services for no less than three consecutive days during the current hospitalization in the requesting hospital prior to the commencement of post-extended care services. These days must have met the Medicaid Agency's approved acute care criteria
- Documentation certifying contact was made with each nursing facility within a reasonable proximity to determine bed non-availability prior to or on the date coverage is sought, and every 15 days thereafter

In order to continue PEC eligibility, re-certification must be made every 30 days. Nursing facility bed non-availability must be forwarded along with request for re-certification.

Reimbursement for PEC Services

Reimbursement for PEC services is made on a per diem basis at the average unweighted per diem rate paid by Medicaid to nursing facilities for routine nursing facility services furnished during the previous fiscal year. There shall be no separate year-end cost settlement. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, for details on rate computation.

A provider must accept the amount paid by Medicaid plus any patient liability amount to be paid by the recipient as payment in full, and further agrees to make no additional charge or charges for covered services.

Any day a patient receives such PEC services is considered an acute care inpatient hospital day. These beds are not considered nursing facility beds.

These services are not subject to the inpatient hospital benefit limitations. At this level of care, PEC days are unlimited if a nursing facility bed is not located.

All PEC services must be billed using the PEC NPI with the exception of outpatient services, pharmaceutical items to include over-the counter products, and prescription drugs.

- Outpatient services such as lab and x-ray services should be billed under the hospital National Provider Identifier number.
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy National Provider Identifier number.
- A Medicaid pharmacy provider outside of the hospital may fill the prescriptions if the hospital pharmacy is not a Medicaid provider.

19.2.3 Swing Beds

General Information

Swing beds are hospital beds that can be used for either skilled nursing facility (SNF) or hospital acute care levels of care on an as needed basis if the hospital has obtained a swing bed approval from the Department of Health and Human Services.

Swing bed hospitals must meet all of the following criteria:

- Have fewer than 100 beds (excluding newborn and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census
- Be Medicare certified as a swing bed provider
- Have a certificate of need for swing beds
- Be substantially in compliance with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals.)
- Must not have in effect a 24 hour nursing waiver

- Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation

Level of Care for Swing Beds

To receive swing bed services, recipients must require SNF level of care on a daily basis. The skilled services provided must be ones that, on a practical basis, can only be provided on an inpatient basis.

A condition that does not ordinarily require skilled care may require this care because of a special medical condition. Under such circumstances the service may be considered skilled because it must be performed by or supervised by skilled nursing or rehabilitation personnel.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. A patient may need skilled services to prevent further deterioration or preserve current capabilities.

Swing bed admissions not covered by Medicare because they do not meet medical criteria are also considered noncovered by Medicaid. These services cannot be reimbursed as a straight Medicaid service.

Benefit Limitations for Swing Beds

Swing bed services are unlimited as long as the recipient meets the SNF level of care medically and meets all other eligibility criteria, including financial criteria.

Admission and Periodic Review for Swing Beds

The Medicaid Long Term Care Admissions/Records (LTC ADMS/Records) Unit performs a pre-admission review of all Medicaid admissions to assure the necessity and appropriateness of the admission and that a physician has certified the need for swing bed care. Medicaid certifies the level of care required by the patient at the time of admission using the XIX-LTC-4 form. A control number is provided for each patient that is admitted.

The Medicaid staff physician(s) will review applications not initially approved by LTC ADMS/Records.

Recipients must meet SNF medical and financial requirements for swing bed admissions just as they are required for SNF admissions.

For recipients who receive retroactive Medicaid eligibility while using swing bed services, the hospital must furnish a form MED-54 to Medicaid. Attach all doctors' orders, progress and nurses' notes for the time in question.

LTC ADMS/Records issues medical approvals if the information provided to Medicaid documents the need for SNF care and the recipient meets criteria set forth in Rule 560-X-10-13 for SNF care.

The admission application packet must be sent to LTC ADMS/Records within 30 days from the date Medicaid coverage is sought and most contain a fully completed Medicaid status notification (form XIX-LTC-4), including documentation certified by the applicant’s attending physician to support the need for the nursing home care.

Once the LTC-4 is reviewed and approved, a prior control number is issued and entered into the Long Term Care Record file.

An LTC-2 form notifies the facility that the patient is medically eligible if the financial eligibility of the patient has been established and entered on the file. If financial eligibility has not been established and noted in the file, an XIX-

LTC-2A is sent to the facility advising that medical eligibility is established but financial eligibility is not. If an LTC-2A is received, the facility should advise the patient or sponsor of the need to establish financial eligibility by applying at the District Office.

Continued stay reviews are required to assure the necessity and appropriateness of skilled care and effectiveness of discharge planning. Re-certification of SNF patients is required 30, 60, and 90 days after admission and then every 60 days thereafter. Physicians must state "I certify" and specify that the patient requires skilled care for continued stay in the facility. Facilities must have written policies and procedures for re-certification. The Inspection of Care team will monitor these during medical reviews to assure compliance.

19.2.4 Billing Medicaid Recipients

Providers may bill recipients for noncovered services, for example, days that do not meet the Alabama Medicaid Adult and Pediatric Inpatient Care Criteria. private room accommodation charges incurred due to patient's request, or personal comfort items.

The provider is responsible for informing the recipient of noncovered services. Medicaid recipients in hospitals may be billed for noncovered inpatient care occurring **after** they have received written notification of Medicaid non-coverage of hospital services. If the notice is issued prior to the recipient's admission, the recipient is liable for full payment if he enters the hospital. If the notice is issued at or after admission, the recipient is responsible for payment for all services provided **after** receipt of the notice.

19.2.5 Outpatient Hospital Services

Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician or dentist at a licensed hospital. Medical services provided in an outpatient setting must be identified and the specific treatment must be documented in the medical record. Outpatient visits (99281, 99282, 99283, 99284 and 99285) are limited to 3 per calendar year unless certified as an emergency. Providers must meet Medicare "provider based status determination" criteria in order to bill Medicaid for outpatient services provided in an 'off-campus' location. Refer to 42 CFR 413.65 for details on "provider based status determination".

Outpatient Surgical Services

Outpatient surgical services are those covered procedures commonly performed on an inpatient basis that may be safely performed on an outpatient basis. Only those surgeries included on the Medicaid outpatient hospital fee schedule will be covered on an outpatient basis. Surgeries included on the Medicaid outpatient surgical list are reimbursable when provided on an inpatient basis if utilization review criteria are met. Hospitals may bill other procedures (within the 90000 range) if they are listed on the Outpatient Fee Schedule located on the Medicaid website: www.medicaid.alabama.gov . Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Surgical procedures that are not listed on Medicaid's outpatient fee schedule may be sent to the Institutional Services Unit to be considered for coverage in the outpatient setting if medically necessary and the procedure is approved by the Medical Director. Refer to the Hospital Fee Schedule on the Medicaid website for a list of covered surgical codes.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

Patients who remain overnight after outpatient surgery, will be considered as an outpatient UNLESS the attending physician has written orders admitting the recipient to an inpatient bed. In such instances all outpatient charges should be combined on the inpatient claim.

NOTE:

Claims for outpatient surgical procedures that are discontinued prior to completion must be submitted with modifier 73 or 74.

Lab and x-ray not directly related to the surgical procedure are not included in the fee and may be billed in addition to the surgical procedures that are reimbursed. Outpatient visits for surgical procedures do not count against the recipient's outpatient visit limit. Surgery procedure codes are billed with units of one.

Any lab and x-ray procedures considered 'directly related' to the surgical procedure are part of the reimbursement for the surgical fee if performed within 3 days (or 72 hours) prior to the surgery.

Any lab and x-ray procedures done as a pre-op for surgery will be covered by Medicaid in instances where the recipient is a 'no-show' for a scheduled surgical procedure.

In instances where a surgical procedure code has not been established or is an unlisted code the provider may bill the most descriptive procedure code with modifier 22 (unusual procedural services) until a covered procedure code is established.

Outpatient surgery reimbursement is a fee-for-service rate established for each covered surgical procedure on the Medicaid outpatient surgical list. This rate is established as a facility fee for the hospital and includes the following:

- All nursing and technician services
- Diagnostic, therapeutic and pathology services
- Pre-op and post-op lab and x-ray services
- Materials for anesthesia
- Drugs and biologicals
- Dressings, splints, casts, appliances, and equipment directly related to the surgical procedure.

In order to bill for bilateral procedures (previously identified by modifier 50), the most appropriate procedure code must be billed on two separate lines and appended by the most appropriate anatomical modifier (i.e. RT, LT, etc).

Medicaid will automatically pay the surgical procedure code with the highest reimbursement rate at 100% of the allowed amount and the subsequent surgical procedures at 50%, minus TPL and copay.

Providers may visit the Medicaid website: www.medicaid.alabama.gov and click on the link for "Outpatient Fee Schedule", or continue to use the AVRS line at HP (1 (800) 727-7848) to verify coverage.

NOTE:

Procedures not listed in Appendix I or the Outpatient Fee Schedule may be covered for special circumstances. Approval must be obtained prior to the surgery. Refer to Chapter 4, Obtaining Prior Authorization. Providers should inform recipients prior to the provision of services as to their responsibilities for payment of services not covered by Medicaid.

Injectable Drugs and Administration

Injectable drugs from the Alabama Medicaid injectable drug list do not count against the yearly outpatient visit limitation. Medicaid has adopted Medicare's Drug Pricing Methodology utilizing the Average Sale Price (ASP) for HCPCS injectable drug codes. Hospitals are required to bill the current CPT codes for chemotherapy and non-chemotherapy administration. Please refer to the Alabama Medicaid website at www.medicaid.alabama.gov for a listing of injectable drug codes.
The following CPT drug administration code-ranges will remain as covered services:

- CPT code ranges 90760 through 90775, and CPT code ranges 96401 through 96542.

These guidelines should be followed by hospitals for billing administration codes:

- No administration fee (infusions, injections, or combinations) should be billed in conjunction with an ER visit (99281 – 99285).

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the services the patient is receiving and the additional codes are secondary to the initial one.

- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has two IV lines per protocol, these services are considered separately billable with a modifier 76.

340-B Hospitals

340-B hospitals 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.

Emergency Hospital Services

Emergency medical services provided in the hospital emergency room must be certified and signed by the attending physician at the time the service is rendered and documented in the medical record if the claim is filed as a "certified emergency."

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

A certified emergency is an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

- The case should be handled on a situational basis. Take into consideration the recipient, their background, extenuating circumstances, symptoms, time of day, and availability of primary care (if a weekend, night or holiday).
- Determine whether the presenting symptoms as reported would be expected to cause the patient to believe that a lack of medical care would result in an unfavorable outcome.
- Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.
- If it is not an emergency, do not certify the visit as one. Follow-up care (such as physical therapy, suture removal, or rechecks) should not be certified as an emergency.
- Children or adults brought to the emergency department for exam because of suspected abuse or neglect may be certified as an emergency by virtue of the extenuating circumstances.

Certified emergency visits are unlimited if the medical necessity is properly documented and certified in the medical record by the attending physician at the time services are rendered. The claim form for a certified emergency must have an “E” in field 73 on the UB-04 claim form.

UB-04 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment.

These procedure codes (99281-99285) may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450.

Hospitals shall not be paid more than three non-certified emergency room visits per year, but the costs of providing additional care shall be accounted for and reported to Alabama Medicaid as a cost of providing care to Medicaid eligible recipients. A recipient **may not** be billed for non-certified emergency room visits past the three day limitation. The line item on the claim will zero pay for all non-certified emergency room visits past the three day limit.

Only one emergency room visit per day per provider will be reimbursed by Medicaid.

Outpatient Hemodialysis

Outpatient dialysis services are covered under the End-Stage Renal Disease Program and cannot be reimbursed as an outpatient hospital service. See Chapter 35, Renal Dialysis Facility, for details.

Obstetrical Ultrasounds

Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient's documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- HP-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

With supportive documentation, the time limit for filing ultrasound claims may be extended for extenuating circumstances, such as TPL claims, miscarriages not known to providers, and dropouts. In these instances the time limit would revert to the 1 year time limit from date of service.

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

Inpatient Admission After Outpatient Hospital Services

If the patient is admitted as an inpatient before midnight of the day the outpatient services were rendered at the same hospital, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered to be the first day of inpatient hospital services.

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 4th through 23rd hour for the evaluation and management of a patient in outpatient observation. which requires these three key components:

Procedure codes 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 are reviewed retrospectively by Medicaid to ensure compliance with the above-stated guidelines and criteria.

Outpatient Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy (HBO) is covered in an outpatient hospital setting under the guidelines listed below. HBO should not be a replacement for other standard successful therapeutic measures. Medical necessity for the use of HBO for more than two months duration must be prior approved. Prior approval (PA) requests for diagnoses not listed below or for treatment exceeding the limitations may be submitted for consideration to the Office of the Associate Medical Director. No approvals will be granted for conditions listed in the exclusion section. HBO should be billed on the UB-04 by the outpatient facility using revenue code 413 and procedure code 99183. Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Physician attendance should be billed on the CMS-1500 using CPT code 99183.

Reimbursement for HBO is limited to that which is administered in a chamber for the following diagnoses:

Air or Gas Embolism

9580 9991

Limited to five treatments per year. PA required after five treatments.

Acute Carbon Monoxide Poisoning

986

Limited to five treatments per Incidence. Treatment should be discontinued when there is no further improvement in cognitive functioning. PA required after five treatments

Decompression Illness

9932 9933

Limited to ten treatments per year. Treatment should continue until Clinical exam reveals no further Improvements in response to therapy.

Gas Gangrene

0400

Limited to ten treatments per year. PA required after ten treatments.

Crush Injury

92700	92701	92702
92703	92709	92710
92711	92720	92721
9278	9279	92800
92801	92810	92811
92820	92821	9283
9288	9290	9299
99690	99691	99692
99693	99694	99695
99696	99699	

Limited to 15 treatments per year. Early application of HBO, preferably within four - six hours of injury, is essential for efficacy. The recommended treatment schedule is three 90 minute treatments per day over the first 48 hours after the injury; followed by two 90 minute treatments per day over the second period of 48 hours; and one 90 minute treatment over the third period of 48 hours.

Chronic Refractory Osteomyelitis
73010 - 73019
Limited to 40 treatments per year. To be utilized for infection that is persistent or recurring after appropriate interventions.

Diabetic wounds of lower extremities

70710 70711
70715 70719
70712 70714

Limited to 30 treatments per year. To be utilized only when wound fails to respond to established medical/surgical management. Requires an aggressive multidisciplinary approach to optimize the treatment of problem wounds. Diabetic wounds of the lower extremities are covered for patients who have type I or II diabetes and if the wound is classified as Wagner grade III or higher.

Radiation tissue damage

52689
990

Limited to 60 treatments per year. To be utilized as part of an overall treatment plan, including debridement or resection of viable tissues, specific antibiotic therapy, soft tissue flap reconstruction and bone grafting as may be indicated.

Skin grafts and flaps
99652
Limited to 40 treatments per year.
Twenty treatments to prepare graft site and 20 after graft or flap has been replaced.

Progressive necrotizing infection (necrotizing fasciitis)
72886
Limited to 10 treatments per year.

PA required after 10 treatments.

Acute peripheral arterial insufficiency
44421 44422 44481
Limited to five treatments per year.
PA required after five treatments.

Acute traumatic peripheral
Cyanide poisoning
Ischemia
90253 90301 9031
9040 90441
Limited to 15 treatments per year.

9877 9890
Limited to five treatments per incident. PA required after five treatments.

Actinomycosis
0390 - 0394
0398 - 0399
Limited to 10 treatments per year.
PA required after 10 treatments.

Exclusions
No reimbursement will be made for HBO provided in the treatment of the following conditions.

Cutaneous, decubitus, and stasis ulcer

Chronic peripheral vascular insufficiency
Anaerobic septicemia and infection other than clostridial
Skin burns
Senility
Myocardial Infarction
Cardiogenic Shock
Sickle Cell Crisis
Acute thermal and chemical pulmonary damage (i.e., smoke inhalation with pulmonary insufficiency)
Acute or chronic cerebral vascular insufficiency
Hepatic necrosis
Aerobic Septicemia
Nonvascular causes of common brain syndrome (i.e., Pick's disease, Alzheimer's disease, Korsakoff's disease)
Tetanus
Systemic aerobic infection
Organ transplantation
Organ storage
Pulmonary emphysema
Exceptional blood loss anemia
Multiple sclerosis
Arthritic diseases
Acute cerebral edema

Nerve Conduction Studies and Electromyography

Added: **Nerve Conduction Studies and Electromyography**

Refer to Chapter 22 of Medicaid's Provider manual for more information on this policy.

Added: Refer to Chapter…on this policy.

Outpatient Lab and Radiology

Outpatient visits made solely for lab and radiology procedures do not count against a recipient's outpatient visit limits.

Claims containing only lab and radiology procedures may be span billed for one calendar month.

Specimens and blood samples sent to the hospital for performance of tests are classified as non-patient hospital services since the patient does not directly receive services from the hospital; therefore, this does not constitute a visit and is not subject to program limitations.

Outpatient Chemotherapy and Radiation

Visits for these services do not count against the outpatient visit limitations and may be span billed for a calendar month. Diagnostic lab, diagnostic x-ray, and blood administration may be span billed in conjunction with outpatient chemotherapy and radiation.

Outpatient Physical Therapy

Physical therapy is a covered service based on medical necessity. Physical therapy is covered in a hospital outpatient setting for acute conditions. Recipients receiving therapy must be under the care of a physician or non-physician practitioner who certifies the recipient's need for therapy.

For all physical therapy services performed as a result of an EPSDT screening refer to Chapter 37, Therapy, for policy only. Outpatient hospital physical therapy services will continue to be limited to those CPT codes listed in this chapter.

If the therapy continues past the 60th day, there must be documentation in the patient's medical record that a physician or non-physician practitioner has recertified the patient within 60 days after the therapy began and every 30 days past the 60th day. Therapy services are not considered medically necessary if this requirement is not met. The 60-day period begins with the therapist's initial encounter with the patient (i.e., day the evaluation was performed). In the event an evaluation is not indicated, the 60-day period begins with the first treatment session. The therapist's first encounter with the patient should occur in a timely manner from the date of the physician's therapy referral.

Documentation in the patient's medical record must confirm that all patients receiving physical therapy services have been seen by the certifying physician as specifically indicated above. Having a physician signature on a certification or re-certification will not meet this requirement.

Therapy performed in an outpatient hospital setting does not count against the recipient's three non-emergency outpatient visit limits. Rehabilitative services are not covered. Rehabilitative services are the restoration of people with chronic physical or disabling conditions to useful activity.

Physical therapy services are limited to those CPT codes listed in this chapter. Maximum units for daily and annual limits are noted for each covered service.

Form 384 (Motorized/Power Wheelchair Assessment Form) may be obtained by contacting the Long Term Care Provider Services at 1-800-362-1504, option 1 for providers.

Records are subject to retrospective review. Physical therapy records must state the treatment plan and must meet the medical criteria below. If the medical criteria are not met or the treatment plan is not documented in the medical record, Medicaid may recoup payment.

Medical Criteria for Physical Therapy

Physical therapy is subject to the following criteria:

- Physical therapy is covered for acute conditions only. An acute condition is a new diagnosis that was made within three months of the beginning date of the physical therapy treatments.
- Chronic conditions are not covered except for acute exacerbations or as a result of an EPSDT screening. A chronic condition is a condition that was diagnosed more than three months before the beginning date of the physical therapy treatments. An acute exacerbation is defined as the sudden worsening of the patient's clinical condition, both objectively and subjectively, where physical therapy is expected to improve the patient's clinical condition. For EPSDT recipients with chronic conditions refer to Chapter 37, Therapy, for policy only regarding physical therapy services. Physical therapy services are limited to those CPT codes listed in this chapter.

Plan of Treatment

In addition to the above stated medical criteria, the provider of service is responsible for developing a plan of treatment. This plan of treatment must be readily available at all times for review in the recipient's medical record. The plan of treatment should contain at least the following information:

- Recipient's name

- Recipient's current Medicaid number
- Diagnosis
- Date of onset or the date of the acute exacerbation, if applicable
- Type of surgery performed, if applicable
- Date of surgery, if applicable
- Functional status prior to and after therapy is completed
- Frequency and duration of treatment
- Modalities
- For ulcers, the location, size, and depth should be documented

The plan of treatment must be signed by the physician who ordered the physical therapy and the therapist who administered the treatments.

Physical Therapy (PT) Assistants

Physical therapy services provided in an outpatient hospital setting must be ordered by a physician and must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants must work under the direction of a physical therapist with the following provisions:

- The PT must interpret the physician's referral.
- The PT must perform the initial evaluation.
- The PT must develop the treatment plan and program, including long and short-term goals.
- The PT must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The PT must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The PT must implement (perform the first treatment) and supervise the treatment program.
- The PT must co-sign each treatment note written by the physical therapy assistant.
- The PT must indicate he/she has directed the care of the patient and agrees with the documentation as written by the physical therapy assistant for each treatment note.

The PT must render the hands-on treatment, write and sign the treatment note every sixth visit.

Outpatient Sleep Studies

Sleep studies are covered services in an outpatient hospital. Medicaid does not enroll sleep study clinics. Indications for coverage are as follows:

Polysomnography includes sleep staging that is refined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). For a study to be reported as polysmnography, sleep must be recorded and staged for 6 hours and an attendant must be present throughout the course of the study.

The following are required measurements:

- Electrocardiogram (ECG)
- Airflow
- Ventilation and respiratory effort
- Gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
- Extremity muscle activity, motor activity-movement
- Extended EEG monitoring
- Gastroesophageal reflux
- Continuous blood pressure monitoring
- Snoring
- Body positions, etc.

For a study to be reported as a polysomnogram:

- Studies must be performed for 6 hours
- Sleep must be recorded and staged
- An attendant must be present throughout the course of the study

Diagnostic testing is covered when a patient has the symptoms or complaints of one of the following conditions:

- Narcolepsy
- Sleep Apnea
- Parasomnias

(Refer to LMRP for further definition of conditions.)

Limitations

Diagnostic testing that is duplicative of previous sleep testing done by the attending physician to the extent the results are still pertinent is not covered because it is not medically necessary if there have been no significant clinical changes in medical history since the previous study.

Home sleep testing is not covered.

Polysomonography will not be covered in the following situations:

- For the diagnosis of patients with chronic insomnia
- To preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected.

- To diagnose chronic lung disease (nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry.)
- In cases where seizure disorders have not been ruled out
- In cases of typical, uncomplicated, and noninjurious parasomnias when the diagnosis is clearly delineated.
- For patients with epilepsy who have no specific complaints consistent with a sleep disorder.
- For patients with symptoms suggestive of the periodic limb movement disorder or restless leg syndrome unless symptoms are suspected to be related to a covered indication for the diagnosis of insomnia related to depression
- For the diagnosis of insomnia related to depression
- For the diagnosis of circadian rhythm sleep disorders (i.e., rapid time-zone change (jet lag), shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non 24-hour sleep wake disorder)

Revenue Codes associated with OP hospital billing:

074X	EEG-general classification
0920	Other diagnostic services-general classification

Refer to the LMRP for ICD-9 Codes that support medical necessity. These ICD-9 Codes are updated occasionally by Medicare.

Outpatient Cardiac Rehabilitation

The following conditions must be met in order for an outpatient hospital based cardiac rehabilitation clinic to provide services:

- Recipient must be referred by their attending physician
- Services must be medically necessary and include at least one of the following medical conditions:
  1. Have a documented diagnosis of acute myocardial infarction within the preceding 12 months.
  2. Began the program within 12 months of coronary bypass surgery.
  3. Have stable angina pectoris (evaluation of chest pain must be done to determine suitability to participate in the cardiac rehabilitation program).
  4. Had heart valve repair/replacement.
  5. Had a percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or
  6. Had a heart or heart lung transplant.
- The frequency and duration of the program is usually two to three sessions per week for 12 to 18 weeks. Any services provided past 36 in a year will require prior authorization by Medicaid.

- Coverage may be extended with sufficient documentation that the patient has not reached the exit level, but will not exceed a maximum of 72 visits annually.

- Each exercise session must include at least one of the following: Continuous cardiac monitoring during exercise and EKG rhythm strip with interpretation and physician's revision of treatment; or examination by the physician to adjust medications or for other treatment changes.

- No more than one EKG stress test with physician monitoring at the beginning of the exercise program with a repeat test in three months is reasonable and necessary. The medical necessity for stress tests in excess of the two allowed must be clearly established in the recipient's medical record.

- A physician must be immediately available in the exercise program area in case of emergency.

- Formal patient education services are not reasonable and necessary when provided as part of a cardiac rehabilitation exercise program; therefore, Medicaid will not pay for these services.

Outpatient Newborn Hearing Screenings

Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Outpatient facility services for newborn screenings are considered covered only in the following circumstances:

- Comprehensive hearing screen codes 92585, 92588 or 92558 may be billed in an outpatient hospital setting for the following circumstances: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge.

- Limited hearing screen codes 92586 and 92587 may be billed in an outpatient hospital setting for the following circumstances: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center.

Prior Approval for Outpatient Services

Certain procedures require prior authorization. Please refer to Section 19.5.2, Revenue Codes, Procedure Codes, and Modifiers, and Appendix I, ASC Procedures List. Medicaid will not pay for these procedures unless authorized prior to the service being rendered. All requests for prior approval must document medical necessity and be signed by the physician. It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after March 2, 2009, providers will be required to request prior authorization from MedSolutions. Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement.

Prior authorization requests for outpatient diagnostic imaging procedures may be made to MedSolutions by phone at (888) 693-3211 or by fax at (888) 693-3210 during normal business hours 7:00 a.m. to 8:00 p.m. C.T. Requests can also be submitted through MedSolutions' secure website at www.MedSolutionsOnline.com . Please refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

Payment of Outpatient Hospital Services

Refer to the *Alabama Medicaid Administrative Code, Chapter 23, Hospital Reimbursement* for details on current hospital payment methodology.

Extracorporeal Shock Wave Lithotripsy (ESWL)

Extracoporeal Shock Wave Lithotripsy (ESWL) is a covered benefit for treatment of kidney stones in the renal pelvis, uretero-pelvic junction, and the upper one-third of the ureter. ESWL is **not** a covered service for urinary stones of the bladder and the lower two-thirds of the ureter.

For ESWL treatment to both kidneys during the same treatment period, Medicaid will pay the facility one-and-a-half time the regular reimbursement rate for this procedure. Repeat ESWL treatments on the same recipient within a ninety-day period will be reimbursed at half the regular reimbursement rate for this procedure.

ESWL treatments are not subject to outpatient benefit limitations.

The ESWL reimbursement rate is an all-inclusive rate for each encounter and all services rendered in conjunction with the treatment (with the exception of the physician's and the anesthesiologist's) are included in the rate, such as lab, x-ray, and observation.

For repeat ESWL treatments on the same recipient within a ninety-day period, Medicaid will reimburse the surgeon at half the regular reimbursement rate for the surgical procedure.

Physician (surgeon) services for the ESWL procedure are not included in the facility's reimbursement rate and can be billed separately. No assistant surgeon services will be covered.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and can be billed separately.

19.2.6 Outpatient and Inpatient Tests

Medicaid pays for medically necessary laboratory tests, x-rays, or other types of tests that have been ordered by the attending physician or other staff physician provided in inpatient or outpatient hospital facilities.

Hospital labs may bill 'routine venipuncture' only for collection of laboratory specimens when sending blood specimens to another site for analysis. Hospital labs may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. Payment may be made to the referring laboratory but only if one of the following conditions is met:

- The referring laboratory is located in, or is part of, a rural hospital;
- The referring laboratory is wholly owned by the entity performing such test, the referring laboratory wholly owns the entity performing such test, or both the referring laboratory and the entity performing such test are wholly-owned by a third entity; or

- The referring laboratory does not refer more than 30 percent of the clinical laboratory tests for which it receives requests for testing during the year (not counting referrals made under the wholly-owned condition described above).

Chlamydia and Gonnorhea

Effective for dates of service on or after September 1, 2012, Chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead.

19.2.7 Crossover Reimbursement

Part A

Medicaid inpatient hospital days run concurrently with Medicare days. Medicaid covers the Part A deductible, coinsurance, or lifetime reserve days, less any applicable copayment. Medicaid will not make such payments if the Medicaid covered days for the calendar year have been exhausted. This benefit limit does not apply for QMB recipients.

Medicaid covers Medicare coinsurance days for swing bed admissions for QMB recipients. Medicaid pays an amount equal to that applicable to Medicare Part A coinsurance, but not greater than the Medicaid swing bed rate.

Part B

Medicaid pays the Medicare Part B deductible and coinsurance according to lesser of the following:

- Reimbursement under Medicare rules
- Total reimbursement allowed by Medicaid

Medicare-related claims for QMB recipients are reimbursed in accordance with the coverage determination made by Medicare. Medicare-related claims for recipients not categorized as QMB recipients are paid only if the services are covered under the Medicaid program.

Hospital outpatient claims are subject to Medicaid reimbursement methodology.

When a Medicaid recipient has third party health insurance of any kind, including Medicare, Medicaid is the payer of last resort. Thus, provider claims for Medicare/ Medicaid-eligible recipients and QMB-eligible recipients must be sent first to the Medicare carrier.

Providers complete the appropriate Medicare claim forms and ensure that the recipient's 13-digit Recipient Identification (RID) is on the form, then forward the completed claim to a Medicare carrier for payment.

QMB-only recipients are eligible for crossover services and are not eligible for Medicaid-only services.

Refer to Chapter 5, Filing Claims, for complete instructions on how to complete the claim form.

Providers in other states who render Medicare services to Medicare/Medicaid-eligible recipients and QMB-eligible recipients should file claims first with the Medicare carrier in the state in which the service was performed.

19.3 Prior Authorization and Referral Requirements

Some procedure codes for hospitalizations require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Prior authorization is required for certain outpatient surgical procedures. Refer to Appendix I or the Outpatient Fee Schedule on the website: www.medicaid.alabama.gov. Prior authorization is not required for inpatient admissions.

Medicaid issues a 10-digit prior authorization number for those stays. This number must appear in form locator 91 on the hospital claim form.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

19.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. This includes bill types 111, 112, 121, and 122 only (with the exception of admit types 1-emergency and 5-trauma).

The copayment amount for an outpatient visit (99281– 99285) is $3.90 per visit or $3.90 per total bill for crossover outpatient hospital claims. The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost - sharing (copayment) amount imposed.

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Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, family planning, renal dialysis, chemotherapy, radiation therapy, physical therapy, and certified emergencies (excluding crossovers). Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

19.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Hospitals that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions

- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-04.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

All inpatient and outpatient claims must contain a valid physician's license number in field 76 of the UB-04 claim form.

Certified Emergency Outpatient Visits

Non-certified visits to the emergency room are limited to three per year. Section 19.2.5, Outpatient Hospital Services, states the visit must be certified as such in the medical record and signed by the attending physician at the time of the visit. Certified emergency claims are also exempt from requiring the Patient 1st referral. Only one emergency room visit per day per provider will be reimbursed by Medicaid. Refer to Chapter 5 (Filing Claims) for claim filing information.

Nonpatient Visits

Specimen and blood samples sent to the hospital for lab work are classified as "nonpatient" since the patient does not directly receive services. This service does not count against the outpatient visit limitations and should be billed as bill type 14X. Refer to Section 5.3, UB-04 Billing Instructions, for description of Type of Bill values.

Recipients with Medicare Part B (Medical Only)

If a Medicaid recipient is Medicare Part B/Medicaid eligible, lab and x-ray procedures are covered under Medicare Part B for eligible recipients. Charges that are covered by Medicare must be filed with Medicare, and Medicaid will process the claim as a crossover claim. The following revenue codes are normally covered for Part B reimbursement (bill type 121): 274, 300, 310, 320, 331, 340, 350, 400, 420, 430, 440, 460, 480, 540, 610, 636, 700, 730, 740, 770, 920, and 942.

Charges that are covered by Medicaid but not by Medicare should be filed directly to Medicaid for consideration. It is not necessary to indicate Medicare on the claim. Providers are not required to file claims with Medicare if the service is not a Medicare-covered service.

Split Billing for Inpatient Claims

Claims that span more than one calendar year must be split billed.

Claims that span a Medicaid per diem rate change must be split billed in order for the hospital to receive the correct reimbursement.

Claims that span a recipient's eligibility change must be split billed.

19.5.1 Time Limit for Filing Claims

Medicaid requires all claims for inpatient and outpatient services and psychiatric hospitals to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

19.5.2 Revenue Codes, Procedure Codes, and Modifiers

Revenue codes are used for both inpatient and outpatient services. Procedure codes must be used for outpatient services.

Refer to the Official UB-04 Data Specifications Manual for a complete listing of valid revenue codes.

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

This section covers revenue codes, procedure codes, and modifier information under the following topics:

- Emergency department
- Pharmacy
- Laboratory services
- Radiation therapy
- Respiratory services
- Occupational therapy
- Speech therapy
- Miscellaneous procedures
- Outpatient revenue codes
- Outpatient observation
- Esophagus
- Radiology
- Blood
- Physical therapy
- Orthotics
- ESWL

Outpatient Revenue Codes

Medicaid will accept all valid revenue and procedure codes on outpatient claims for dates of service 10/1/04 and after. Reimbursement methodology has not changed; therefore, detail lines with noncovered revenue and procedure codes will continue to deny.

Emergency Department

Emergency and/or outpatient hospital services performed on the day of admission (at the same hospital) must be included on the inpatient billing.

Hospital providers should use the following procedure codes when billing for emergency department services:

Hospitals are to utilize the definitions from the 'old Z codes' when billing for ER visits as described in the two tables below:

'Old Z Codes'	Description
Z5299	Brief – Emergency Department Includes use of facility, equipment, oral medications and incidental supplies, e.g., linens, tongue blades, and tissue.

'Old Z Codes'	Description
Z5300	Limited – Emergency Department Includes use of facility, equipment, oral medications and additional supplies, e.g., IV solutions, splints, dressing, sterile trays, etc.
Z5301	Critical Care – Emergency Department Includes use of facility, equipment, oral medication and additional supplies for the treatment of multiple injured, critically ill and/or comatose patients. This code should not be used unless critical care is rendered.

CPT Code	***Rev Code***	***Description***
99281 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A problem-focused history, • A problem-focused examination, and • Straightforward medical decision making
99282 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of low complexity
99283 (old code Z5299)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • An expanded problem-focused history, • An expanded problem-focused examination, and • Medical decision making of moderate complexity
99284 (old code Z5300)	450	Emergency department visit for the evaluation and management of a patient that requires these three components: • A detailed history, • A detailed examination, and • Medical decision making of moderate complexity
99285 (old code Z5301)	450	Emergency department visit for the evaluation and management of a patient that requires these three components within the constraints imposed by the urgency of the patient's clinical condition and mental status: • A comprehensive history, • A comprehensive examination, and • Medical decision making of high complexity

NOTE:

The above procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-04 claim form with revenue code 450. Revenue code 450 should not be billed for surgical procedures provided in the emergency room. In these instances the appropriate ER facility fee (99281-85) must be used. Surgical procedures may be billed only when an operating room has been opened for the surgery. Surgical codes must be billed with revenue code 360.

Outpatient Observation

Outpatient Observation is medically necessary extended outpatient care provided to a patient who presents to the emergency department and whose condition warrants more than the three hours of care already included in the emergency department procedure codes 99281-99285. This service is covered only when certified by the attending physician at the time of the service.

Outpatient observation is limited to 23 hours (the first three hours included in the ER facility fee plus up to 20 hours of the appropriate observation code).Observation (G0378) may be billed only in conjunction with procedure codes 99281-99285. It may not be billed in conjunction with outpatient surgery. If observation spans midnight, the date of admission should also be the date of discharge on the claim form even though the patient was actually discharged the following day.

Revenue Code	***Procedure Code***	***Description***
76X	G0378	Each hour, 4th hour through 23rd hour (maximum units 20), low severity

Pharmacy

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H of this manual for more information.

Esophagus

Use revenue code 309 with a valid procedure code for Esophagus - Acid reflux test.

Laboratory Services

Use revenue codes 300-310 with valid CPT codes for Laboratory services.

NOTE:

Services may be span billed if claim contains lab procedure codes. Refer to Section 5.3, UB-04 Billing Instructions, for information on span billing.

Radiology

Use revenue codes 320-331 with valid CPT codes for radiology. Refer to Chapter 22, Independent Radiology, for procedure codes that require prior authorization.

Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

Blood Transfusions

Procedure code 36430 should be billed only once a day regardless of how many units were administered during that episode.

Revenue Code	***Procedure Code***	***Description***
39X	36430	Transfusion, blood or blood components

Respiratory Services

Revenue Code	***Procedure Code***	***Description***
412	94010	Spirometry, including graphic record, vital capacity, expiatory flow rate
412	94060	Bronchospasm evaluation
412	94150	Vital capacity total
412	94200	Maximum breathing capacity
412	94240	Functional residual capacity
412	94350	Pulmonary function test, lung volume
412	94360	Determination of resistance to airflow
412	94370	Determination of airway closing volume, (PFT S/B oxygen)
412	94375	Respiratory flow volume loop
412	94620	Pulmonary stress testing
412	94664	Aerosol or vapor inhalations for diagnosis
412	94665	Aerosol or vapor inhalations for sputums
412	94720	PFT - diffusion
412	94642	Aerosol inhalation of pentamidine for pneumocystis carinii (pneumonia treatment for Prophylaxis)
412	94650	Inhalation Services - Intermittent pressure breathing-treatment, air or oxygen, with or without medication
412	94680	Oxygen uptake
412	94770	Carbon Dioxide, expired gas determination
412	94772	Pediatric Pneumogram

Physical Therapy and Occupational Therapy

Procedure codes listed below may be billed by a PT or OT. Procedure codes marked with * must be billed in conjunction with therapeutic codes (97110-97542). Use revenue code 42X for PT claims and revenue code 43X for OT claims.

Procedure Code	***Physical Therapy***	***See Note***	***Max Units***	***Annual Limit***
97010	Application of a modality to one or more areas; hot or cold pack	1, 3	1	12
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
95832	Muscle, testing, manual, hand		1	12
95833	Total evaluation of body, excluding hands		1	12
95834	Total evaluation of body, including hands		1	12
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	10
97001 97001-22	Physical therapy evaluation Physical therapy evaluation-Motorized Wheelchair Assessment		1 1	1 1
97002	Physical therapy re-evaluation		1	
97003 (OT only)	Occupational Therapy evaluation		1	1
97004 (OT only)	Occupational Therapy re-evaluation		1	1
97012*	Traction, mechanical*	1	1	12
97014*	Electrical stimulation, unattended*	1, 2	4	12
97016	Vasopnueumatic device*		1	12
97018*	Paraffin bath*	1, 3	1	24
97020*	Microwave*	3	1	24
97022	Whirlpool	3	1	24
97024*	Diathermy*	1	1	24
97026*	Infrared*	1	1	24
97028	Ultraviolet		1	24
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97033	Lontophoresis, each 15 minutes	3	4	96
97034	Contrast baths, each 15 minutes	3	4	96
97035	Ultrasound, each 15 minutes	3	4	96
97036	Hubbard tank, each 15 minutes	3	4	96
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3	4	96

Procedure Code	***Physical Therapy***	***See Note***	***Max Units***	***Annual Limit***
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	Aquatic therapy with therapeutic exercises*		1	24
97116	Gait training (includes stair climbing)	4	1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	3	1	8
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97530	Therapeutic activities, direct pt contact by the provider, each 15 minutes	3 and 5	4	96
97532	Development of cognitive skills to improve attention, memory, problem solving, (included compensatory training), direct (one on one) patient contact by the provider, each 15 minutes	3~~-4~~	4	36
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes	3~~-4~~	4	36
97542	Wheelchair management/propulsion training, each 15 minutes	3	4	24
97597	Removal of devitalized tissue from wounds	3	1	104
97598	Removal of devitalized tissue from wounds	3	8	104
97750	Physical performance test or measurement, (for example, muscoloskeletal, functional capacity) with written report, each 15 minutes	3	12	12
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3-4	4	16
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	16
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes	3	4	12

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient on the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for the procedure, not the maximum units allowed for both providers.
4. 97760 should not be reported with 97116 for the same extremity.
5. 97530 requires an EPSDT referral

Orthotics

NOTE:

Prosthetic/Orthotic devices are covered only when services are rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 274 when billing L codes.

Orthotics provided by hospitals is limited to the L codes listed on the Outpatient Fee Schedule found on the Medicaid website: www.medicaid.alabama.gov .

Speech Therapy

NOTE:

Speech Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient. Use revenue code 44X when billing speech therapy codes.

Hospitals may bill the following CPT codes for EPSDT referred speech therapy services.

92506-92508	92597

ESWL

Revenue Code	***Procedure Code***	***Description***
790	50590	Lithotripsy, Extracorporeal shock wave

19.5.3 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

19.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

19.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

19.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Outpatient Fee Schedule	www.medicaid.alabama.gov
Lab & Xray Fee Schedule	www.medicaid.alabama.gov

20

20 Independent Laboratory

Laboratory services are professional and technical laboratory services in one of the following four categories. Independent lab services are:

- Ordered, provided by, or under the direction of a provider within the scope of their practice as defined by state law
- Ordered by a physician but provided by a referral laboratory
- Provided in an office or similar facility other than a hospital outpatient department or clinic
- Provided by a laboratory that meets the requirements for participation in Medicare

The policy provisions for Independent Laboratory providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 9.

20.1 Enrollment

HP enrolls Independent Laboratory providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an independent laboratory provider is added to the Medicaid system with the National Provider Identifier provided at the time the application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for laboratory-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Independent laboratory providers are assigned a provider type of 28 (Independent Laboratory). The valid specialties for Independent Lab providers include the following:

- Independent Lab (280)
- Department of Public Health Lab (550)

Enrollment Policy for Independent Laboratories

To participate in the Alabama Medicaid Program, Independent Laboratories must meet the following requirements:

- Possess certification as a Medicare provider
- Possess certification as a valid CLIA provider if a clinical lab
- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state

20.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

20.2.1 Covered Services

Medicaid reimburses Independent Labs for services described by procedures that fall between ranges 80049-89399 in the CPT manual. Medicaid also pays for procedures defined in the locally assigned Healthcare Common Procedural Coding System (HCPCS) to supplement the listing in the CPT manual.

Medicaid only pays Independent Lab providers for covered services which they are certified to perform and which they actually perform.

Independent Lab providers may only bill for routine venipuncture for collection of laboratory specimens when sending blood specimens to another site for analysis. Labs may not bill the collection fee if the lab work and specimen collection is performed at the same site. Labs may not bill the collection fee if they perform analysis in a lab owned, operated, or financially associated with the site in which the specimen was drawn.

Qualitative Drug Screening (This policy was effective for dates of service on or after January 1, 2012)

The following drug screens are 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. 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

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 of 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.

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.

Chlamydia and Gonorrhea

Effective for dates of service on or after September 1, 2012, Chlamydia (87491) or gonorrhea (87591), when billed on the same date of service for any one patient will deny. If both procedures are performed on the same date of service, procedure code 87801 (infectious agent antigen detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique) should be billed instead.

ESRD Laboratory Services

Laboratory tests listed in Chapter 35 (Renal Dialysis Facility) are considered routine and are included in the composite rate of reimbursement. When any of these tests are performed at a frequency greater than specified, the additional tests are separately billable and are covered only if they are medically necessary and billed directly by the actual provider of the service. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

20.2.2 Non-Covered Services

Medicaid does not pay packing and handling charges for referred laboratory services.

The referred laboratory receives payment for referred tests only at the normal rate. Medicaid shall monitor this policy through post-payment review.

20.2.3 Clinical Laboratory Improvement Amendments (CLIA)

All laboratory testing sites providing services to Medicaid recipients, either directly by provider, or through contract, must be CLIA certified to provide the level of complexity testing required. The Independent Lab must adhere to all CLIA regulations. As regulations change, Independent Labs must modify practices to comply with the changes. Providers are responsible for providing Medicaid waiver or certification numbers as applicable.

Laboratories which do not meet CLIA certification standards are not eligible to provide services to Medicaid recipients or to participate in Medicaid.

NOTE:

The Health Care Financing Administration (HCFA), now known as CMS, implemented the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective for dates of service on or after September 1, 1992. The CLIA regulations were published in the February 28, 1992 Federal Register. More detailed information regarding CLIA can be found at http://www.cms.hhs.gov/clia/

CLIA Certificates

CLIA certificates may limit the holder to performing only certain tests. Medicaid bills must accurately reflect those services authorized by the CLIA program and no other procedures. There are two types of certificates that limit holders to only certain test procedures:

- Waiver certificates – Level 2 certification
- Provider Performed Microscopy Procedure (PPMP) certificates – Level 4 certification

A complete listing of laboratory procedures limited to waived certificates (level 2 certification) and PPMP certificates (level 4 certification) may be accessed via the web at www.cms.hhs.gov/clia/.

20.3 Prior Authorization and Referral Requirements

The Trofile Assay will be a covered service by Medicaid with prior authorization effective December 1, 2008. The procedure code to be billed is 87999 (unlisted microbiology procedure). In order to be reimbursed by Medicaid for the Trofile Assay, the ordering provider must submit a Prior Authorization electronically or by paper on form 342.

Providers requesting a PA should include:

- Any past history of antiretroviral medications prescribed to include date prescribed and the date the drug was discontinued;
- The name and contact information of the HIV clinic that the provider is affiliated with if the requesting provider is not enrolled in Medicaid with specialty of infectious disease, and;
- The result of the most current HIV-1 RNA.

If you need further information, refer to chapter 4, Obtaining Prior Authorization, for general guidelines.

20.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided for laboratory services.

20.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent Laboratory providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

20.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Laboratory providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

20.5.2 Diagnosis Codes

Claims for lab services must contain a valid diagnosis code. The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

20.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Medicaid denies claims without procedure codes or with codes that are invalid.

Medicaid also recognizes modifiers when applicable. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following sections describe procedure codes and modifiers that apply when filing claims for independent lab services.

Repeat Laboratory Procedures

Modifier '91' may be utilized to indicate that a laboratory test was performed multiple times on the same date of service for the same recipient. Modifier '91' may not be used when laboratory tests are rerun:

- To confirm initial results
- Due to testing problems encountered with specimens or equipment
- For any other reason when a normal, one-time, reportable result is all that is required.

Distinct Procedural Service

Modifier '59' (distinct procedural service) may be utilized to identify a distinct service. When laboratory services are performed, modifier '59' should be used to report procedures that are distinct or independent, such as performing the same procedure (which uses the same procedure code) for a different specimen. Modifier '59' should not be used when a more descriptive modifier is available.

Blood Specimens

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities.

A hospital lab may bill Medicaid on behalf of the reference lab that a specimen is sent to for analysis. It is the responsibility of the referring lab (hospital) to make sure that the reference lab does not bill these services to Medicaid.

Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

Laboratory Paneling and Unbundling

A *panel* is a group of tests performed together or in combination. Medicaid follows the CPT guidelines for panel tests.

The term “unbundling” refers to the practice of using more than one procedure code to bill for a procedure that can more appropriately be described using fewer codes. The use of unbundled codes results in denial of payment, with the exception of organ and disease panels.

All organ and disease oriented panels must include the tests listed with no substitutions. If only part of the tests included in a defined panel is performed, the panel code should not be reported. If additional tests to those indicated in a panel are performed, those tests should be reported separately in addition to the panel code. If two panels overlap, the physician or laboratory will be required to unbundle one of the panels and bill only for the tests that are not duplicative.

Urinalysis – Claims for the same recipient billed by the same provider that contain two or more of the following services (81000, 81001, 81002, 81003, 81005, 81007, 81015, and 81020) for the same date of service will be considered an unbundled service and will be denied.

During post-payment review, Medicaid may recoup payment from providers for claims submitted containing unbundling of laboratory services.

Modifiers

Modifier	***HCPCS-Modifier(s)***	***Description***	***Note***
26	26	Professional Component	Labs providing professional component services include modifier 26 with the procedure code on the claim
59	59	Distinct Procedural Service	To indicate a distinct procedure (using the same procedure code) performed on the same date of service.
77	77	Repeat Procedure by another physician	To indicate that a basic procedure performed by another physician had to be repeated
91	91	Repeat Clinical Diagnostic laboratory Test	To indicate a repeat clinical laboratory test performed on the same date of service for the same recipient.
TC	TC	Technical Component	

NOTE:

Claims submitted for a repeat of the same procedure on the same date of service without modifiers will be denied as duplicate services.

Added: **Oncotype DX™** section

Oncotype DX™

Effective for dates of service, July 1, 2013 and thereafter, Medicaid will cover the Oncotype DX™ genetic profiling lab test if the patient meets Medicaid's prior authorization criteria. Oncotype DX™ is a genetic profiling test developed to classify the risk of recurrence among women treated for early stage breast cancer.

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

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

Limitations:

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

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

The Oncotype DX™ will be exempt from Patient 1st and EPSDT requirements. The Form 342 must be completely filled out, signed by the ordering physician and indicate the name and phone number of the ordering physician. The Form 342 will suffice as the prescription for the test. The test must be performed by an enrolled independent laboratory and ordered by a physician.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.
- **Professional component**, the provider does **not** own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The professional component is billed by adding modifier 26 to the procedure code.
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

20.5.4 Place of Service Codes

The only valid Place of Service Codes for Independent Laboratory providers is 81.

POS Code	*Description*
81	Independent Laboratory

20.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.9, Required Attachments, for more information on attachments.

20.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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21

21 Independent Certified Registered Nurse Practitioner (CRNP)

Independent certified registered nurse practitioners (CRNP) who are certified by the appropriate national organization as a family nurse practitioner, pediatric nurse practitioner, neonatal nurse practitioner, or women's health care practitioner may participate in the Alabama Medicaid Program.

The policy provisions for nurse practitioners can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 49.

21.1 Enrollment

HP enrolls nurse practitioners and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

A CRNP may not enroll with Medicaid if he or she is employed and reimbursed by a facility, such as a hospital or rural health clinic that receives reimbursement from the Alabama Medicaid Program for services provided by the nurse practitioner. In this case, the CRNP services are already being paid through that facility's cost report.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an independent CRNP is added to the Medicaid system with the NPI provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for CNRP-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Independent CRNPs are assigned a provider type of 09 (Independent Nurse Practitioner). Valid specialties for Independent CRNPs include the following:

- EPSDT Screening (560)
- Family Practice (092)
- Neonatology (730)
- Nurse Practitioner (093)
- Pediatrics (090)
- Women's Health Care (091)

Enrollment Policy for Independent CRNP Providers

To participate in the Alabama Medicaid Program, nurse practitioners must meet the following requirements:

- Proof of current Alabama registered nurse licensure card
- Copy of current certification as a certified registered nurse practitioner in the appropriate area of practice (family, pediatric or neonatal) from a national certifying agency recognized by Medicaid

21.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Independent CRNPs may only bill and be directly reimbursed for those services that are listed in this manual.

For services performed by a CRNP to be covered, a CRNP must be under the supervision of a licensed, active Medicaid physician.

NOTE:
Payment will be made only for injectable drugs, select CPT codes identified in Appendix O, and all CLIA-certified laboratory services. EPSDT services will be covered only if the CRNP is enrolled in the EPSDT program.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. CRNP and PA services have been expanded. Please refer to Chapter 28, Physician, and Appendix O for additional information.

21.3 Prior Authorization and Referral Requirements

CRNP procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st to determine whether your services require a referral from the Primary Medical Provider (PMP).

Some procedure codes are limited as EPSDT-referred services only. Those services require an EPSDT referral form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program. Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form (form 362).

21.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

Deleted: ~~The copayment amount…Medicaid required copayment.~~

Added: for office

Added: is:

Added: The copayment amount…including crossovers is:

Added: $3.90 for procedure…$10.01 and $25.00

Added: The following CPT…for each procedure:

Added: 90847, 90849, 90853…99348, 99349, 99350

Added: If any of…then copay applies.

Added: Copayment does not…Medicaid required copayment.

21.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Nurse practitioners who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

21.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent CRNPs to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

21.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

21.5.3 Procedure Codes and Modifiers

CRNP services are **limited** to the CPT codes found in Appendix O, CRNP and PA Services, injectable drug codes referenced in Appendix H, Alabama Medicaid Physician Administered Drugs, and all laboratory services, which are CLIA certified.

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.

21.5.4 Place of Service Codes

The following place of service codes apply when filing claims for CRNP services:

POS Code	***Description***
11	Office
12	Home
22	Outpatient Hospital
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic

21.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

21.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

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22

22 Independent Radiology

The policy provisions for radiology providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 34.

22.1 Enrollment

HP enrolls Independent Radiology providers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an independent radiology provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for radiology-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Independent Radiology providers are assigned a provider type of 29 (Independent Radiology). Valid specialties for Independent Radiology providers include the following:

- Mammography (292)
- Nuclear Medicine (327)
- Physiological Lab (Independent Diagnostic Testing Facility) (570)
- Portable X Ray Equipment (291)
- Radiology (290)

Enrollment Policy for Independent Radiology Providers

To participate in Medicaid, Independent Radiology providers must meet the following requirements:

- Possess certification as a Medicare provider
- Possess a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies if a physiological labs

- Exist independently of any hospital, clinic, or physician's office
- Possess licensure in the state where located, when it is required by that state
- For mammography services, possess a certification issued by the FDA.

22.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Radiology services are professional and technical radiological services, ordered and provided under the direction of a physician or other licensed practitioner of the healing arts. Within the scope of his practice as defined by state law and are provided in an office or similar facility other than an outpatient department of a hospital or clinic and meets the requirements for participation in Medicare. Radiology services are restricted to those that are described by procedures in the CPT manual. Providers will be paid only for covered services, which they actually perform.

An Independent Radiology provider may perform diagnostic mammography, a radiological procedure furnished to a man or woman with signs or symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease. A diagnostic mammogram includes a physician’s interpretation of the results of the procedure. Services are unlimited, but should be billed with procedure codes 77055 and 77056.

An Independent Radiology provider may perform screening mammography, a radiological procedure furnished to a woman without signs or symptoms of breast disease for the purpose of early detection of breast cancer. A screening mammogram includes a physician’s interpretation of the results of the procedure. Services are limited to one screening mammogram every 12 months for women ages 50 through 64. This screening should be billed under procedure codes 77052 and 77057.

An Independent Radiology provider may bill for obstetrical ultrasounds. Medicaid covers two obstetrical ultrasounds per year for recipients under fee-for-service. Ultrasound payment is limited to one per day. Medicaid may approve additional ultrasounds if a patient’s documented medical condition meets the established criteria. Requests for additional obstetrical ultrasounds must include the required patient information as well as the following:

- Date of requested ultrasound
- Date of request
- A list of all dates of prior ultrasounds for the current pregnancy
- A diagnosis code for each ultrasound that has been done, starting with number one
- Recipient date of birth and Medicaid number
- HP-Estimated Date of Confinement
- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

For patients covered under the Maternity Care Program, refer to Chapter 24, Maternity Care Program. Refer to Chapter 4, Obtaining Prior Authorization, for more information.

Nerve Conduction Studies and Electromyography

Added: **Nerve Conduction Studies and Electromyography** section

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

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

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

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

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

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

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

Use of EMG with Botulinum Toxin Injection

Added: **Use of EMG with Botulinum Toxin Injection** section

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

Added: **Limitations** section

Limitations

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

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

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

Documentation Requirements

Added: Documentation Requirements

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

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

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

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

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

Added: Note

NOTE:

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

22.3 Prior Authorization and Referral Requirements

For all MRI's, MRA's, CT scans, CTA's, and PET scans performed on or after March 2, 2009, providers will be required to request prior authorization from MedSolutions. Scans performed as an inpatient hospital service, as an emergency room service, or for Medicaid recipients who are also covered by Medicare are exempt from the PA requirement.

The radiology program applies only to the following Medicaid recipients:

- Those certified as children through the SOBRA (Sixth Omnibus Budget Reconciliation Act) Program.
- Those certified through the Medicaid for Low Income Families Program
- Refugees
- Those certified for Supplemental Security Income (SSI)

Services provided to eligibles certified as follows do not require prior authorization:

- Dual Eligibles (Medicare/Medicaid)
- Plan First Eligible
- SOBRA Adults
- Individuals granted emergency Medicaid due to their illegal alien status

Prior authorization requests for outpatient diagnostic imaging procedures may be made to MedSolutions by phone at (888) 693-3211 or by fax at (888) 693-3210 during normal business hours 7:00 a.m. to 8:00 p.m. C.T. Requests can also be submitted through MedSolutions' secure website at www.MedSolutionsOnline.com. Requests by third party companies are not allowed. Only the performing provider (facility) or the referring/ordering provider may request prior authorization from MedSolutions. Prior authorization must be obtained prior to the test being performed. In the event of an urgent situation (when the prior authorization cannot be obtained before the test is performed), a PA may be requested within 14 days from the date of service. The case must then meet the "urgent" criteria before it will be considered for review. Providers are allowed 30 days from the date of service to submit a request to change or add a code to an approved case.

Prior Authorization is required for the following radiology codes:

PET SCANS
78459 Myocardial -metabolic
78491 Myocardial-single-rest/stress
78492 Myocardial, perfusion-mult.
78608 Brain-metabolic
78609 Brain, perfusion
78811 Limited area
78812 Skull base to mid-thigh
78813 Whole body
78814 w/CT; limited area
78815 w/CT skull base to mid-thigh

78816 w/CT whole body
CTA
70496 Head
70498 Neck
71275 Chest (non-coronary)
73206 Upper extremity
73706 Lower extremity
75635 Aortobifemoral runoff
CT
70450 Head/brain w/o contrast
70460 Head/brain w/ contrast
70470 Head/brain w/o & w/contrast
70480 Orbit w/o contrast
70481 Orbit w/ contrast
70482 Orbit w/o & w/contrast
70486 Maxllfcl w/o contrast
70487 Maxllfcl w/ contrast
70488 Maxllfcl w/o & w/contrast
70490 Soft tissue neck w/o contrast
70491 Soft tissue neck w/o, w/contrast
70492 Soft tissue neck w/o & w/contrast
71250 Thorax w/o contrast
71260 Thorax w/contrast
71270 Thorax w/o & w/contrast
72125 C-spine w/o contrast
72126 C-spine w/contrast
72127 C-spine w/o & w/contrast
72128 T-spine w/o contrast
72129 T- spine w/contrast
72130 T-spine w/ & w/o contrast
72131 L-spine w/o contrast
72132 L-spine w/contrast
72133 L-spine w/o & w/ contrast
72192 Pelvis w/o contrast
72193 Pelvis w/contrast
72194 Pelvis w/o & w/ contrast
73200 UE- w/o contrast
73201 UE- w/contrast
73202 UE w/o & with contrast
73700 LE w/o contrast
73701 LE w/ contrast
73702 LE w/o & w/contrast

74150 Abdomen w/o contrast
74160 Abdomen w/contrast
74170 Abdome w/o & w/contrast
74176 Abdomen & Pelvis w/o contrast
74177 Abdomen & Pelvis with contrast
74178 Abdomen & Pelvis; w/o & w/contrast
75571 Heart w/o contrast. Added: Code 75571-is age restricted 0-18 years; on their 19th birthday they become ineligible.
75572 Heart with contrast. Added: Code 75572 is age restricted 0-18 years; on their 19th birthday they become ineligible
75573 Heart with contrast, in the setting of CHD. Added: Code 75573 is age restricted 0-18 years; on their 19th birthday they become ineligible
75574 Heart CT Angiography. Added: Code 75574 is age restricted 0-18 years; on their 19th birthday they become ineligible
76380 Limited or localized f/u study
76497 Unlisted Computed Tomography procedure

MRA
70544 Head w/o contrast
70545 Head w/contrast
70546 Head w/ & w/o contrast
70547 Neck w/o contrast
70548 Neck w/contrast
70549 Neck w/o & w/contrast
71555 Chest w/ or w/o contrast
72198 Pelvis w/ or w/o contrast
73225 UE w/ or w/o contrast
73725 LE w/ or w/o contrast
74174 CTA, Abdomen and pelvis with contrast
74185 Abdomen w/ or w/o contrast
MRI
70336 TMJ
70540 Face, orbit, &/or neck w/o contrast
70542 Face orbit &/or neck w & w/o cont.
70543 Face,orbit, &/or neck w & w/o cont.
70551 Brain w/o contrast
70552 Brain w/ contrast
70553 Brain w/& w/o contrast
71550 Chest w/o contrast
71551 Chest w/ contrast
71552 Chest w & w/o contrast
72141 C-spine w/o contrast
72142 C-spine w/contrast
72146 T-spine w/o contrast

72147 T-spine w/contrast
72148 L-spine w/o contrast
72149 L spine w/contrast
72156 c-spine w/ & w/o contrast
72157 T-spine w/ & w/o contrast
72158 L-spine w/ & w/o contrast
72195 Pelvis w/o contrast
72196 Pelvis w/ contrast
72197 Pelvis w/&w/o contrast
73218 UE w/o contrast
73219 UE w/contrast
73220 UE w/& w/o contrast
73221 UE joint w/o contrast
73222 UE joint w/contrast
73223 UE joint w/& w/o contrast
73718 LE w/o contrast
73719 LE w/ contrast
73720 LE w/ & w/o contrast
73721 LE joint w/o contrast
73722 LE joint w/ contrast
73723 LE joint w & w/o contrast
74181 Abdomen w/o contrast
74182 Abdomen w/contrast
74183 Abdomen w & w/o contrast
75557 Cardiac w/o contrast
75559 Cardiac w/o contrast,w/stress imag.
75561 Cardiac w & w/o contrast
75563 Cardiac w & w/o contrast,w stress imag.
76498 Unlisted magnetic resonance procedure
77058 Breast w/ & or w/o contrast, unilat.
77059 Breast w/& or w/o contrast, bilat.
77084 Bone marrow blood supply

22.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Independent Radiology providers.

22.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Radiology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

22.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Independent Radiology providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

22.5.2 Diagnosis Codes

For dates of service 01/01/99 and after,valid diagnosis codes **are required**. The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P. O. Box 10950, Chicago, IL 60610.

For dates of service prior to 01/01/99, Independent Radiology providers are not required to provide valid diagnosis codes. Providers must bill diagnosis code V729 on hard copy and electronically submitted claims.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

22.5.3 Procedure Codes and Modifiers

Radiology providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Radiology Facilities are limited to billing CPT radiology procedure codes. The range of codes is 70010 through 79999. Physiological labs are **restricted** to the codes listed in their contract with Medicaid.

The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers.
- **Professional component**, the provider does not own the equipment. The provider operates the equipment and/or reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient)
  - 22 (outpatient)
  - 23 (emergency room - hospital)
  - 24 (ambulatory surgical center)
  - 32 (nursing facility)
  - 51 (inpatient psychiatric facility)
  - 61 (comprehensive inpatient rehab facility)
  - 62 (comprehensive outpatient rehab facility)
  - 65 (end stage renal disease facility)
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code.

22.5.4 Place of Service Codes

The following place of service code applies when filing claims for radiology services:

POS Code	*Description*
11	Clinic

22.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

22.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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23 Licensed Social Workers

Medicaid enrolls Licensed Social Workers but limits services to those provided to Medicare QMB recipients. Medicaid reimburses only as a crossover claim.

23.1 Enrollment

HP enrolls Licensed Social Workers and issues provider contracts to applicants who meet the licensure and certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a Licensed Social Worker provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for social work-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Licensed Social Workers are assigned a provider type of 11 (Crossovers Only). The valid specialty for Licensed Social Workers is Medicare/Medicaid Crossover Only 116.

Enrollment Policy for Licensed Social Workers

To participate in the Alabama Medicaid Program, Licensed Social Workers must meet the following requirements:

- Possess certification as a Medicare provider
- Possess current certification as a licensed social worker from the Board of Social Work Examiners

Deleted: ~~Submit a copy~~
Added: Possess

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

23.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Licensed Social Workers are limited to crossover claims for those services to QMB recipients only.

23.3 Prior Authorization and Referral Requirements

Prior Authorization and referral requirements do not apply to Licensed Social Workers because all services are limited to Medicare crossover claims.

23.4 Cost Sharing (Copayment)

Copayment does not apply to Licensed Social Workers.

23.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Licensed Social Workers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a Medical Medicaid/Medicare-related Claim Form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

23.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Licensed Social Workers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

23.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

23.5.3 Procedure Codes and Modifiers

When filing Medicare/Medicaid crossovers, be sure to use the same procedure codes and modifiers as filed to Medicare. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

23.5.4 Place of Service Codes

When filing Medicare/Medicaid crossovers, be sure to use the same place of service code as filed to Medicare.

23.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

23.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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24 Maternity Care Program

The Alabama Medicaid Maternity Care Program allows Medicaid to establish locally coordinated systems of care, in which targeted populations receive maternity care in environments that emphasize quality, access, and cost-effective care.

The purpose of this managed care effort is to ensure that every Medicaid eligible pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health.

In most cases the Primary Contractor develops subcontracts with other providers capable of providing the requisite services. The responsibility remains with the Primary Contractor to assure qualitative and quantitative adequacy of the service.

Policy provisions for Maternity Care are found in the *Alabama Medicaid Agency Administrative Code,* Chapter 45, available on the Medicaid web page.

24.1 Enrollment

HP enrolls providers who contract with Alabama Medicaid as a Maternity Care Provider. A copy of this contract will be required with the request to enroll as a Maternity Care Provider.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Providers who contracts with Alabama Medicaid as a Maternity Care Provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Maternity Care related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Maternity care providers are assigned a provider type of Maternity Care (61). The valid specialty for maternity care providers is Maternity Care Program (920).

Districts

Medicaid has established fourteen maternity care districts. Potential Primary Contractors must show that a care system operates in the entire district. Contractors are required to provide maternity care services to most women eligible for maternity care in the specified district.

Providers should advise recipients that if they intentionally go outside of the provider network for non-emergency care, the recipient must pay the bill if they do not get approval from the Primary Contractor.

District	***Counties***
District 1	Colbert, Franklin, Lauderdale, Marion
District 2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
District 3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
District 4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
District 5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
District 6	Clay, Coosa, Randolph, Talladega, Tallapoosa
District 7	Greene, Hale
District 8	Choctaw, Marengo, Sumter
District 9	Dallas, Wilcox, Perry
District 10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
District 11	Barbour, Chambers, Lee, Macon, Russell
District 12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
District 13	Coffee, Dale, Geneva, Henry, Houston
District 14	Mobile

Deleted: ~~553-8154~~
Added: 532-2744

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Added: 532-2744

District	***Primary Contractor***	***Phone Number For Recipients***	***Phone Number For Providers***	***1-800 Phone Number***	***Start Date***
District 1	HealthGroup of Alabama	(256) 532-2744	(256) 532-2748 Laura Thompson	1 (888) 500-7343	01/01/10
District 2	HealthGroup of Alabama	(256) 532-2744	(256) 532-2748 Laura Thompson	1 (888) 500-7343	01/01/10
District 3	Quality of Life	(256) 492-0131	(256) 492-0131 Amelia Wofford	1 (888) 490-0131	01/01/10
District 4	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	01/01/10
District 5	Alabama Maternity, Inc. (VIVA Health)	(205) 558-7405	(205) 558-7587 Kim Reach	1 (877) 997-8377	01/01/10
District 6	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1 (877) 826-2229	01/01/10
District 7	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	01/01/10
District 8	Tombigbee Healthcare Authority LLC	(334) 287-2673	(334) 287-2579 Marcia Lankster-Pugh	1 (888) 531-6262	01/01/10
District 9	Greater Alabama Network	(205) 345-1905	(205) 345-5205 Becky Henderson	1 (877) 553-4485	01/01/10
District 10	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1 (877) 826-2229	01/01/10
District 11	Maternity Services of District 11	(334) 528-6830	(334) 528-6833 Donna Guinn-Taylor	1 (877) 503-2259	01/01/10
District 12	Southwest Alabama Maternity Care Program	(334) 272-1820	(334) 272-1820 Jeanette Gibson	1 (877) 826-2229	01/01/10
District 13	Southeast Alabama Maternity Care Program	(334) 699-8111	(334) 699-8111 Gary Bennett	1 (800) 735-4998	01/01/10
District 14	USA Medical Center	(251) 415-8585	(251) 415-8585 Susan Eschete	n/a	08/01/05

24.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 2, Verifying Recipient Eligibility, for general benefit information and limitations.

24.2.1 Eligibility

The following Medicaid recipients who are pregnant are required to participate in the Maternity Care Program:

- Those certified through the SOBRA (Sixth Omnibus Budget Reconciliation Act) Program
- Those certified through the Medicaid for Low Income Families (MLIF) Program (formerly AFDC)
- Refugees
- Supplemental Security Income (SSI) eligible women

The following recipients are not required to participate and should not be enrolled:

- Dual eligibles (Medicare/Medicaid)
- Individuals granted emergency Medicaid due to their illegal alien status
- DYS women with a county code of 69

Recipients are notified at the time of Medicaid application of the requirement to participate in the program.

If a dual eligible recipient receives retroactive Medicare and has previously had a Medicaid paid maternity claim, you must reverse claim payment and inform all sub-contractors to bill Medicare. The Primary Contractor is to send a hard copy claim to the Alabama Medicaid Agency, P.O. Box 5624, Montgomery, Alabama 36103-5624, for procedure code 99199 and bill $365. $100 is the administration fee and the care coordination is $265. This claim will appear as an adjustment on your Remittance Advice (RA).

24.2.2 Covered Services

The Primary Contractor is responsible for all pregnancy-related care with the following exceptions: inpatient and outpatient hospital care related to the pregnancy diagnosis, and services provided by a teaching facility as described in the State Plan. The Primary Contractor is responsible from the 1st of the month in which the woman is certified until the end of the month in which the 60th postpartum day falls.

- Antepartum care
- Outpatient care

Effective 01/01/10 all outpatient hospital services associated with the pregnancy diagnosis are to be billed fee for service by the performing provider utilizing the most appropriate CPT codes with the exception of the professional component for ultrasounds and anesthesia. The professional components of ultrasounds and anesthesia remain the responsibility of the Primary Contractor and are a component of the global negotiated rate. Refer to section 24.6 for information regarding care provided by a teaching facility as described in the State plan.

- Delivery
- Hospitalization

Effective 01/01/10 all inpatient hospital services associated with the pregnancy diagnosis are to be billed fee for service by the performing provider utilizing the most appropriate CPT codes with the exception of the professional component for ultrasounds and anesthesia. The professional components of ultrasounds and anesthesia remain the responsibility of the Primary Contractor and are a component of the global negotiated rate. The 16 day benefit limit is applicable. If the recipient has exceeded the inpatient benefit limit additional days may be covered for the delivery only through the prior authorization process. Refer to section 24.6 for information regarding care provided by a teaching facility as described in the State plan.

- Postpartum care
- Care coordination services
- Assistant Surgeon Fees
- Associated services
- Anesthesia services
- Home visits
- Ultrasounds

Antepartum Care

Antepartum care includes the following usual prenatal services:

- Initial visit at the time pregnancy is diagnosed
- Initial and subsequent histories
- Maternity counseling
- Risk assessments
- Physical exams
- Recording of weight
- Blood pressure recordings
- Fetal heart tones
- Lab work appropriate to the level of care including hematocrit and chemical urinalysis

Delivery

Delivery includes vaginal delivery, with or without episiotomy, with or without forceps or cesarean section delivery. More than one fee **may not** be billed for a multiple birth delivery. Delivery includes, but is not limited to, professional services, such as physician's services and anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number. Please refer to Chapter 28 for charges that are billable fee-for-service by physicians.

Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-04), which includes but is not limited to the following:

- Labor
- Delivery or operating room
- Room and board including well baby nursery days
- Drugs, supplies, and lab/radiology services obtained during hospitalization

Effective 01/01/10 inpatient and outpatient hospital services are to be billed fee for service by the performing provider utilizing the most appropriate CPT codes with the exception of the professional component for ultrasounds and anesthesia.

NOTE:

Sterilization procedures performed during delivery stays are included as covered services under the global fee and may not be billed separately by the hospital. Physician sterilization charges may be billed fee-for-service.

Effective 01/01/10 all outpatient hospital services associated with a pregnancy related condition for recipients assigned to the Maternity Care Program are excluded from the Primary contractor global capitated fee and are to be billed as fee for service by the Provider of service utilizing the most appropriate CPT code with the exception of the professional component for ultrasounds and anesthesia. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services.**

Postpartum Care

Postpartum care includes office visits, home visits, and in-hospital visits following delivery for routine care through the end of the month of the 60-day postpartum period. The postpartum exam should be accomplished four to eight weeks after delivery.

Care Coordination Services

The care coordinator arranges a coordinated system of obstetrical care for pregnant women based on specific guidelines for care coordination services.

Assistant Surgeon Fees

The global rate includes assistant surgeon fees for cesarean (c-section) deliveries.

Associated Services

The global fee includes all services associated with treatment of the pregnancy during the antepartum and postpartum period. Refer to table 24.5.4 for details.

Anesthesia Services

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

Home Visits

Postpartum Home visits are not skilled care nursing visits. Maternity Care Program home visits are for evaluation, assessment and referral and are accomplished by social workers or nurses at the discretion of the Primary Contractor. Home visits are optional, unless the required post partum care coordination encounter in the hospital is missed.

Ultrasounds

Medicaid pays for obstetrical ultrasounds for reasons of medical necessity. Ultrasound payment is limited to one per day. Payment will **not** be made to determine only the sex of the infant.

For recipients assigned to Maternity Care Primary Contractors the following applies:

Primary Contractors in each district are financially responsible for payment of medically necessary ultrasounds associated with each pregnancy. The primary contractor may have their own prior authorization system for those recipients that are required to participate in the Maternity Care Program. It is the Primary Contractor's responsibility to maintain a record of the dates of all ultrasounds for each pregnancy. The physician's professional-component for ultrasounds performed in the outpatient hospital is also the responsibility of the Primary Contractor and a component of the global associated capitated payment. The technical component for ultrasounds is to be billed fee for service by the performing provider utilizing the most appropriate CPT code. The exception is for ultrasounds performed in a teaching facility (i.e. UAB and USA Maternal Fetal Medicine) as designated in the State Plan (See Section 24.6).

For recipients not required to participate in the Maternity Care Program and not assigned to a primary Contractor in the Maternity Care Program (Fee for Service Billing) the following applies:

A limit of two ultrasounds will be approved without requiring a prior authorization. PA requests shall be submitted to HP following normal PA procedures for ultrasounds exceeding two.

The following information is required shall accompany all ultrasound requests for authorization:

- Prior Authorization Request Form
- Date of the requested ultrasound
- Date of the request
- A list of **all dates and diagnoses of prior ultrasounds** for the current pregnancy
- Recipient's date of birth and Medicaid number
- EDC-Estimated Date of Confinement

- Medical diagnosis to substantiate the ultrasound that is being requested
- Benefit of the ultrasound that is being requested
- Anticipated total number of ultrasounds for the current pregnancy

Requests for authorization should be submitted prior to the service being rendered. However, certain extenuating circumstances necessitate a retroactive authorization for OB ultrasound services provided. These circumstances include TPL claims, miscarriages not known to providers, and Maternity Care Program dropouts. In these limited cases (supportive documentation required), the time limit for obtaining authorization is not applicable. However, the claim time-filing-limit, 1 year from date of service, does apply.

Separately Billable Services

Services provided outside the scope of the global fee that may be billed separately are listed below:

Separately Billable Service	***Description***
Drugs	Family planning or general drugs (for example, oral contraceptives or iron pills) prescribed by a provider with a written prescription to be filled later may be billed on a fee-for-service basis. In addition, women on Plan First have the option of obtaining oral contraceptives, the contraceptive ring, or the contraceptive patch, with a prescription from a private provider, at a Medicaid-enrolled community/outpatient pharmacy. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron). Smoking cessation products for pregnant women will be covered after prior authorization through the Pharmacy Administrative Services contractor. The recipient must be enrolled and receiving counseling services through the Alabama Department of Public Health Quitline. Approval will be granted up to 3 months at a time.
Lab Services	All lab services except hemoglobin, hematocrit, and chemical urinalysis.
Radiology	All radiology services are outside of the global fee unless performed during an inpatient stay or for ultrasounds and non-stress tests. The professional component for radiology services is a component of the primary contractor global fee and should be billed separately to the primary contractor with the exception of teaching hospitals.
Dental	Dental services are covered for recipients under 21 years of age. For SOBRA-eligible recipients, services must be pregnancy-related.
Physician	Physician fees for family planning procedures (for example, sterilization), and genetic counseling. Claims for circumcision, standby and infant resuscitation may be billed under the mother's name and number on a fee-for-service basis.
Family Planning Services	Any claim with a family planning procedure code or indicator, with the exception of hospital claims for sterilization procedures performed during the delivery stay may be billed on a fee-for-service basis. 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.
Emergency Services	Outpatient emergency room services (including the physician component) (claims containing a facility fee charge of 99281, 99282, 99283, 99284, or 99285) and associated physician charges (99281-99288) will be reimbursed separately from the global fee. Access to emergency services will not be restricted by the Maternity Care Program.

Separately Billable Service	***Description***
Transportation	Transportation as allowed under the Alabama Medicaid State Plan may be billed on a fee-for-service basis.
Fees for Dropouts	All services provided to dropouts should be billed fee-for-service. However, the provider of service must submit the claims to the Primary Contractor for Administrative Review. Appropriate claims will then be referred to Medicaid by the Primary Contractor.
Mental Health	**S**creening, **B**rief Intervention, and **R**eferral to **T**reatment (SBIRT) are services designed to identify individuals who are at risk for development of substance use disorders, assist individuals in implementing strategies to reduce the potential for development of substance use disorders, and refer individuals who have identified needs for substance abuse treatment to specialized substance abuse treatment providers. Note: The intent of SBIRT is referral for Substance Abuse to include alcohol and drug abuse as smoking cessation is covered in the Maternity Care Program under Care Coordination Services. <u>Screening</u>: A full screen, as reimbursable through this benefit, is a structured process used to identify an individual whose current use of alcohol and/or other drugs creates a clearly defined risk for harm in some life dimension. A non-reimbursable pre-screening process must provide documentation of the need for a full screen. The pre-screening process may consist of, as few as, one to two brief questions incorporated into a general health questionnaire; a valid and reliable short screening tool; observations of attending medical personnel; interview and self-report; laboratory results; and/or concerns expressed by significant others. The full screen must be conducted utilizing an authorized, evidence-based screening tool with established reliability and validity in the identification of individuals who are at risk for developing substance use disorders. The tool must also provide enough information to establish an appropriate level of intervention in relation to each individual's identified risk factors. Authorized tools that may be used to conduct the full screen include the following: • Alcohol, Smoking, and Substance Involvement Test (ASSIST) • Drug Abuse Screening Test (DAST) • Alcohol Use Disorders Identification Test (AUDIT) • Car, Relax, Alone, Forget, Family or Friends, Trouble (CRAFFT) Questionnaire • Problem Oriented Screening Instrument for Teenagers (POSIT) Additional tools that conform to the criteria specified above may be utilized to provide the full screen. Prior to use, however, each tool not listed above must be reviewed and authorized for use by the Alabama Medicaid Agency. The full screening process includes the provider's evaluation of the results and an explanation of these results to the individual who has been screened. The provider must clearly explain the level of risk associated with the identified alcohol and/or drug use pattern, and describe the corresponding implications within the context the individual's health and other life dimensions. The provider's response to low risk substance use shall be provided during the screening process as according to the identified needs of the individual. This may include, but is not limited to, the dissemination of material that provides information on the risks associated with drinking and drug use, for example:

Separately Billable Service	***Description***
	• Potential alcohol and drug interactions with medications the individual is taking. • The potential for exacerbation of a health condition with alcohol and drug use. • The potential impact of alcohol or drug use on pregnancy. If the individual has a positive full screen, indicative of a moderate to high risk for a substance use disorder, the provider must be prepared to conduct or obtain brief intervention services during this same visit. **BRIEF INTERVENTION** A brief intervention is an organized encounter that includes, at a minimum, a provider and an individual who has been identified through a full screening process as being at moderate to high risk for development of a substance use disorder. Through the use of motivational strategies with demonstrated effectiveness, the goals of a brief intervention are to increase the individual's awareness and insight regarding current alcohol and/or drug use; to establish acceptance of a need for change; and to support the individual in development and implementation of a plan for change. The brief intervention may consist of a single brief (15 minutes) session or multiple brief sessions dependent upon the unique needs of each individual. Referrals for specialized substance abuse treatment services are provided in conjunction with brief interventions. During any brief intervention, including the first session, the provider must be prepared to make a direct referral to a specialized substance abuse treatment provider for individuals who are at high risk for severe substance use and related consequences. Referrals must be initiated as soon a need for such is established. **SERVICE UNITS/LIMITS** **Screening:** H0049 **Service Unit:** Episode **Limit:** One per pregnancy Providers may bill for time that is spent face-to-face administering an authorized screening tool, discussing the screening results, and providing recommendations for further actions. Providers may not bill for the time during which an individual self-administers a screening tool. **Brief Intervention:** H0050 **Service Unit:** 15 minutes **Limit:** 1/day, 2/pregnancy Providers may bill for time that is spent face-to-face implementing strategies to assist individuals with moderate to high risks for development of substance use disorders in behavior modification that supports risk reduction. Allowable strategies include efforts made by the provider to assist the individual in accessing specialty substance abuse treatment services when there is an identified need for such. **Restrictions:** SBIRT services are not a covered benefit for: • Smoking and tobacco abuse. • Individuals who have been diagnosed with a substance use disorder. • Individuals who have had previous and/or are now receiving treatment for a substance use disorder.

Separately Billable Service	***Description***
	Service Documentation: Documentation of services provided shall incorporate the following: • The need for and method of identification of the need for SBIRT as established during a pre-screening process. • Identification of the screening tool used to conduct the full screening process. • The results of the full screening process. • Brief intervention goals unique to each individual. • Summary report of each brief intervention session conducted, including the implementation of established motivational strategies. • Referrals made and outcomes. • Follow-up services provided. **Approved Providers:** Coverage of Screening, Brief Intervention, and Referral for Treatment (SBIRT) for pregnant women is covered in conjunction with antepartum care provided by physicians, physician employed nurse practitioners, nurse midwives, physician-employed physician assistants and FQICs. Prior to offering the services health care professionals must complete an online tutorial which can be accessed at http://www.mh.alabama.gov/SATR/AlabamaSBIRT/Default.aspx . The Mental Health and Substance Abuse Services Division of the Alabama Department of Mental Health will notify the Medicaid Maternity Care Program of health care professionals' successful completion of the tutorial. Procedure codes H0049 (screening for substance use) and H0050 (brief intervention and referral to treatment) will then be billable for the health care professional who has successfully completed the online tutorial. A diagnosis code of V222 must be billed by the provider on the claim form.
Miscarriages less than 21 weeks	All services may be billed fee-for-service. If the claim does not contain the miscarriage diagnosis code, it must be sent to the Primary-Contractor, who must submit an Administrative Review Form to the Alabama Medicaid Agency prior to the services being billed fee-for-service.
Referral to Specialists	Services provided by non-OB specialty physicians (i.e. cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner or perinatologist is not considered a specialty provider.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service. The Primary contractor must submit an Administrative Review Form to the Alabama Medicaid Agency and get approval for the exemption prior to the claims being billed.
Non-Pregnancy Related Care	Services provided that are not pregnancy-related are the responsibility of the beneficiary unless she is eligible under regular Medicaid benefits.

24.3 Prior Authorization and Referral Requirements

A prior authorization is required for fee-for-service recipients (recipients not required to participate in the Maternity Care Program and not assigned to a primary Contractor in the Maternity Care Program) receiving ultrasound number three and above (refer to ultrasound section 24.1.2.) Referrals to specialty providers for a pregnancy related care (i.e., Cardiology, Endocrinology, etc.) are paid fee-for-service, if the condition is pregnancy related for the SOBRA recipients and are billable fee-for-service for any medical condition covered by Medicaid for full-Medicaid recipients.

24.4 Cost Sharing (Copayment)

Copayment does not apply to services provided for pregnant women.

24.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Primary Contractors who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

24.5.1 Time Limit for Filing Claims

Medicaid requires all claims from Primary Contractors to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

24.5.2 Diagnosis Codes

Primary Contractors are to bill all claims to HP utilizing the appropriate CPT code. **A pregnancy diagnosis code, primary or secondary, must be used when billing maternity care services**.

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

24.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Claims for maternity care services are limited to the following five procedure codes and modifiers:

Code	*Modifier*	*Description*
59400		Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy or forceps) and postpartum care.
59410		Vaginal delivery and postpartum care only.
59510		Routine obstetric care including antepartum care, cesarean delivery and postpartum care.

Code	*Modifier*	*Description*
59515		Cesarean delivery and postpartum care only
99199		Maternity Care Drop-Out Fee. Patient must have enrolled with the Primary Contractor for their district of residence prior to delivery.

Reimbursement for Services

Global/delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full. **Recipients may not be billed for any services covered under this program.** Delivery-only fees paid by Medicaid to the Primary Contractor represent payment in full for all services provided from the time of delivery through the postpartum period. Recipients may be billed for services provided prior to the time of delivery.

For recipients who receive total care through the Primary Contractor network, a global fee should be billed.

For recipients who receive no prenatal care through the Primary Contractor's network, a delivery-only fee must be billed. The components of the delivery-only fee include those services provided from the time of delivery through the postpartum period.

Drop-out fees may be billed using procedure code 99199 for women who have enrolled into the MCP in her county of residence. This code is used when the recipient miscarries or moves out of district and changes her county code. Once this code is billed primary contractors are to send hard copy claims with an Administrative Review Form to Alabama Medicaid Agency, P. O. Box 5624, Montgomery, Alabama 36103-5624. These claims for prenatal visits, or other services will be stamped with an over ride stamp in order to pay fee-for-service.

Billing for other districts—this policy will apply when the recipient moves to another county outside of the district for which she is eligible and DOES NOT CHANGE HER COUNTY CODE, the billing district will bill the global using her/his own global rate. The biller of the global will keep $100 for an administrative fee and send all of the bills from her/his district and the global less $100 to the district for which she billed. The district receiving the global less $100 will pay the bills from both districts. You may not bill a drop out and use this policy.

24.5.4 Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	Description
00842	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; amniocentesis
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium)
00942	Anesthesia for colpotomy, vaginectomy, colporrhaphy, and open urethral procedures)
00948	Anesthesia for cervical cerclage)
00950	Anesthesia for culdoscopy)
00952	Anesthesia for hysteroscopy and/or hysterosalpingography)
01958	Anesthesia for external cephalic version procedure
01960	Anesthesia for; vaginal delivery only
01961	Anesthesia for; cesarean delivery only

Procedure Code	Description
01965	Anesthesia for incomplete or missed abortions
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for c-section delivery following neuraxial labor
01996	Daily hospital management of continuous epidural
10140	Incision and drainage of hematoma, seroma, or fluid collection
10160	Puncture aspiration of abscess, hematoma, bulla, or cyst
10180	Incision and drainage, complex, postoperative wound infection
56405	Incision and drainage of vulva or perineal abscess
56420	Incision and drainage of Bartholin's gland abscess
56440	Marsupialization of Bartholin's gland cyst
56441	Lysis of labial adhesions
56820	Coloscopy of the vulva
56821	Coloscopy of the vulva with biopsy
57000	Colpotomy; with exploration
57010	Colpotomy
57020	Colpocentesis (separate procedure)
57022	Incision and drainage of vaginal hematoma; obstetrical/postpartum
57150	Irrigation of vagina and/or application of medicament
57400	Dilation of vagina under anesthesia
57410	Pelvic examination under anesthesia
57460	Colposcopy of the cervix including upper/adjacent vagina
59000	Amniocentesis, any method
59001	Therapeutic amniotic fluid reduction
59012	Cordocentesis (intrauterine), any method
59020	Fetal contraction stress test
59030	Fetal scalp blood sampling
59150	Removal of ectopic pregnancy
59160	Curettage, postpartum
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin)
59300	Episiotomy or vaginal repair by other than attending physician
59320	Cerclage of cervix, during pregnancy
59325	Cerclage of cervix, during pregnancy; abdominal
59350	Hysterorrhaphy of ruptured uterus
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care
59412	Delivery; external Cephalic
59414	Delivery of placenta following delivery of infant outside of hospital
59425	Antepartum care only (4 to 6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only

Procedure Code	Description
59515	Cesarean delivery only; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous cesarean delivery
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only , following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care
59871	Removal of cerclage suture under anesthesia
59899	Unlisted procedure, maternity care and delivery
76801	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76802	Ultrasound, pregnant uterus, real time image documentation, with fetal and maternal evaluation
76805	Ultrasound, pregnant uterus, B-scan and/or real time with imagine documentation; complete
76810	Ultrasound, complete, multiple gestation, after the first trimester
76811	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76812	Ultrasound, pregnant uterus, real time image with documentation, with fetal and maternal evaluation
76813	Ultrasound pregnant uterus, real time with image documentation, 1st trimester
76814	Ultrasound for each additional gestation use in conjunction with 76813
76815	Ultrasound, limited (fetal size, heartbeat, placental location, fetal position, or emergency in the delivery room)
76816	Ultrasound, follow-up or repeat
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76818	Fetal biophysical profile
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velcocimetry, fetal, umbilical artery
76821	Doppler velocimetry, fetal, middle cerebral artery
76825	Echocardiography, fetal
76826	Echocardiography, fetal, follow-up or repeat study
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal, follow-up or repeat study
81000	Urinalysis, by dipstick or tablet reagent
81001	Urinalysis, automated, with microscopy
81002	Urinalysis, non-automated, without microscopy
81003	Urinalysis, automated, without microscopy
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81007	Urinalysis; bacteriuria screen, except by culture or dip stick
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, glycated

Procedure Code	Description
85013	Spun micro-hematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
99058	Office services provided on an emergency basis
99201	Office or other outpatient visit for E&M
99202	Office or other outpatient visit for E&M
99203	Office or other outpatient visit for E&M
99204	Office or other outpatient visit for E&M
99205	Office or other outpatient visit for E&M
99211	Office or other outpatient visit for E&M
99212	Office or other outpatient visit for E&M
99213	Office or other outpatient visit for E&M
99214	Office or other outpatient visit for E&M
99215	Office or other outpatient visit for E&M
99217	Observation care discharge day management
99218	Initial observation care, per day, for E&M
99219	Initial observation care, per day, for E&M
99220	Initial observation care, per day, for E&M

NOTE:

The global fee includes the associated codes and the maternity care codes.

24.5.5 Place of Service Codes

The following place of service code applies when filing claims for maternity care services:

POS Code	*Description*
21	Inpatient Hospital

24.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

24.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

25

25 Nurse Midwife

Nurse Midwives manage the care for normal healthy women and their babies in the areas of prenatal; labor and delivery; postpartum care; well-woman gynecology, including family planning services; and normal newborn care.

The practice of Nurse Midwifery must be performed under appropriate physician supervision.

The policy provisions for nurse midwife providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 21.

25.1 Enrollment

HP enrolls nurse midwives and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a nurse midwife provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nurse midwifery-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Nurse Midwives are assigned a provider type of 09 (Other).The valid specialty for nurse midwives is Nurse Midwife (095).

Enrollment Policy for Nurse Midwives

Providers in this program must possess a license as a Registered Nurse and also a license as a Certified Nurse Midwife.

Nurse midwives must submit the following documents for participation in Medicaid:

- Copy of the current licensure or licensure renewal card
- Copy of the American Midwifery Certification Board (AMCB) certificate
- Copy of the Certified Nurse Midwifery Protocol signed by your collaborating physician
- Letter from the hospital granting admitting privileges for deliveries

If the application is approved, Medicaid offers the applicant a one-year renewable contract.

25.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. The following policy refers to maternity care billed as fee for service and not as a part of the Maternity Care Program. Refer to Chapter 24, Maternity Care, for more details.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for nurse midwife providers.

The services provided by nurse midwives must be within the scope of practice authorized by state law and regulations. Alabama law provides rules under which properly trained nurses can be licensed to practice Nurse Midwifery. Federal law requires that Medicaid include the services of nurse midwives.

A hospital-based nurse midwife who is employed with and paid by a hospital may not bill Medicaid for services performed at the hospital and for which the hospital is reimbursed.

A nurse midwife who is not employed with and paid by a hospital may bill Medicaid using a CMS-1500 claim form.

25.2.1 Covered Services

The maternity services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a nurse midwife provides total obstetrical care, the claim form should reflect the procedure code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery.

When a nurse midwife provides eight or more prenatal visits, performs the delivery, and provides postpartum care, the midwife uses a "global" obstetrical code in billing the services. If a nurse midwife submits a "global" code for maternity services, the visits covered by this code are not counted against the recipient's limit of physician office visits per calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time that she is eligible are covered.

Antepartum Care

Antepartum care includes all usual prenatal services, such as the initial office visit when the pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, and maternity counseling. Additional claims for routine services should not be filed. Antepartum care also includes routine lab work (such as hemoglobin, hematocrit, and chemical urinalysis). Additional claims for routine lab work should not be filed.

In order to bill for Antepartum Care Only services, nurse midwife providers must use the appropriate procedure codes when billing for the services (i.e., CPT code 59425 for four to six visits or CPT code 59426 for seven or more visits). Antepartum Care Only services filed in this manner do not count against the recipient's annual office visit benefit limits.

Nurse midwives who provide fewer than four visits for antepartum care must use office visit procedure codes when billing for the services. The office visit procedure codes count against the recipient's annual benefit limits for office visits.

Delivery

Delivery includes vaginal delivery (with or without episiotomy) and postpartum care or Vaginal Delivery Only services. The nurse midwife will use the appropriate CPT code when billing delivery services. Do not bill more than one delivery fee for a multiple birth (i.e., twins, triplets). Delivery fees include all professional services related to the hospitalization and delivery services provided by the nurse midwife. Additional claims for the nurse midwife's services in the hospital (e.g., admission) may not be filed.

EXCEPTION: When a nurse midwife's first and only encounter with the recipient occurs at delivery ("walk-in" patient), the midwife may bill for a hospital admission (history and physical) in addition to delivery charges.

Postpartum Care

Postpartum care includes office visits following vaginal delivery for routine postpartum care within 60 days after delivery. Additional claims for routine visits during this time should not be filed. Family planning services performed by the delivering provider on the day of the postpartum exam or within five days of the postpartum exam are noncovered as they are included in the postpartum exam. The only exception to this is Extended Contraceptive Counseling visits, which are performed at the same time as the postpartum exam.

If the provider does not perform the delivery but does provide the postpartum care, family planning services rendered within five days of the postpartum exam are noncovered, as they are included in the postpartum exam.

Family Planning

Family planning services include services that prevent or delay pregnancy. Such services include office visits for evaluation and management of contraceptive issues, including procedures and supplies as appropriate for effective birth control. Nurse midwives are not authorized to perform sterilization procedures. Other surgical procedures such as diaphragm fittings, IUD insertions or removals, and contraceptive implant procedures, are covered when provided according to state laws and regulations.

The nurse midwife may be reimbursed for well-woman gynecological services including the evaluation and management of common medical or gynecological problems such as menstrual problems, Pap smear screenings, menopausal and hormonal treatments, treatment of sexually transmitted diseases, and treatment of minor illnesses (e.g., a minor pelvic inflammatory disease).

25.2.2 Required Written Records

When a patient is accepted for maternity services, the midwife's care must include plans to accomplish the delivery in a licensed hospital. In an emergency, delivery may be accomplished elsewhere. The plans need not be submitted to Medicaid, but the midwife's file should contain written evidence that such plans exist for each patient accepted for global care.

All nurse midwife services must be rendered under appropriate physician supervision. The physician may not bill for these supervisory services.

Midwives' written records should include records naming the supervisory physician(s) and stating the working arrangement. The statement of the working arrangement need not be a formal contract, but it must contain the signature of both parties and must show the date on which it was signed.

Nurse midwives must maintain a complete medical record for each recipient for whom the nurse midwife provides services.

25.2.3 Payment to Physicians

The supervising physician may not bill for supervisory services. The physician may bill Medicaid, however, if it becomes necessary for the physician to perform the delivery or complete a delivery service for the nurse midwife. When the physician bills the delivery-only service, the midwife may bill antepartum care, postpartum care, or both, depending on which service(s) the nurse midwife performed. If the physician bills for delivery only, including postpartum care, the nurse midwife may bill only for the antepartum care provided.

Medicaid covers sterilization at the time of delivery only if the physician performs the procedure, and only if all other Medicaid requirements for sterilization are met. Refer to Chapter 28, Physician, for sterilization requirements.

25.3 Prior Authorization and Referral Requirements

Nurse midwife procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

25.4 Cost Sharing (Copayment)

The copayment does not apply to antepartum care, delivery, and postpartum care and family planning provided by nurse midwives. Copayment is required for well-woman gynecological services except for those recipients under the age of 18.

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

25.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Nurse midwives providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

25.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Nurse Midwife providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

25.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

Family Planning diagnosis codes are in the V25 category and maternity care diagnosis codes are in the 600 category of the ICD-9-CM.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

25.5.3 Procedure Codes and Modifiers

Nurse midwife providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

Nurse Midwives are generally reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

Nurse midwives may submit claims and receive reimbursements for the following services:

Family Planning

Nurse midwives may submit claims and receive reimbursements for Family Planning services, excluding sterilization procedures. See Appendix C, Family Planning, for these procedure codes. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

GYN Services

Nurse midwives may bill office procedure codes 99201-99233.

Maternity Care

Code	*Procedure Description*
59400	Routine obstetric care includes antepartum care, vaginal delivery (with or without episiotomy and/or forceps), and postpartum care
59409	Vaginal delivery only
59410	Vaginal delivery only (with or without episiotomy, and/or forceps), including postpartum
59414	Delivery of placenta following delivery of infant outside of hospital
59425*	Antepartum care only (4-6 visits)
59426	Antepartum care only (7 or more visits)
59430	Postpartum care only
54150	Circumcision

NOTE:

* For three or fewer visits, use office visit codes: 99201-99233

25.5.4 Place of Service Codes

The following place of service codes apply when filing claims for nurse midwife services:

POS	*Description*
21	Inpatient Hospital
11	Physician's Office
12	Patient's Home
22	Outpatient
23	ER-Hospital
25	Birthing Center

25.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

25.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

26

26 Nursing Facility

Medicaid reimburses medically necessary nursing facility services. Nursing facilities must meet the licensure requirements of the Alabama Department of Public Health and the certification requirements of Title XIX and XVIII of the Social Security Act, and must comply with all applicable state and federal laws and regulations.

A nursing facility is an institution that primarily provides one of the following:

- Nursing care and related services for residents who require medical or nursing care
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons
- Health care and services to individuals who require a level of care available only through institutional facilities

A facility may not include any institution for the care and treatment of mental disease except for services furnished to individuals age 65 and over or any institutions for the mentally retarded or persons with related conditions.

The policy provisions for nursing facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10, and Part 483 of the Code of Federal Regulations.

26.1 Enrollment

HP enrolls nursing facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a nursing facility provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nursing facility-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Nursing facility providers are assigned a provider type of 03 (Nursing Facility). The valid specialty for nursing facility providers is Nursing Facility (035).

Enrollment Policy for Nursing Facility Providers

To participate in the Alabama Medicaid Program, nursing facility providers must meet the following requirements:

- Possess certification for Medicare Title XVIII
- Submit a budget to the Provider Reimbursement Section at Medicaid for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Resident Agreement with Medicaid

The Provider Agreement details the requirements imposed on each party to the agreement. It is also the document that requires the execution of the Nursing Facility/Resident Agreement.

The Nursing Facility/Resident Agreement must be executed for each resident on admission and annually thereafter. If the liability amount changes for the resident or if there are policy changes, the agreement must be signed and dated as these changes occur. One copy of the agreement is given to the resident/personal representative and a copy is retained by the nursing facility. The completed Nursing Facility/Resident Agreement becomes an audit item by Medicaid.

HP is responsible for enrolling all nursing facility providers including any Medicare certified nursing facilities who wish to enroll as a QMB Medicare only provider.

Renewal Process for Nursing Facilities

The Alabama Department of Public Health conducts annual recertification of all nursing facility providers and provides the recertification information to Medicaid.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

26.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Nursing facilities must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and the Disabilities Act of 1990.

Nursing facilities must maintain identical policies and practices regarding transfer, discharge, and covered services for all residents regardless of source of payment.

Nursing facilities must have all beds in operation certified for Medicaid participation.

Nursing facilities must not require a third party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility.

Nursing facilities may require an individual who has legal access to a resident's income or available resources to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Covered Services

The following services are included in basic covered nursing facility charges:

- All nursing services to meet the total needs of the resident, including treatment and administration of medications ordered by the physician
- Personal services and supplies for the comfort and cleanliness of the resident. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance such as hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, basic personal laundry and incontinence care.
- Room (semiprivate or ward accommodations) and board, including special diets and tube feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.
- All services and supplies for incontinent residents, including diapers and linen savers
- Bed and bath linens
- Nursing and treatment supplies as ordered by the resident’s physician as required, including needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W)

- Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents
- Materials for prevention and treatment of bed sores
- Medically necessary over-the-counter (non-legend) drug products when ordered by a physician. Generic brands are required unless brand name is specified in writing by the physician
- OTC drugs are covered under the nursing facility per diem rate with the exception of insulin covered under the Pharmacy program

Non-covered Services

Special (non-covered) services, drugs, or supplies not ordinarily included in basic nursing facility charges may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between the resident, or their personal representative and the nursing facility

- Prosthetic devices, splints, crutches, and traction apparatus for individual residents

If payment is not made by Medicare or Medicaid, the facility must inform the resident/personal representative that there will be a charge, and the amount of the charge. Listed below are general categories and examples of items:

- Telephone;
- Television/radio for personal use;
- Personal comfort items, including smoking materials, notions and novelties, and confections;
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- Personal clothing;
- Personal reading matter;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and entertainment offered outside the scope of the required activities program;
- Noncovered special care services such as privately hired nurses or aides;
- Private room, except when therapeutically required (for example: isolation for infection control);
- Specially prepared or alternative foods request instead of the food generally prepared by the facility;
- Beauty and barber services provided by professional barbers and beauticians;
- Services of licensed professional physical therapist;
- Routine dental services and supplies;
- Tanks of oxygen.

Medicaid provides other services under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

Payment for Reservation of Beds

Neither Medicaid residents, nor their families, nor their personal representative, may be charged for reservation of a bed for the first four days of any period during which a Medicaid resident is temporarily absent due to admission to a hospital. Prior to discharge of the resident to the hospital, the resident, the family of the resident, or the personal representative of the resident is responsible for making arrangements with the nursing home for the reservation of a bed and any costs associated with reserving a bed for the resident beyond the covered four-day hospital reservation period. The covered four-day hospital stay reservation policy does not apply to:

- Medicaid-eligible residents who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
- Any non-Medicaid residents;
- A resident who has applied for Medicaid but has not yet been approved; provided that if such a resident is later retroactively approved for Medicaid and the approval period includes some or all of the hospital stay, then the nursing home shall refund that portion of the bed hold reservation charge it actually received from the resident, family of the resident, or personal representative of the resident for the period that would have been within the four covered days policy; or
- Medicaid residents who have received a notice of discharge for non-payment of service.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the resident will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held in accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

Therapeutic Visits

Payments to nursing facilities may be made for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter. A therapeutic leave visit may not exceed three days per visit. A resident may have a therapeutic visit that is one, two, or three days in duration as long as the visit does not exceed three days per visit or six days per quarter. Visits may not be combined to exceed the three-day limit.

The nursing facility must ensure that each therapeutically indicated visit by a resident to home, relatives, or friends is authorized and certified by a physician.

Payments to ICF/MR facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid is not responsible for the record-keeping process involving therapeutic leave for the nursing facility. Medicaid will track the use of therapeutic leave through the claims processing system.

The nursing facility must provide written notice to the resident and a family member or legal representative of the resident, specifying the Medicaid policy when a resident takes therapeutic leave and when a resident transfers to a hospital.

The nursing facility or ICF/MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility. Residents are readmitted immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

Residents with Medicare Part A

Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.

An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. Medicaid will make no payment for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

Nursing facilities must ensure that Medicaid recipients eligible for Medicare Part A benefits first use Medicare benefits before accepting a Medicare/Medicaid recipient as a Medicaid resident.

Residents who do not agree with adverse decisions regarding level of care determinations by Medicare should contact the Medicare fiscal intermediary.

Application of Medicare Coverage

Nursing facility residents, either through age or disability may be eligible for Medicare coverage up to 100 days.

Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.

Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

Individuals with income in excess of the Federal Benefit Rate (FBR) can become eligible for Medicaid after they have been in an approved medical institution for 30 continuous days. After completing 30 continuous days the individual is entitled to retroactive coverage to the first day of the month of entry provided the recipient meets all other points of eligibility.

Individuals entering the nursing facility who are Medicaid eligible through SSI will be eligible for the month in which they enter the nursing facility. Eligibility after the first month must be established through the Medicaid District Office unless the individual's income is less than $50. An individual with income less than $50 must be certified for SSI by the Social Security Administration.

An applicant must be medically approved by Medicaid or Medicare prior to financial approval.

Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 25.

Retroactive Medicaid coverage is an exception to the above. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.

For retroactive Medicaid coverage the determination of level of care will be made by the nursing facility's RN. The nursing facility should furnish the Long Term Care Division or its designee, a Form 161B, a Form 161, and the financial award letter for the retro period of time.

Nursing Aide Training

A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility for more than four months unless the individual has completed training and a competency evaluation program approved by the state.

The Alabama Department of Public Health is responsible for the certification of the Competency Evaluation programs and maintains a nurse aide registry.

Pre-admission Screening and Resident Review

Prior to admission, all individuals seeking admission into a nursing facility must be screened for suspected mental illness (MI), intellectual disability (ID), or a related condition (RC) to determine if the individual's care and treatment needs can most appropriately be met in the nursing facility or in some other setting.

A Level I Screening document (LTC-14) must be completed in its entirety and submitted to the OBRA PASRR Office for a Level I Determination prior to admission. The Level I Screening can be completed by anyone who has access to the medical records excluding family members.

The nursing facility is responsible for ensuring that the applicant is not admitted into the nursing facility without a Level I Screening, Level I Determination and Level II Determination, if applicable, from the Department of Mental Health. The nursing facility is responsible for ensuring that the Level I Determination is signed and dated by the RN indicating that the Level I Screening is accurate based on the available medical records.

The Department of Mental Health is responsible for conducting a Level II Evaluation on all applicants and residents with a suspected diagnosis of MI/ID/RC to determine the individual's need for mental health specialized services and medical eligibility. For all residents with a primary or secondary diagnosis of MI/ID, the Department of Mental Health will make the determination of appropriate placement in a nursing facility, based on the results of the Level II Screening and the application of Medicaid medical criteria.

If the nursing facility fails to obtain the Level I Screening, Level I Determination and Level II Determination, if applicable, made by the Department of Mental Health prior to admitting the resident into their facility, the Alabama Medicaid Agency will recoup all Medicaid payments for nursing facility services from the date of the resident's admission and continuing until the Level I Determination or Level II Determination, if applicable is received.

If a resident is discharged into the community for more than 30 days, a new Level I Screening, Level I Determination, and Level II Determination, if applicable, is required before admission.

If the nursing facility's interdisciplinary team identifies a significant change in the condition of a resident with a diagnosis of MI/ID/RC, an updated Level I Screening must be completed and submitted to the Department of Mental Health's PASRR Office within 14 days of the resident's status change to receive an updated Level II Determination to establish continued eligibility. If the nursing facility fails to update the Level I Screening for a significant change in a resident's condition, the Alabama Medicaid Agency may recoup all Medicaid payments for nursing facility services from 14 days of the resident's change in condition and continuing until the updated Level II Determination is received.

Admission Criteria

The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person receives covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for nursing facility care under the following circumstances:

- The physician must certify the need for admission and continuing stay.
- The recipient requires nursing care on a daily basis.
- The recipient requires nursing services that as a practical matter can only be provided in a nursing facility on an inpatient basis.
- Nursing services must be furnished by or under the supervision of a RN and under the general direction of a physician.

A nursing care resident must require **two or more** of the following specific services:

a. Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment
b. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
c. Nasopharyngeal aspiration required for the maintenance of a clear airway
d. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
e. Administration of tube feedings by naso-gastric tube
f. Care of extensive decubitus ulcers or other widespread skin disorders
g. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
h. Use of oxygen on a regular or continuing basis
i. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post operative, or chronic conditions
j. Comatose resident receiving routine medical treatment
k. Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).

2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).

5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).

9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

NOTE:

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.

Four 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.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy, ileostomy or urostomy.

NOTE:

The above criteria will be applied to all initials admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing facility and residents who are re-admitted in less than 30 days after discharge into the community. These residents need to meet only one criteria (a-k) in paragraph two, of the above.

Individuals admitted to a nursing facility as a private pay resident in spend down status with no break in institutional care for more than 30 days and becomes financially eligible for Medicaid, must meet only one of the criteria to transfer from private pay to a Medicaid admission.

Admission to a Nursing Facility from an Inpatient Psychiatric Hospital

A resident may temporarily transfer from an inpatient psychiatric hospital to a nursing facility for a two week trial period. If the resident leaves the nursing facility before the two week period has elapsed, the inpatient psychiatric hospital is responsible for reimbursing the nursing facility. If the resident has a successful trial period with the expectation of remaining in the facility long term, then the inpatient psychiatric facility will discharge the resident so that the nursing facility can admit him/her. The nursing facility must ensure that the resident meets the nursing facility admission criteria. Additionally, the nursing facility must ensure that all required documents, Pre-Admission Screening and Resident Review and the Minimum Data Set are completed for these residents. The nursing facility will be reimbursed by Medicaid if financial eligibility and medical criteria are met.

Medical Director

The nursing facility shall retain a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full time basis as is appropriate for the needs of the residents and the facility.

- If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.
- A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, or a hospital medical staff, or through another similar arrangement.

The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents.

The medical director is responsible for the development of written by laws, rules, and regulations that are approved by the governing body and include delineation of the responsibilities of attending physicians.

The medical director coordinates medical care by meeting with attending physicians to ensure that they write orders promptly upon admission of a resident, and periodically evaluating the professional and supportive staff and services.

The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety. The medical director gives the administrator appropriate information to help ensure a safe and sanitary environment for residents and personnel.

The medical director is responsible for the execution of resident care policies.

Conditions Under Which Nursing Facility Is Classified as Mental Disease Facility

If the facility under examination meets one of the following criteria, Medicaid considers the facility to be maintained primarily for the care and treatment of individuals with mental disease:

- It is licensed as a mental institution.
- More than fifty percent (50%) of the residents receive care because of disability in functioning resulting from a mental disease.

Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and *Statistical Manual of Mental Disorders, Current Edition, International Classification of Diseases*, adopted for use in the United States, (ICD 9) or its successor, except mental retardation.

Conditions Under Which Nursing Facility Is Not Classified as Mental Disease Facility

Nursing facilities located on grounds of state mental hospitals or in the community must meet specific conditions in order to qualify for federal matching funds for care provided to all individuals eligible under the state plan.

Medicaid is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet any of the following criteria:

- The facility is established under state law as a separate institution organized to provide general medical care, and provides such care.
- The facility is licensed separately under state law governing licensing of medical institutions other than mental institutions.
- The facility is operated under standards that meet those for nursing facilities established by the responsible State authority.
- The facility is dually certified under Title XVIII and XIX.
- The facility is not maintained primarily for the care and treatment of individuals with mental disease.
- The facility is operated under policies that are clearly distinct and different from those of the mental institutions, and the policies require admission of residents from the community who need the care it provides.

Nursing facilities in the community must meet all but the last of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

Nursing facilities on the grounds of mental hospitals must meet all of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

The facilities that do not meet the conditions listed above are classified as institutions for mental diseases for Medicaid payment purposes. In such facilities, unless the facility is JCAHO-accredited as an inpatient psychiatric facility, payments are limited to Medicaid residents who are 65 years of age and older. If the facility is JCAHO-accredited as an inpatient psychiatric facility, payments may be made on behalf of the individuals who are under age 21 or are 65 years of age and older.

Medicaid Per Diem Rate Computation

The Medicaid per diem rate is determined under reimbursement methodology contained in the *Alabama Medicaid Agency Administrative Code*, Chapter 22. The rates are based on the cost data contained in cost reports (normally covering the period July 1 through June 30).

Reimbursement and Payment Limitations

Reimbursement is made in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 22*.*

Each nursing facility has a payment rate assigned by Medicaid. The resident's available monthly income minus an amount designated for personal maintenance (and in some cases, amounts for needy dependents and health insurance premiums) is first applied against this payment rate, and then Medicaid pays the balance.

- The nursing facility may bill the resident for services not included in the per diem rate (non-covered charges) as explained in this section.
- The monthly income is prorated if the resident is not in the facility for the entire month.
- Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

Medicaid defines a ceiling for operating costs for nursing facilities. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, or contact the Provider Audit Division at the Agency for more details.

Nursing Facility Records

Nursing facilities are required to keep the following minimum records:

- Midnight census by resident name at least one time per calendar month (more frequent census taking is recommended)
- Ledger of all admissions, discharges, and deaths
- Complete therapeutic leave records
- A monthly analysis sheet that summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days

Cost Reports

Each provider is required to file a complete uniform cost report for each fiscal year ending June 30. Medicaid must receive the complete uniform cost report on or before September 15. Should September 15 fall on a state holiday or weekend, the complete uniform cost report is due the next working day. Please prepare cost reports carefully and accurately to prevent later corrections or the need for additional information.

Review of Medicaid Residents

Medicaid or its designated agent will perform a review of Medicaid nursing facility/ICF/MR facility residents' records to determine appropriateness of admission.

Medicaid or its designee will conduct a retrospective review on a monthly basis of 10% sample of admissions, re-admissions and transfers to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Agency or its designee within ten working days from receipt of the faxed letters shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Agency may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Clinical Services & Support Division, Medical & Quality Review Unit with supporting documentation.

The records should be mailed to the following address with a completed coversheet, found on the website at this link, *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* .

HP ENTERPRISE SERVICES

P.O. BOX 244032

MONTGOMERY, AL 36124-4032

26.3 Establishment of Medical Need

The Medicaid Agency has delegated authority for the initial and subsequent level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

The process to establish medical need includes medical and financial eligibility determination.

- The determination of level of care will be made by an RN of the nursing facility staff.
- Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

- New Admissions

  XIX LTC-9 Form 161. If criterion unstable medical condition is one of the established medical needs the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission.

A fully completed Minimum Data Set. However, the entire MDS does not have to be submitted for a retrospective review. Only the sections of the MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.

PASRR screening information, including the Level I Screening and Level I Determination and Level II Screening and Level II Determination if applicable.

Readmissions

XIX-LTC-9 Form 161

Updated PASRR screening information as required.

All Medicaid certified nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

- New Admissions

  Medicaid Patient Status Notification (Form 199).

  Form XIX LTC-9 Form 161

  PASRR screening information, including the Level I Screening and Level I Determination and Level II Screening and Level II Determination if applicable.

All Medicaid certified ICF/MR facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/MR level of care needs.

- New Admissions

  A fully completed Medicaid Patient Status Notification (Form 199).

  A fully completed ICF/MR Admission and Evaluation Data (Form XIX-LTC-18-22).

  The resident's physical history.

  The resident's psychological history.

  The resident's interim rehabilitation plan.

  A social evaluation of the resident.

- Readmissions

  Medicaid Patient Status Notification (Form 199).

  ICF/MR Admission and Evaluation Form.

A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings: (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for

Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the LTC-9 on new admissions.

- Authorization of eligibility by Medicaid physician

For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Clinical Services & Support Division, Medical & Quality Review Unit. The nurse reviewer will review and assess the documentation submitted and make a determination based on the total condition of the applicant. If the nurse reviewer cannot make the medical determination then the Alabama Medicaid Agency physician will approve or deny medical eligibility.

Application Denials

On each denied admission application, Medicaid advises the resident and/or personal representative, the attending physician, and the facility of the resident's opportunity to request a reconsideration of the decision and that they may present further information to establish medical eligibility.

If the reconsideration results in an adverse decision, the resident and/or personal representatives are advised of the resident's right to a fair hearing. If the reconsideration results in a favorable decision, normal admitting procedures are followed.

Signature Requirement

Under Alabama's Uniform Electronic Transactions Act, effective January 1, 2002, Alabama law recognizes the validity of electronic signatures. For all Medicaid Nursing Homes Forms, the signature must be an original signature or an approved electronic signature of the recipient's attending physician. Provider certification is made via standardized electronic protocol.

26.4 Coverage for Ventilator-Dependent and Qualified Tracheostomy Care Residents

Ventilator-dependents and qualified tracheostomy residents recipients can choose any Medicaid nursing facility that has been approved to provide services to ventilator-dependent recipients.

Information regarding the required medical eligibility and 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

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 with ONLY the Medicaid ID stating, "The record is ready for review." Do not send any PHI in the e-mail.

26.5 Cost Sharing (Copayment)

Copayment does not apply to services provided by nursing facility providers.

26.6 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Nursing facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

26.6.1 Time Limit for Filing Claims

Medicaid requires all claims for nursing facilities to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

26.6.2 Diagnosis Codes

The *International Classification of Diseases - Current Edition - Clinical Modification* (ICD-9-CM) manual or its successor, lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

26.6.3 Covered Revenue Codes

The type of bill for nursing facilities is 21X.

Nursing facilities are limited to the following revenue codes:

Code	*Description*
101	All inclusive room & board
183	Therapeutic leave
947	Nursing Home Ventilator

26.6.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

26.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

26.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

27

27 Pharmacy

The Alabama Medicaid Agency pays for certain legend and non-legend drugs that meet both of the following criteria:

- Prescribed by medical doctors and other practitioners including, but not limited to, nurse practitioners, dentists, and optometrists who are legally authorized to prescribe these drugs and who are enrolled in the Alabama Medicaid program as a Medicaid provider or as an Ordering, Referring, or Prescribing Only provider (new PT 97)
- Dispensed and/or administered by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws

The policy provisions for Pharmacy providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

27.1 Enrollment

HP enrolls Pharmacy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a pharmacy provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for pharmacy related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Pharmacy providers are assigned a provider type of 24 (Pharmacy). Valid specialties for Pharmacy providers include the following:

- Government Pharmacy 241

- Institutional Pharmacy 242
- Retail Pharmacy 240

Enrollment Policy for Pharmacy Providers

To participate in the Alabama Medicaid Program, Pharmacy providers must meet the following requirements:

- Operate under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered.
- Agree to abide by the rules and regulations of third party billing procedures. Refer to Section 3.3.6, Third Party Liability, for more information.
- Maintain records, including prescriptions, to fully disclose the extent of services rendered. Pharmacies should maintain records, such as purchase invoices and recipient signature logs, within the state of Alabama. At a minimum, prescription files, recipient signature logs, and invoices must be available for examination.
- Agree that Medicaid or its designated representative may conduct audits of required records as necessary. Invoice records must be maintained and readily available for inspection.

Out-of-State Pharmacies

Under State and Federal regulations, a pharmacy must sign an agreement with Alabama Medicaid Agency. However, when a recipient is in another state and requires service, the following procedure has been adopted.

Pharmacies Bordering Alabama

- Pharmacies bordering Alabama may participate in the Alabama Medicaid Program by completing an application for out-of-state pharmacies, and upon certification of the State Board of Pharmacy in that state that the pharmacy is registered and has been issued a permit.
- The pharmacy must then sign a Pharmacy Vendor Agreement with Alabama Medicaid Agency and agree to abide by the State pharmacy provider tax law.
- Pharmacies bordering Alabama are defined as those pharmacies located not more than 30 miles from the border of Alabama.

Pharmacies Not Bordering Alabama

- Drugs dispensed must be in concurrence with the limitations in place for in-state providers.
- Reimbursement will be made only for hemophilia factor products and specialty drugs which are not readily available in-state, and drugs dispensed to Medicaid recipients who may be traveling outside the state of Alabama.
- Providers of specialty drugs shall list the names of the drugs for which they intend to request reimbursement as well as the GCN or NDC numbers for each drug in the letter requesting enrollment with the Alabama Medicaid Agency.
- Pharmacies not bordering Alabama will be enrolled by the Medicaid fiscal agent on a temporary basis.

- Pharmacies not bordering Alabama are defined as those pharmacies located more than 30 miles from the border of Alabama.

27.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid pays for approved drug items when they are properly prescribed for eligible Medicaid recipients and dispensed in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 16.

The number of outpatient pharmacy prescriptions for all recipients except as specified below is limited to four brand name drugs per month per recipient. In no case can total brand name prescriptions exceed ten per month per recipient. There is no limit on generic and covered over-the-counter prescriptions. Prescriptions for Medicaid eligible recipients under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and prescriptions for Medicaid eligible nursing facility residents are excluded from these limitations.

Brand name anti-psychotic and anti-retroviral agents may be paid up to ten prescriptions per month but in no case can total brand name prescriptions exceed ten per month per recipient.

Coverage of up to ten brand name prescriptions per month may be allowed through overrides for drugs classified by American Hospital Formulary Services (AHFS) or First Data Bank (FDB) Therapeutic Class as Antineoplastic Agents, Antiarrhythmic Agents, Cardiotonic Agents, Miscellaneous Vasodilating Agents, Miscellaneous Cardiac Agents, Nitrates and Nitrites, Alpha Adrenergic Blocking Agents, -Beta Adrenergic Blocking Agents, Dihydropyridines, Miscellaneous Calcium Channel Blocking Agents, Diuretics, Angiotensin-Converting Enzyme Inhibitors, Angiotensin II Receptor Antagonists, Mineralocorticoid (Aldosterone) Receptor Antagonists, Central Alpha Agonists, Direct Vasodilators, Peripheral Adrenergic Inhibitors, Miscellaneous Hypotensive Agents, Hemostatics, Calcium Replacements, Electrolyte Depleters, Immunosuppresives, Alpha Glucosidase Inhibitors, Amylinomimetics, Biguanides, Dipeptidyl Peptidase-4 Inhibitors, Incretin Mimetics, Insulins, Meglitinides, Sulfonylureas, Thiazolidinediones and Miscellaneous Diabetic Agents. Overrides will be granted only in cases in which the prescribing physician documents medical necessity for the recipient to be switched from a product in one of the above named classes to a brand name product within the same therapeutic class in the same calendar month. The first product must have been covered by Medicaid.

Medicaid will not compensate pharmacy providers for:

- DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act
- Agents when used for anorexia, weight loss, or weight gain except for those specified by the Alabama Medicaid Agency
- Agents when used to promote fertility except for those specified by the Alabama Medicaid Agency

- Agents when used for cosmetic purposes or hair growth except for those specified by the Alabama Medicaid Agency
- Agents when used for the symptomatic relief of cough and cold except for those specified by the Alabama Medicaid Agency
- Agents when used to promote smoking cessation, unless authorized for pregnant females or Plan First recipients.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations and others as specified by the Alabama Medicaid Agency
- Nonprescription drugs except for those specified by the Alabama Medicaid Agency
- Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee
- Barbiturates except for those specified by the Alabama Medicaid Agency and for dual eligibles effective January 1, 2013 when used for the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications
- Benzodiazepines except for those specified by the Alabama Medicaid Agency and for dual eligible individuals effective January 1, 2013 as Part D will cover all indications
- Agents when used for the treatment of sexual or erectile dysfunction unless prior approved through medical necessity.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 16 for drugs not covered by Alabama Medicaid.

Unit Dosing in Nursing Facilities

Covered drug items may be dispensed to recipients, using an approved unit dose system for solid oral forms of the prescribed drug. Only one claim per drug per recipient may be submitted each month by any pharmacy using an approved unit dose system. Only the amount of the prescribed drug actually consumed by the patient may be billed.

Each dose of a drug dispensed using an approved unit dose system must be individually packaged in a sealed, tamper proof container and carry full disclosure labeling, including, but not limited to, product name and strength, manufacturer's or distributor's name, lot number and expiration date.

Prescriptions for controlled drugs must be filled or dispensed from a signed original or direct copy of the physician's prescription order.

27.2.1 Prescription Requirements

Medicaid reimburses for prescriptions documented and dated appropriately for legend and over-the-counter drugs covered by Medicaid.

Schedule II drug prescriptions require the manual signature of the prescribing physician before dispensing. Stamped or typewritten signatures are not acceptable. In accordance with the Code of Federal Regulations, § 1306.05, all prescriptions for schedule II substances shall be dated and signed by the prescribing physician the day when issued and

shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name and address and registration number of the practitioner.

Prescriptions dispensed by telephone for drugs other than Schedule II drugs are acceptable without subsequent signature of the practitioner.

Pharmacy providers should document any changes to the original prescription, such as physician approved changes in dosage, on the original prescription.

The pharmacy may refuse to accept Medicaid reimbursement for a Medicaid-covered item and bill the recipient as a regular paying patron if the provider informs the recipient prior to dispensing the prescription. The recipient has the right to have the prescription filled by any other authorized Medicaid pharmacy.

Effective April 1, 2008, all prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. The term “written prescription” does not include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated to the pharmacy by telephone by a prescriber. This requirement does not apply to refills of written prescriptions which were executed before April 1, 2008. It also does not apply to drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other institutional and clinical settings to the extent the drugs are reimbursed as part of a per diem amount or where the order for a drug is written into the medical record and the order is given directly to the pharmacy by the facility medical staff.

- If a written prescription is received which is not on a tamper-resistant prescription blank, the pharmacy must contact the prescribing provider and either have the prescription re-submitted in compliant written form or convert the prescription, where otherwise allowable, into verbal, faxed or electronic form.

- In an emergency situation where the pharmacy is unable to contact the prescribing provider, the pharmacy may choose to fill the prescription from the non-compliant form and subsequently obtain a prescription in compliant form. If a compliant prescription cannot be obtained within 72 hours, the pharmacy must withdraw the claim.

- To be considered tamper-resistant on or after April 1, 2008, a prescription pad must contain at least one of the following three characteristics:

    1. one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; or
    2. one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; or
    3. one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

- To be considered tamper-resistant on or after October 1, 2008, a prescription pad must contain all of the foregoing three characteristics.

Effective May 1, 2008, an override will be required for a brand name drug with an exact generic equivalent submitted with a Dispense as Written code of 1. In this case, the provider must provide documentation of the medical necessity for the brand name, rather than the available generic equivalent and receive an override. This override applies to those instances where the prescriber has written a prescription for a brand name drug when a pharmaceutically and therapeutically equivalent drug product is available generically. Exclusions to this process include carbamazepine, levothyroxine, phenytoin, and warfarin. Overrides may be completed and faxed or mailed to the Pharmacy Administrative Services contractor, currently Health Information Designs.

27.2.2 Appropriate Utilization of Dispense As Written (DAW) Codes

Dispense As Written (DAW) product selection codes are an integral part of accurate billing to the Alabama Medicaid Agency and provide the agency with the reason why a specific brand or generic is dispensed based on the prescriber's instructions. Failure to accurately use DAW codes results in misinformation to the Pharmacy program and its decision making process. Misinformation on claims may also result in retrospective pharmacy review and/or recoupment. Inaccurate usage of DAW codes is among one of the discrepancies found during an audit and is one of the Primary Pharmacy Audit Components listed in the Provider Billing Manual Section 27.2.5. The following codes are the various DAW codes available to the Alabama Medicaid Pharmacy program with explanations that have been taken from the National Council on Prescription Drug Programs (NCPDP) version 5.1 data dictionary for field 408-D8 Product Selection Codes. Providers should utilize the correct codes based upon the information submitted on the prescription and the prescriber's signature:

- **0=No Product Selection Indicated-**This is the field default value that is appropriately used for prescriptions where product selection is not an issue. Examples include prescriptions written for single source brand products and prescriptions written using the generic name and a generic product is dispensed.

- **1=Substitution Not Allowed by Prescriber**-This value is used when the prescriber indicates, in a manner specified by prevailing law, that the product is to be Dispensed As Written.

- **2=Substitution Allowed-Patient Requested Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the patient requests the brand product. 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. *(Not permitted by Alabama Medicaid)*

- **3=Substitution Allowed-Pharmacist Selected Product Dispensed**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist determines that the brand product should be dispensed. This can occur when the prescriber writes the prescription using either the brand or generic name and the product is available from multiple sources.

- **4=Substitution Allowed-Generic Drug Not in Stock**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since a currently marketed generic is not stocked in the pharmacy. This situation exists due to the buying habits of the pharmacist, not because of the unavailability of the generic product in the marketplace.

- **5=Substitution Allowed-Brand Drug Dispensed as a Generic**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the pharmacist is utilizing the brand product as the generic entity.

- **6=Override** *(Not permitted by Alabama Medicaid)*

- **7=Substitution Not Allowed-Brand Drug Mandated by Law**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted but prevailing law or regulation prohibits the substitution of a brand product even though generic versions of the product may be available in the marketplace.

- **8=Substitution Allowed-Generic Drug Not Available in Marketplace**-This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted and the brand product is dispensed since the generic is not currently manufactured, distributed, or is temporarily unavailable. *(In the event of an audit, provider shall make available documentation to validate product unavailability).*

- **9=Substitution Allowed- Plan Requests Brand Dispensed –** This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the plan's formulary requests the brand product to be dispensed.

To indicate instructions to the dispensing pharmacy, a physician simply signs the prescription in a manner specified by prevailing law to indicate to a providing pharmacy whether or not generic substitution is allowed. Effective May 1, 2008 an override form and Medwatch 3500 form is required in order to medically justify a provider's reason for requesting a branded product when an exact generic equivalent is available. DAW overrides and the Medwatch 3500 form should be submitted to the Pharmacy Prior Authorization contractor.

27.2.3 Quantity Limitations

Claims must be submitted in the units specified on the prescription by the prescribing physician up to a 34 day supply. Medications supplied in a dosage form that would prevent the dispensing of an exact 30-34day supply for chronic medications, such as insulin, may require quantities that exceed the 34 day maximum and would not be subject to recoupment as long as the pharmacist can provide appropriate documentation.

Pharmacies may not split a 34 day supply into small units and submit them as separate claims.

A pharmacist should not change quantities (units) of drugs prescribed by a physician except by authorization of the physician. The pharmacist must contact the prescribing physician for authorization to reduce the quantity of any Medicaid prescription and note physician authorization on the prescription form.

If the prescription to be paid by Medicaid exceeds the drug's maximum unit limit allowed per month, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the recipient can be charged as a cash recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be "split billed" (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied. A prescriber should not write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process.

NOTE:
A provider's failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service.

If the full quantity prescribed is not available at the time of dispensing, the pharmacist may dispense the quantity available. In this case the pharmacist must note on the prescription the number of units dispensed and retain the claim until the balance of medication is dispensed. Only one claim with one dispensing fee may be billed.

27.2.4 Prescription Refill

Prescriptions cannot exceed eleven refills for non controlled prescriptions and five refills for Control III-V prescriptions. Medicaid will deny claims for prescription refills exceeding eleven for non controlled prescriptions and five for Control III-V prescriptions. Prescriptions may be refilled only with the prescribing provider's authorization. Failure of the prescribing provider to designate refills on a prescription will be interpreted as no refills authorized. If a prescription is refilled, the date the prescription is refilled must appear on the prescription.

Pharmacy providers should refill all prescriptions only in quantities corresponding to dosage schedule and refill instructions.

The use of automatic refills by pharmacies is not allowed by the Medicaid Agency. Prescriptions that have been filled but not picked up by the patient or patient's authorized representative should be credited back to pharmacy stock and Medicaid through claims reversal within sixty days.

Violations of these policies may result in unauthorized charges. The pharmacy may be held liable or Medicaid may cancel the pharmacy vendor agreement.

Early Refills

Pharmacies should not dispense refill medication to recipients until the recipient has used at least 75% of the original supply. Pharmacists must document on the original prescription that the prescribing physician was consulted and the physician approved dispensing early refills.

NOTE:

Medicaid may recoup payments for early refills.

Health Information Designs (HID) is contracted with the Alabama Medicaid Agency to assist pharmacists receiving hard denials, such as early refills, therapeutic duplication and excessive quantity. Pharmacies must receive an override from HID before payment will be made. **Contact HID at 1 (800) 748-0130**. Only HID can issue the necessary override.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the patient will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held in accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

27.2.5 Reimbursement for Covered Drugs and Services

This section describes reimbursement for multiple source drugs, over-the-counter medications and other drugs, dispensing fees, vaccine administration and pricing.

Multiple Source Drugs

Medicaid reimbursement for covered multiple source drugs will not exceed the lowest of the:

- Federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS, plus a reasonable dispensing fee
- Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee
- Provider's Usual and Customary Charge to the general public for the drug

- Alabama State Maximum Allowable Cost (MAC) defined as the Average Acquisition Cost of a drug multiplied by 1.0 plus a reasonable dispensing fee that will apply to all multisource drugs within a particular drug grouping.

NOTE:

AEAC is defined the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%.

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases, the provider must provide documentation of the medical necessity for the brand name rather than the available generic equivalent and receive an override.

Prescription Compounding

Deleted: ~~can~~
Added: must

Added: Bulk products (i.e.powders)…claim will deny.

Deleted: ~~Pharmacists may also…minutes expended compounding.~~

Added: The finished compound…before being covered.

Added: The maximum payable…HID at 1 (800) 748-0130

Alabama Medicaid pays for prescription drugs through the billing of NDCs. Pharmacists may dispense compounded medications when prescribed and must bill for each ingredient with a valid NDC on a single claim. Bulk products (i.e. powders) used for compounded medications are non-covered for adults (aged 21 and older). Some exclusions may apply. Bulk products must be submitted as a compound claim. Bulk products submitted on a pharmacy claim will deny.

The finished compound must not be available as a legend or over-the-counter product in an equivalent dosage form/route of administration. Compound products are subject to review, must meet medical criteria and may require peer-reviewed medical literature before being covered.

The maximum payable amount for a compounding product is $200 per claim. Requests for overrides for compounded products that exceed $200 should be referred to HID at 1 (800) 748-0130.

Other Drugs

Reimbursement for covered drugs other than multiple source drugs will not exceed the lower of the Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee, OR the provider's Usual and Customary Charge to the general public for the drug. For blood clotting factor products, Medicare Part B Drug pricing plus a reasonable dispensing fee is utilized.

Dispensing Fees

A reasonable dispensing fee is set by the Agency. The fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted. The dispensing fee paid by the agency effective September 22, 2010 is $10.64.

Only one dispensing fee is allowed for a 34 day supply of the same drug per month unless the recipient qualifies for an “early refill”. To qualify for an “early refill”, the recipient must have used 75% of the original supply or there is a documented consultation with the prescribing physician authorizing the refill.

Over-the-Counter Medications (OTCs)

Medicaid pays for certain OTCs through the Medicaid pharmacy program. OTCs dispensed to an eligible Medicaid recipient may be submitted for payment by utilizing the appropriate NDC number.

Over-the-counter medications require a prescription from a physician or other practitioner legally licensed by the State of Alabama to prescribe the drugs authorized under the program. Telephone prescriptions are acceptable for OTCs.

Long term care facilities may bill OTC insulins covered by the Medicaid pharmacy program by submitting for payment the NDC number utilized. All other OTCs should be billed by the nursing facility using the facility cost report.

Do not dispense more medication than indicated on the prescription unless authorized by the prescribing physician to do so.

Medicaid will reimburse for covered OTCs as stated under Multiple Source Drugs.

Non-Drug Items

Alabama Medicaid Agency reimburses for certain non-drug items, including but not limited to spacers, syringes, and tablet splitters, through the pharmacy program with a valid prescription and NDC number. Other supplies such as blood glucose testing strips and lancets may be billed through Durable Medical Equipment. Please refer to chapter 14.2 for complete information.

Vaccine Administration

Alabama Medicaid will reimburse Medicaid-enrolled pharmacy providers for the administration of the influenza, Tdap and pneumococcal vaccines for eligible recipients age 19 and older. 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 99999-9992-11 for pneumococcal vaccine administration, and 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, email, mail) each recipient's PMP upon administration of any vaccines 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) 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.

Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.

Total Parenteral Nutrition

Alabama Medicaid Agency may reimburse for total parenteral nutrition (TPN) through the pharmacy program if the order/prescription and recipient meets certain requirements. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN) and intraperitoneal nutrition (IPN). Please refer to chapters 35.2 and 28.2 for complete information.

340 B Pricing

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible 340B entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

Eligible entities are defined in 42 U.S.C. § 256b(a)(4).

When an eligible 340B entity other than a disproportionate share hospital, a children's hospital excluded from the Medicare prospective payment system, a free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital submits a bill to the Medicaid Agency for a drug purchased by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency.

A disproportionate share hospital, children's hospital excluded from the Medicare prospective payment system, free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital may bill Medicaid the total charges for the drug. As manufacturer price changes occur, the entities must ensure that their billings are updated accordingly.

Eligible 340B entities are identified on the Department of Health and Human Service's website. These entities shall notify Medicaid of their designation as a 340B provider.

Audits of the eligible entities' (claims submissions and invoices) will be conducted by the Medicaid Agency. Eligible 340B entities, other than the providers listed above, must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency in accordance with Chapter 33 of the Administrative Code.

27.2.6 Primary Pharmacy Audit Components

The following information serves as a general guide to the components of a Medicaid Pharmacy Audit. Although the list provided may not be all-inclusive, it covers approximately 95% of discrepancies found through on-site and desk review audits. Questions regarding this information may be directed to Medicaid at (334) 242-5734.

- **DAW Audits** - Use of the Dispense As Written (DAW) codes will be audited on a regular basis to ensure correct billing.
- **Usual & Customary (U&C)** - For specified products, submitted charge will be compared to cash price to general public. Adjustments may be initiated.
- **Inaccurate Billing** - The NDC number of the product actually dispensed should be billed. The NDC number is package size and manufacturer specific. Days supply should be clinically appropriate according to prescription or physician's instructions.
- **Multiple Dispensing Fees** - Providers must have documentation to include call-in and hard copy prescriptions to support the multiple dispensing of the same product, same strength to the same patient within a 30 day period.
- **Drug Name, Form Strength & Quantity Differs From Prescription –** On CII prescriptions, the prescribing physician must authorize all changes from the original prescription before dispensing. Any change must be documented on the prescription.

- **Requirements for Signatures and Prescriptions** - Schedule II products require original prescription and signature. Other drugs may be called in without the subsequent signature of the physician as allowed by State law.
- **Tamper Resistant Prescriptions** - Prescriptions for outpatient drugs for Medicaid recipients which are executed in written (and non-electronic) form must be executed on tamper-resistant prescription pads. Non-compliant prescriptions will result in recoupments.
- **Changing Claim Information to Force Payment** - The system recognizes and denies exact duplicates. Providers may not alter NDC number, date of service, prescription number, or any other claim requirement to force payment through duplicate edits.
- **Timely Prescription Reversal-** If a patient or a patient's authorized representative has not picked up his/her prescription within sixty (60) days, the pharmacy is required to reverse the claim and credit Medicaid the amount originally billed.
- **Total Parenteral Nutrition (TPN)-** TPN prescriptions/orders include those used for hyperalimentation intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). A certification statement of medical necessity must be written or stamped on the prescription/order, or accompany all TPN prescriptions/orders.

Continued violations of Medicaid claims processing policies may result in recoupment and referral to the Alabama Attorney General's Office for investigation of fraud.

27.2.7 Drug Utilization Review (DUR)

The objective of DUR is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical outcomes.

This section contains information about the components of the DUR Program:

- General Information
- Prospective Drug Utilization Review (Pro DUR)
- Online Drug Utilization Review (Online DUR)
- National Council for Prescription Drug Programs (NCPDP) Standards
- Retrospective Drug Utilization Review (Retro DUR)

General Information

The DUR Program uses educational tools directed to physicians and pharmacists in order to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care by addressing:

- Potential and actual drug reactions
- Therapeutic appropriateness
- Over-utilization
- Under-utilization

- Appropriate use of generic products
- Therapeutic duplication
- Drug/disease contraindications
- Drug interactions
- Incorrect drug dosage or duration
- Drug allergy interactions
- Clinical abuse/misuse

The DUR Program reviews, analyzes and interprets patterns of drug usage against standards consistent with the American Medical Association Drug Evaluations, United States Pharmacopoeia Drug Index, American Hospital Formulary Service Drug Index, and peer reviewed medical literature.

DUR will be conducted for drugs dispensed to residents of nursing facilities.

NOTE:

Pharmacists should refer cases of possible fraud or abuse to the Medicaid Program Integrity Division. Information may be provided through the Medicaid Agency's Fraud hotline by calling 1(866) 452-4930. Calls may be made anonymously.

Prospective DUR

Prospective DUR (Pro-DUR) is required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include screening, patient counseling, and use of patient profiles.

Pro-DUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement for participation in the program.

Online DUR

Medicaid provides an online system to assist the dispensing pharmacist. Incoming drug claims are compared to the patient's medical and pharmacy claims history files to detect potential therapeutic problems. DUR alert messages are returned to the pharmacist for significant problems discovered by this review.

Potential problems identified include:

- Therapeutic duplication – Examples of therapeutic duplication, involving overlapping periods of time where such therapy is not medically indicated, include:
  - Two or more doses of the same drug
  - At least two drugs from the same therapeutic class
  - At least two drugs from different therapeutic classes with similar pharmacological effects being used for the same indication
- Drug/Disease contraindications
- Drug interactions

- Incorrect dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse or misuse
- Preferred drug status

Medicaid distributes criteria and standards to providers in Medicaid Provider Notices and Bulletins.

Pharmacists must respond to prospective DUR alerts to continue claims processing through HP.

Pharmacies without computers must screen based on guidelines provided by the Alabama State Board of Pharmacy Practice Act and criteria and standards endorsed by Medicaid's DUR Board.

National Council for Prescription Drug Programs (NCPDP) Standards

Pharmacy claim telecommunication standards dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert. Displaying these fields to the pharmacist facilitates communication when health care providers discuss the potential therapeutic problems discovered by online prospective DUR.

This section explains DUR fields and information, lists standard response fields and codes, shows example DUR alert messages, and lists DUR alerts in order of priority.

Field Name	***Information Displayed in the Field***
Conflict Code	Alerts the pharmacist that the incoming drug claim conflicts with information in the patient's history file or with predetermined screening criteria ER = Early Refill TD = Therapeutic duplication DD = Drug Interaction EQ = Excessive Quantity
Clinical Significance/Severity Index Code	Indicates database-assigned significance of the conflict. 0 = Not applicable 1 = Major 2 = Moderate 3 = Minor
Other Pharmacy Indicator	Informs the pharmacist of the originating location of the claim with which the incoming drug claim conflicts. 0 = Not applicable 1 = Your Pharmacy 3 = Other Pharmacy
Previous Date of Fill	The last recorded date of the active medication in the patient's history file with which the incoming drug claim conflicts.
Quantity of Previous Fill	Quantity of previously filled prescription with which the incoming drug claim conflicts
Database Indicator	Identifies source of DUR conflict information 0 = Not applicable 1 = First DataBank. 4 = Processor Developed
Other Prescriber Indicator	Identifies the prescriber of the previously filled prescription with which the incoming drug claim conflicts. 0 = Not applicable 1 = Same Prescriber 2 = Other Prescriber
Free Text Message	30-character field that transmits decoded information regarding the DUR conflict.

To respond to an alert, the pharmacist must enter the corresponding codes to describe the action taken on the alert in the response fields. For a claim that generates multiple alerts, the pharmacist's response indicates that each alert has been considered and the response should be applied to all alerts generated by this claim.

The pharmacist should respond to alerts with the appropriate conflict code. For example, enter TD for Therapeutic Duplicate in response to a therapeutic duplication alert.

Do not change any claim information such as the NDC code or Quantity unless you are indicating your change with the appropriate Outcome Codes listed in the table below**.** Changing claim information could cause your claim to deny online.

Response fields and codes are listed in the following table:

Response Field	***Response Codes***
Conflict Codes	HD – High Dose ER – Early Refill LR – Late Refill DD – Drug-Drug Interaction TD – Therapeutic Duplication PS – Product Selection
Intervention Codes	M0 – Prescriber consulted P0 – Patient consulted R0 – Pharmacist consulted other source
Outcome Codes	1A - Filled As Is, False Positive 1B - Filled Prescription As Is 1C - Filled, with Different Dose 1D - Filled, with Different Directions 1E - Filled, with Different Dose 1F - Filled, with Different Quantity 2A - Prescription Not Filled 2B - Not Filled, Directions Clarified

NOTE:

Intervention codes contain the number zero, not the letter O. Using the letter O will cause your claim to deny online.

Proprietary pharmacy software for prescription processing systems may display DUR alerts in different formats. Examples of standard content of DUR messages are presented below. These may differ from the message actually displayed on the pharmacist's computer screen.

Example DUR Alert Messages	
On April 2, 1998, the pharmacist attempts to dispense an aspirin-containing product to a patient currently receiving welfare in prescribed by the same physician and filled at another pharmacy:	
CONFLICT CODE:	DD - DRUG INTERACTION
SEVERITY:	1 = Major
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980315 (March 15, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
MESSAGE:	Coumadin
On April 19, the pharmacist attempts to dispense a refill for which the previous prescription has greater than 25 percent of days supply remaining:	
CONFLICT CODE:	ER - OVERUTILIZATON
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980301 (March 1, 1998)
QUANTITY OF PREVIOUS FILL:	90
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
The pharmacist attempts to dispense a refill of levothyroxine on May 15, a date equal to greater than 125 percent of previous prescription's days supply:	
CONFLICT CODE:	LR - UNDERUTILIZATION
OTHER PHARMACY INDICATOR:	1 = Same Pharmacy
PREVIOUS FILL DATE:	19980401 (April 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
OTHER PRESCRIBER INDICATOR:	1 = Same Prescriber
On May 12, the pharmacist attempts to dispense flurazepam to a patient with an active prescription for triazolam:	
CONFLICT CODE:	TD - THER. DUPLICATION
OTHER PHARMACY INDICATOR:	3 = Other Pharmacy
PREVIOUS FILL DATE:	19980501 (May 1, 1998)
QUANTITY OF PREVIOUS FILL:	30
DATABASE INDICATOR:	1 = First DataBank
OTHER PRESCRIBER INDICATOR:	2 = Other Prescriber
MESSAGE:	Triazolam
The pharmacist attempts to dispense acetaminophen w/codeine, three tablets every 4 hours (dose exceeds usual adult daily maximum):	
CONFLICT CODE:	HD - HIGH DOSE
DATABASE INDICATOR:	1 = First DataBank
The pharmacist attempts to dispense an NDC that is not a preferred drug.	
CONFLICT CODE:	PS - PRODUCT SELECT OPPORTUNITY
DATABASE INDICATOR:	4 = Processor Developed

The system displays up to three DUR alerts for a prescription. To access additional alerts pertaining to the prescription, the pharmacist may call the HP Help Desk at 1(800) 456-1242.

Multiple alerts on a prescription are prioritized according to the following hierarchy:

1. Drug-drug interactions
2. Therapeutic duplication
3. Overutilization (early refill)
4. Incorrect dose (high dose)
5. Underutilization (late refill)
6. Preferred drug

Retrospective DUR

The retrospective DUR Program reviews, analyzes and interprets patterns of recipient drug usage through periodic examination of claims data to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care.

27.3 Prior Authorization and Referral Requirements

Pharmacy providers must contact Health Information Designs (HID) at 1(800) 748-0130 for overrides and prior authorization of drugs requiring prior approval. Only HID can issue prior authorizations and overrides.

HID should respond within 24 hours of receipt of requests for prior authorization and overrides. In cases of emergency, HID will make provisions for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug.

Federal Law also makes a provision for a 72-hour supply by using the following authorization number: 0000999527. This number is to be used only in cases of emergency. Utilization of this code will be strictly monitored and recoupments will be initiated when the code is found to have been used inappropriately.

27.3.1 Hemophilia Management Standards of Care

In order to be paid for providing blood clotting factor to Alabama Medicaid recipients, the provider must agree to provide, at the minimum, the following clinically appropriate items and services to their patients with hemophilia and blood clotting factor-related diseases:
(1) Home or office delivery of blood clotting factor and supplies. All shipments/delivery of clotting factor, including overnight deliveries, must use appropriate cold chain management and packaging practices to ensure proper temperature, drug stability, integrity, and efficacy are maintained during shipment.

(2) Educational materials and programs.

(a) The provider shall develop a training library at each enrolled provider location with materials for patient use, to include but not limited to, audio, video, electronic, and written materials.

(b) The provider shall offer educational materials to patient or family/caregiver at minimum at initiation of participation with the provider, yearly during the in-home assessment, and upon the request of Medicaid, the prescribing physician, or patient or family/caregiver. Topics of education shall include, but not be limited to, specific patient and family/caregiver education aimed at preventing injury that would result in a bleed, self-administration and reconstitution of blood clotting products.

(3) Medically necessary ancillary supplies required to perform the actual IV administration of clotting factor. Supplies may be billed to Medicaid through the Durable Medical Equipment (DME) program. In addition, sharps containers and any other necessary biohazardous waste containers shall be provided, as well as pickup and disposal of waste containers according to national, state and local biohazardous waste ordinances.

(4) Emergency telephone support 24 hours a day, 7 days a week to ensure patients are directed appropriately for care in emergent situations.

(5) For the purposes of this Rule and the Alabama Medicaid Agency hemophilia management standards of care, “clinical staff trained in hemophilia and related blood clotting factor related diseases” is defined as follows:

(a) Pharmacists are required to obtain a minimum of 2 Continuing Education (CE) credit hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

(b) Nurses and social workers are required to obtain a minimum of 4 Continuing Education (CEU) hours per year that are specific to hemophilia or related blood clotting factor-related diseases.

Continuing education must be specific to hemophilia or related blood clotting factor-related diseases and recognized by a state or national hemophilia or bleeding disorder education/support group (for example: Hemophilia Federation of America or the National Hemophilia Association).

(6) Emergency delivery of blood clotting factor within 24 (with a target of less than 12) hours of the receipt of a prescription for a covered person’s emergent situation, or notification of the patient with an existing valid prescription. Emphasis should be placed during patient education of the importance of keeping an adequate supply on hand and self-administration for emergent situations.

(7) A pharmacist, nurse, and/or a case representative assigned to each patient. A case representative shall maintain, at a minimum, monthly telephone contact with the patient or family/caregiver to include, but not limited to:

-Inquiry regarding patient’s current state of well-being

-Assessment of patient/family compliance/adherence, and persistence with the medical treatment plan

-Incidence of adverse events

-Incidences of supply or equipment malfunctions

-Home inventory check of factor and supplies

-Confirmation of next delivery date

Case representatives may include administrative support staff, but must coordinate with clinical staff (as described in (5) above) in the event a clinical issue should arise.

(8) Compliance programs.

(a) The provider must assess patient adherence on monthly telephone contact (see (7) above) and on all in-home visits by a pharmacist, nurse, or case manager.

(b) The provider must verify the amount of clotting factor the patient has on hand prior to each dispense. Blood clotting factor and related products are not to be sent to the patient on an auto-ship basis. The provider shall discourage “stockpiling” of product.

(c) The number of bleeds and infusions from the prior shipment shall be tracked to validate the need for additional product or non-compliance with the medical treatment plan.

(9) Notification of product recalls or withdrawals.

(a) Any stock of recalled medications/equipment/supplies shall be removed from stock and quarantined immediately.

(b) Any recalled items dispensed to patients shall be retrieved and quarantined; notification to patients must occur within 24 hours of the recall receipt.

(c) The prescribing physician shall be notified of a medication recall. A prescription for an alternative product shall be obtained, if necessary.

(10) Visiting clinical services.

(a) At minimum, an initial and subsequent yearly in-home assessment of the patient, family/caregiver, and environment shall be conducted by a nurse or pharmacist trained in blood clotting factor related diseases.

(b) Additional in-home assessments of the patient, family/caregiver, and environment deemed necessary by the physician or patient situation shall be conducted.

(c) Visits may be provided directly by the provider or by arrangement with a qualified local home health care agency. All hemophilia-related clinical staff must be trained in hemophilia and bleeding disorder related diseases.

(11) A registered pharmacist trained in blood clotting factor related diseases to perform assay to prescription management. Variance in assay to prescription/target dose should not exceed +/- 10%.

(12) Adverse drug reaction and drug interaction monitoring and reporting.

(a) Pharmacists shall counsel the patient or family/caregiver in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to encourage appropriate medication use, promote realistic therapy expectations, help recipients manage or minimize expected adverse effects and encourage compliance.

(b) Pharmacists shall report any issues or concerns related to the patient's medications to the physician. For significant events, utilization of the FDA 3500 MedWatch voluntary reporting form is encouraged.

(13) Continuation of Care. The provider shall not present any bill to or collect any monies from a covered Medicaid recipient with whom the provider has agreed to the provision of services and supplies for the home treatment of bleeding episodes associated with hemophilia, except as follows:

(a) to collect the copayments/coinsurance amounts the covered person is required to pay under the terms defined by Medicaid, or

(b) if the service/product has been deemed "non-covered" and the recipient has been notified in advance as outlined in the Alabama Medicaid Agency Administrative Code and Provider Billing Manual.

Upon discontinuation of services by the provider, the provider shall, at a minimum, coordinate for another designated health care provider to provide services to covered persons, prior to withdrawal of any hemophilia-related services from the home of any covered person. The provider shall continue to provide services and supplies to a covered individual until the individual obtains an alternate source of services and supplies. Every effort shall be made by the provider (including notification to the Medicaid Director of Pharmacy) to find an alternative provider to ensure that the coordination of care/transition follows the minimum standards of care as set forth in this document.

(14) The Alabama Medicaid Agency (or its designated representative), to ensure clinically appropriate services are being given to hemophilia patients, shall monitor providers of blood clotting factor by prospective and retrospective audits, as well as administer a patient/family/caregiver satisfaction survey to include, but not limited to, measurement of:

(a) staff availability

(b) staff knowledge

(c) timeliness of deliveries

(d) accuracy of supplies and equipment

(e) overall satisfaction

If a provider does not meet one or more of the standards for care, as outlined in this Rule, the Alabama Medicaid Agency shall provide a written notice of that determination, with an explanation therefore, to the provider. The provider will not be reimbursed for blood clotting factor or hemophilia related services until the provider meets the standards as approved by the Agency.

27.4 Cost Sharing (Copayment)

Copayment amounts vary and are described in this section. **Copayments do not apply to services provided for pregnant women, long term care (nursing home) residents, emergencies, recipients under 18 years of age, or family planning**.

Copayments do not apply to Native American Indians that present an “active user letter” issued by Indian Health Services (IHS). The provider must enter a value of ‘4’ in the prior authorization type code field indicating co-pay exemption for a Native American Indian with an active user letter.

A provider may not deny services to any eligible Medicaid recipient because of the recipient’s inability to pay the cost sharing (copayment) amount imposed.

- If the physician has indicated on the prescription that the recipient is pregnant, enter “P” in the copay block.

NOTE:
Do not enter a dollar amount in the copay block.

The copayment schedule is based on the total charge amount (ingredient cost plus dispensing fee):

Pharmacy Charge	***Copay Amount***
$10.00 or less	$ 0.65
$10.01 to $25.00	$1.30
$25.01 to $50.00	$2.60
$50.01 or more	$3.90

Deleted: 1~~.50~~
Added: 0.65
Deleted: ~~1.00~~
Added: .1.30
Deleted: ~~2.00~~
Added: 2.60
Deleted: ~~3.00~~
Added: 3.90

NOTE:

Copayment amount should be collected on the original prescription as well as any refills.

Providers may use various resources to verify recipient eligibility:

- Provider Electronic Solutions software
- Software developed by the provider's billing service, using specifications provided by HP
- Automated Voice Response System (AVRS) at 1(800) 727-7848
- Contacting the HP Provider Assistance Center at 1(800) 688-7989

Appendix B, Electronic Media Claims Guidelines, provides an overview of the HP Provider Electronic Solutions software, which providers may use to verify recipient eligibility and submit claims. Instructions for requesting the software are also included in this appendix.

Providers who use a billing service may be able to verify eligibility through the billing service's software, providing the service obtained a copy of the vendor specification. Please refer to Appendix B for contact information.

Appendix L, AVRS Quick Reference Guide, provides instructions for using AVRS to verify recipient eligibility. Providers can obtain a faxed response verifying eligibility by following the instructions provided.

27.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, provider should bill Medicaid claims electronically.

Pharmacy providers who bill Medicaid claims electronically receive the following benefits:

- Faster claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

Most pharmacy claims are submitted electronically for online adjudication. Claims filed electronically use Provider Electronic Solutions software from HP or Point of Sale proprietary pharmacy software.

NOTE:

When filing a claim on paper, an XIX-DC-10-093 pharmacy claim form is required.

Paper claims may also be filed. The pharmacist must initiate a two-part Medicaid Pharmacy Claim. The pharmacy must retain the original claim for State and audit purposes, and submit a duplicate claim to HP for payment. HP will furnish pharmacy claim forms upon request. Pharmacy claim forms can be purchased from HP for $35.44 per 1,000 forms. Claim forms will be mailed after receipt of payment.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

27.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Pharmacy providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

27.5.2 Diagnosis Codes

Diagnosis Codes do not apply when filing the pharmacy claim form.

27.5.3 Procedure Codes and Modifiers

Procedure Codes and Modifiers do not apply to Pharmacy billing.

27.5.4 Place of Service Codes

Formerly named Patient Location Code, new code values have been assigned. A value of either 31, 32, or 54 in 307-C7 will indicate the patient is in a Long Term Care (LTC) facility and the claim will be processed accordingly.

27.5.5 Required Attachments

Attachments are not required for pharmacy claims.

27.5.6 Third Party Liability (TPL) Payments

As a general rule, pharmacy providers are required to file a patient's primary insurance prior to filing Medicaid. Once the primary payer has responded, the patient's claim can be submitted to Medicaid. Medicaid will pay the Medicaid rate less any payment and applicable contractual adjustment. Medicaid should not pay more than the than the sum of the health plan's patient co-pay, coinsurance and/or deductible.

The following NCPDP codes should be used when billing Medicaid as the secondary payer:

- Other coverage code "02" (NCPDP field 308-C8) will require a TPL amount (431-DV) greater than zero.
- Other coverage code***s*** "02" and "04" (NCPDP field 308-C8) will require a patient responsibility amount (352-NQ) greater than zero.

- Other coverage code "03 - Other coverage exists- claim not covered" (NCPDP field 308-C8) will not require either TPL amount or patient responsibility amount to be greater than zero.

An exception to the rule is when the patient has a point of sale (POS) drug plan, which requires the cost of the prescription to be paid up front by the patient. Then a claim can be submitted to the insurance plan for reimbursement directly to the patient. These POS drug plans require special handling when the patient is also a Medicaid recipient.

Click the following link for special instructions for pharmacies when the recipient has both Medicaid and a point-of-sale drug plan:

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.1_Benefit_Coordination_Third_Party/6.1.1.2_Pharmacy_Claims.aspx

27.5.7 Prescription Origin Code

The code indicating the means used to deliver a prescription to a pharmacy – this is a required field. Valid values are:

0 = Not Known
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile
5 = Pharmacy

27.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
XIX-DC-10-093 Claim Filing Instructions	Section 5.6
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

27.7 Alabama Medicaid Pharmacy Questions and Answers (Q&A)

The Medicaid Pharmacy Q&A has been developed to provide guidance and clarification on pharmacy issues. Questions may be submitted to:

Medicaid Program Management, Fax (334) 353-7014

Responses will be published in the quarterly Medicaid Pharmacy Newsletter.

Are original prescriptions and signatures required for all drugs?

Medicaid requires original, signed prescriptions for Schedule II drugs. Schedule III, IV, and V drugs may be called in, as allowed by state pharmacy regulations.

Can I make a therapeutic or strength substitution without calling the prescribing physician?

No. Alabama State law requires the pharmacist to have the approval of the prescribing physician before dispensing anything other than what has been indicated on the prescription. If the physician has indicated product selection is allowed, the pharmacist may dispense generic substitution without subsequent contact with the physician.

What is the appropriate action when a physician writes a prescription that exceeds the Medicaid monthly dosing units?

When a prescription is denied for excessive quantity or monthly limit exceeded, claims will deny. In order to receive an override, providers (either the pharmacy or physician) should contact the HID help desk at 1(800) 748-0130 for consideration of an override.

Can I "split bill" a prescription if the prescribed quantity exceeds the maximum units allowed?

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

How long is a prescription valid?

In accordance with state law, controlled substance prescriptions, for schedule III-V, may be refilled up to five times within six months from the original issue date. Non-controlled prescriptions are reimbursable by Medicaid for up to 12 months from the date of the original dispensing date.

Can I receive authorization for additional refills from the prescribing physician after the 12 months have expired?

No. A new prescription should be obtained after 12 months from the date of the original dispensing date. Medicaid will make payment for up to 5 refills on an original prescription for Control III-V prescriptions and 11 refills on non controlled prescriptions.

Why is it important that I bill the exact NDC number dispensed if the product is a generic?

According to the State Board of Pharmacy, pharmacies dispensing controlled substances and submitting claims with different NDC numbers would have problems with the Drug Enforcement Agency (DEA). Additionally, Medicaid provider contracts require that claims be submitted accurately. Under federal law, manufacturers rebate Medicaid for use of their drugs. When an NDC is submitted on a claim that is not the actual NDC dispensed, Medicaid may incorrectly invoice the manufacturer for the rebate. Rebate dollars provide a significant source of money to offset pharmacy benefit costs. Therefore, NDC numbers reported on pharmacy claims should be the exact NDC number dispensed to the patient.

Can referrals be made to the Medicaid Agency when a provider believes a recipient is defrauding the program?

Yes. Any information regarding inappropriate and/or illegal drug-related activity by Medicaid recipients can be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**. All complaints are researched. If evidence is found to support recipient abuse or fraud, recipients can be locked in to one physician and one pharmacy or removed from the Medicaid program.

Does Medicaid make payment for benefits when a patient is in a state or county correctional facility?

Medicaid benefits are not available for individuals who are inmates of public institutions as defined by CFR 435.1009. It is the responsibility of the correction facility to provide medical care. Incarcerated recipients still receiving Medicaid benefits may be referred to the **Medicaid Fraud Hotline** at **1(866) 452-4930**.

If a provider receives multiple dispensing fees for the same patient, same drug and strength within the same month, will the additional dispensing fees be recouped?

Medicaid auditors look specifically for providers who split 30-day prescriptions into shorter time periods and amounts. Intentionally splitting prescriptions to receive multiple dispensing fees is fraud and monies paid will be recouped. Multiple dispensing fees within the same month for the same patient and same drug are acceptable if the provider has documentation supporting the need for multiple dispensings. Example: A child needs a 10 mg tablet for school and a 20 mg tablet for home to take at night; the provider should have in his documentation prescriptions for both.

If a provider is audited and cannot produce documentation while Medicaid auditors are in the store, is there a period of time allowed to provide the documentation before recoupments are initiated?

If an auditor requests documentation that is not present in the provider's facility, the provider should indicate to the auditor where the documentation is and when it can be provided for review. If additional information is needed by the state as a result of discrepancies identified in an audit, the provider should submit the requested information within 30 days of the request. Failure to submit documentation within 30 days may result in recoupment.

Is it important to bill the correct days supply?

Yes, days supply is an instrumental portion of a legitimate claim. Retroactive audits may consider the day supply billed, along with quantity of medication billed, in regards to the original prescription. Day supply billed should be clinically appropriate according to the physician's instructions on the prescription.

Can a pharmacy provider advertise waived copays for their Medicaid patients?

No. Advertising the waiver of or routinely waiving Medicaid copayments is a prohibited remuneration under Section 22-1-11, Code of Alabama and 1128B of the Social Security Act (SSA). Please refer to the Provider Manual, Chapter 7 "Understanding your rights and responsibilities as a provider", Section 7.1.7 "Provider Certification" for more information on offering incentives and advertising discounts.

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28

28 Physician

Physician's services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, refer to services provided by a physician:

- Within the scope of practice of medicine or osteopathy as defined by state law; and
- By or under the personal supervision of an individual licensed under state law to practice medicine of osteopathy.

The policy provisions for physicians can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 6.

28.1 Enrollment

HP enrolls physicians and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*. For the purpose of enrollment, a physician is defined as: a physician who is fully licensed and possesses a current license to practice medicine.

HP also enrolls Physician Assistants (PA), Certified Registered Nurse Practitioners (CRNP), Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician. Physician-employed includes physicians practicing in an independent practice or in a group practice relationship.

Refer to Chapter 38, Anesthesiology, for more information on CRNA and AA services.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a physician is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for physician-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Physicians are assigned a provider type of 31 (Physician). Physician-Employed Nurse Practitioners are assigned a provider type of 09 or Physician-Employed Physician Assistants are assigned a provider type of 10 and Certified Registered Nurse Anesthetists and Anesthesiology Assistants are assigned a provider type of 09(CRNA).

Valid specialties for physicians and physician-employed practitioners are listed below:

Specialty	***Code***
Allergist	310
Anesthesiologist	311
Anesthesiology Assistant	101
Cardiac surgery	312
Cardiovascular disease	313
Certified Registered Nurse Anesthetist	094
Cochlear implant team	740—See Chap. 10, Audiology/Hearing Services
Colon and rectal surgery	750
Dermatology	314
EENT	760
Emergency medicine Practitioner	315
Endocrinology	770
EPSDT	560
Family practice	316
Gastroenterology	317
General practice	318
General surgery	319
Geriatrics	320
Hand surgery	321
Hematology	780
Infectious diseases	790
Internal medicine	800
Mammography	292
Neonatology	323
Nephrology	630
Neurological surgery	325
Neurology	326
Nuclear medicine	327
Nutrition	230
Obstetrics/Gynecology	328
Oncology	329
Ophthalmology	330
Oral and maxillofacial surgery	272
Orthopedic	810
Orthopedic surgery	331
Otorhinolaryngology	332
Pathology	333
Pediatrics	345
Physician-Employed Nurse Practitioner	093
Physician-Employed Physician Assistant	100
Plastic, reconstructive, cosmetic surgery	337
Primary care provider (not a screening provider but can refer patients)	720
Proctologist	338

Specialty	*Code*
Psychiatrist	339
Pulmonary disease Specialist	340
Radiology	341
Rheumatology	830
Telemedicine	931
Thoracic surgeon	342
Urologist	343
Vascular surgery	313

Enrollment Policy for Physicians

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program. The PA or CRNP must send a copy of the prescriptive authority granted by the licensing board in order for the PA or CRNP to be added to the Provider License File for the purpose of reimbursing the pharmacist for the prescriptions written by the PA or CRNP. This copy must be sent to HP Provider Enrollment, P.O. Box 241685, AL 36124-1685.

HP will not enroll physicians having limited licenses unless complete information as to the limitations and reasons are submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment.

28.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Physicians are expected to render medically necessary services to Medicaid patients in the same manner and under the same standards as for their private patients, and bill the Alabama Medicaid Agency their usual and customary fee.

Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, a physician or physician of the same specialty and subspecialty from the same group practice are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year.

Medicaid will no longer require physicians enrolled in and providing services through a **residency** training program be assigned a pseudo Medicaid license number to be used on prescriptions written for Medicaid recipients. Effective for claims submitted on or after January 1, 2012, interns and non-licensed residents must use the NPI or license number of the teaching, admitting, or supervising physician.

Written medication prescriptions should have a typed or printed name of the prescriber on the prescription and the handwriting must be legible. Pharmacists **must have the physician's license number** prior to billing for prescriptions. Pharmacies shall use the correct physician license number when submitting a pharmacy claim to Medicaid.

Supervising physicians may bill for services rendered to Medicaid recipients by residents enrolled in and providing services through (as part of) an approved residency training program. The following rules shall apply to physicians supervising residents as part of an approved residency training program:

a. The supervising physician shall sign and date the admission history and physical progress notes written by the resident.

b. The supervising physician shall review all treatment plans and medication orders written by the resident.

c. The supervising physician shall be available by phone or pager.

d. The supervising physician shall designate another physician to supervise the resident in his/her absence.

e. The supervising physician shall not delegate a task to the resident when regulations specify that the physician perform it personally or when such delegation is prohibited by state law or the facility's policy.

Payments from Medicaid funds can be made only to physicians who provide the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

The physician agrees when billing Medicaid for a service that the physician will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. Conditional collections from patients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The physician may bill the patient, in addition to the cost-sharing fee, for services rendered when benefit limitations are exhausted for the year or when the service is a Medicaid non-covered benefit. However, the provider (or their staff) must advise each patient prior to services being rendered when Medicaid payment will not be accepted, and the patient will be responsible for the bill. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

A hospital-based physician-employed by and paid by a hospital may not bill Medicaid for services performed for which the hospital is reimbursed. A hospital-based physician shall bill the Medicaid Program on a CMS-1500, Health Insurance Claim Form or assign their billing rights to the hospital, which shall bill the Medicaid Program on a CMS-1500 form. A hospital-based physician who is not employed by and paid by a hospital may bill Medicaid using a CMS-1500 claim form.

A physician enrolled in a residency training program and whose practice is limited to the institution in which that resident is placed shall not bill Medicaid for services performed therein for which the institution is reimbursed through the hospitals' cost reports. For tracking purposes, these physicians will be assigned pseudo Medicaid license numbers.

Hospital-based physicians are reimbursed under the same general system as is used in Medicare. Bills for services rendered are submitted as follows:

- All hospital-based physicians, including emergency room physicians, radiologists, and pathologists, will bill Medicaid on a CMS-1500 claim form, or assign their billing rights to the hospital, which shall bill Medicaid on a CMS-1500 claim form.
- Physician services personally rendered for individual patients will be paid only on a reasonable charge basis (i.e., claims submitted under an individual NPI on a physician claim form). This includes services provided by a radiologist and/or pathologist.

- Reasonable charge services are: 1) personally furnished for a patient by a physician; 2) ordinarily require performance by a physician and; 3) contribute to the diagnosis or treatment of an individual patient.

Off Site Mobile Physician's Services shall comply with all Medicaid rules and regulations as set forth in the State Plan, Alabama Medicaid Administrative Code, and Code of Federal Regulations including but not limited to the following requirements:

(a) Shall provide ongoing, follow-up, and treatment and/or care for identified conditions,

(b) Shall provide ongoing access to care and services through the maintenance of a geographically accessible office with regular operating business hours within the practicing county or within 15 miles of the county in which the service was rendered,

(c) Shall provide continuity and coordination of care for Medicaid recipients through reporting and communication with the Primary Medical Provider,

(d) Shall maintain a collaborative effort between the off-site mobile physician and local physicians and community resources. A matrix of responsibility shall be developed between the parties and available upon enrollment as an off-site mobile physician,

(e) Shall provide for attainable provider and recipient medical record retrieval,

(f) Shall maintain written agreements for referrals, coordinate needed services, obtain prior authorizations and necessary written referrals for services prescribed. All medical conditions identified shall be referred and coordinated, for example:

  (i) Eyeglasses,

  (ii) Comprehensive Audiological services,

  (iii) Comprehensive Opthalamological services,

  (iv) Patient 1st and EPSDT Referrals,

(g) Shall not bill Medicaid for services which are offered to anyone for free. Provider shall utilize a Medicaid approved sliding fee scale based on Federal Poverty Guidelines,

(h) Shall ensure that medical record documentation supports the billing of Medicaid services, and

(i) Shall obtain signed and informed consent prior to treatment.

NOTE:

If a provider routinely accepts Medicaid assignments, he/she may not bill Medicaid or the recipient for a service he/she did not provide, i.e., "no call" or "no show".

Locum Tenens and Substitute Physician Under Reciprocal Billing Arrangements

It is common practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee. The substitute physicians are generally called "locum tenens" physicians.

Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement. The regular physician shall identify the services as substitute physician services by entering HCPCS modifier **Q5** (Service Furnished by a Substitute Physician under a Reciprocal Arrangement) or HCPCS modifier **Q6** (Service Furnished by a Locum Tenens Physician) after the procedure code. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physician should keep a record on file of each service provided by the substitute physician and make this record available to Medicaid upon request. Claims will be subject to post-payment review. Please refer to section 28.5.3 Procedure Codes and Modifiers for information regarding modifiers Q5 and Q6.

28.2.1 Physician-Employed Practitioner Services

Medicaid payment may be made for the professional services of the following physician-employed practitioners:

- Physician Assistants (PAs)
- Certified Registered Nurse Practitioners (CRNPs)

Nurse Practitioner is defined as a Registered Professional Nurse who is currently licensed to practice in the state, who meets the applicable State of Alabama requirements governing the qualifications of nurse practitioners.

Physician Assistant means a person who meets the applicable State of Alabama requirements governing the qualifications for assistants to primary care physicians.

All services requiring additional education and training beyond the scope of practice billed by a CRNP/PA must be documented in the approved collaborative agreement from the Board of Medical Examiners (BME) and the Alabama Board of Nursing (ABN) between the practitioner and physician. The only exception is for those "routine" services <u>within the scope of practice</u> approved by the applicable licensing and governing boards. Services billed outside a CRNP/PA scope of practice and/or collaborative agreement are subject to post-payment review.

Medicaid will make payment for services of Physician Assistants (PAs) and Certified Registered Nurse Practitioners (CRNPs) who are legally authorized to furnish services and who render the services under the supervision of an employing physician with payment made to the employing physician. Medicaid will not make payment to the PA or CRNP. Generally, CRNPs and PAs are reimbursed at 80% of the allowed amount for all services except lab and injectables, which should pay at 100%.

The employing physician must be a Medicaid provider in active status.

The PA or CRNP **must enroll with the Alabama Medicaid Agency** and receive a NPI number with the employing physician as the payee.

Covered services furnished by the PA or CRNP must be billed under the PA's or CRNP's name and NPI.

The covered services for PAs and CRNPs are limited to injectable drugs, laboratory services in which the laboratory is CLIA certified to perform, and the CPT codes identified in Appendix O, CRNP & PA Services.

The office visits performed by the PA or CRNP count against the recipient's yearly benefit limitation.

The PA or CRNP may make physician-required visits to nursing facilities.

The PA or CRNP may not make physician-required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits.

CRNP and PA services have been expanded. Please refer to Appendix O for a list of covered services and references. For more specific information on coverage, you may call the Provider Assistance Center at 1-800-688-7989.

The employing-physician need not be physically present with the PA or CRNP when the services are being rendered to the recipient; however, the physician must be immediately available to the PA or CRNP for direct communication by radio, telephone, or telecommunication.

The PA's or CRNP's employing physician is responsible for the professional activities of the PA or CRNP and for assuring that the services provided are medically necessary and appropriate for the patient.

There shall be no independent, unsupervised practice by PAs or CRNPs.

28.2.2 Covered Services

In general, Medicaid covers physician services if the services meet the following conditions:

- Considered medically necessary by the attending physician
- Designated by procedure codes in the Physicians' Current Procedural Terminology (CPT), or HCPCS. This table contains details on selected covered services.
- Consistent with the implementation of the mandated Medicaid NCCI edits effective November 9, 2010. Refer to this link, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for more information regarding NCCI.

Abdominoplasty	Medical necessity criteria must be met and Prior Authorization obtained, or the procedure will be considered cosmetic and will not be covered. See Chapter 4, Obtaining Prior Authorization.
Add-on Code	Add-on Code definition in the CPT is recognized and allowed for payment with the appropriate primary code.
Administration Fee	Please refer to Appendix H, Medicaid Physician Administered Drugs, section H.1 (Policy) for information regarding office visits, chemotherapy, and administration fees. When an Evaluation and Management service is provided *and* a Drug Administration code (96372, 96373, 96374, 96375, and 96376) is provided at the same time, the E&M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with the Drug Administration code for consideration of payment for the E&M Code. A **Modifier 25** must be appended to the E&M service for recognition as a "**Significant Separately Identifiable Service".** Medical Record documentation must support the medical necessity of the visit as well as the level of care provided. However, when no **Significant Separately Identifiable** E&M service is actually provided at the time of a Drug Administration, an E&M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without a **Significant Separately Identifiable** E&M service being provided. These services will be subject to post payment review. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).
Allergy Treatments	Please refer to Appendix H, Medicaid Physician Administered Drugs for information.
Anesthesia	Anesthesia is covered. See Chapter 38, Anesthesiology.
Artificial Eyes	Artificial eyes must be prescribed by a physician. Refer to Chapter 15, Eye Care Services for specific coverage information.
Bariatric Procedures	Considered cosmetic unless specific medical criteria are met and with Prior Authorization. Bariatric surgical procedures are considered for Medicaid eligible recipients between 18 and 64 years of age, effective June 1, 2009. See Chapter 4, Obtaining Prior Authorization.
Breathing or Inhalation Treatments	Breathing or inhalation treatments are a covered service. Any medication provided during a breathing treatment (e.g., Albuterol) is considered a component of the treatment charge. EXCEPTION: See Appendix H related to coverage of J2545 Pentamidine Isethionate.
Cardiac Catheterization	Cardiac Catheterization codes may be subject to the multiple procedure/surgery reductions.
Cerumen Removal	CPT code 69210 is a covered service. The key points for using this code are as follow: 1) Ear lavage alone is insufficient : the ear wax must be removed by curette or instrumentation; 2) The billing provider must perform the service, not the nurse or medical assistant: 3) The cerumen must be impacted, which means it must have one of these four characteristics: a) Visual considerations: Cerumen impairs exam of clinically significant portions of the external auditory canal tympanic membrane, or middle ear condition; b.) Qualitative considerations: Extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc; c) Inflammatory considerations: Associated with foul odor, infection, or dermatitis; d) Quantitative considerations: Obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring physician skills. If the ear wax is not impacted, meeting the criteria above, it is not separately reported.

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Chemotherapy Administration	When an Evaluation and Management service is provided *and* a Hydration, Therapeutic, Prophylactic, Diagnostic and Chemotherapy Administration code is provided at the same time, the E&M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with these administration codes for consideration of payment for the Evaluation and Management Code. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Code 99211 will not be allowed with a modifier 25 or when billed in conjunction with the above administration codes. Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.
CT Scans	CT scans are covered as medically necessary. Effective for dates of service March 2, 2009, and thereafter, CT scans require prior authorization for coverage. See Chapter 4, Obtaining Prior Authorization, Chapter 19, Hospital and Chapter 22, Independent Radiology.
Chiropractors	Chiropractic services are covered only for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Circumcision	Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered. These services will be subject to post payment review.
Dental Varnishing	Refer to Chapter 13, Dentist for specific coverage information.
Developmental Testing Intensive Level (Multi-disciplinary Team only)	Refer to Appendix A, Well Child Check-Up (EPSDT) for specific coverage information.
Diet Instruction	Diet instruction performed by a physician is considered part of a routine visit.
Drugs	Refer to Appendix H, Physician Drug List for coverage information.
Endovenous **Laser** Ablation of Varicose Veins, Endoluminal **Radiofrequency** Ablation of Saphenous Varicose Veins, Sclerotherapy, and Ambulatory phlebectomy	The following procedure codes require prior authorization before services are rendered to a recipient: 1. Procedure codes**36478** (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, **laser**; first vein treated) and **Add on** code **36479** (second and subsequent veins treated in a single extremity, each through separate access sites) should only be billed along with the primary code (36478). 2. Procedure codes **36475** (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, **radiofrequency**; first vein treated, and **Add on** code **36476** (second and subsequent veins treated in a single extremity, each through separate access sites) should only be billed along with the primary code (36475). 3. **Effective 1/1/2013**, the following procedure codes will require prior authorization: **36470** (Injection of **sclerosing** solution; single vein), **36471** (multiple veins, same leg), **37765** (Stab **phlebectomy** of varicose veins, 1 extremity; 10-20 stab incisions), and **37766** (more than 20 incisions). ** **These procedures are not covered for cosmetic purposes.**
Eustachian Tube Inflation	Effective 8/25/2008, only physicians with specialties of EENT and Otorhinolaryngology may bill eustachian tube inflation, transnasal; with catherization (69400), without catheterization (69401).

Examinations	Physician visits for examinations are counted as part of each recipient's benefit limit of 14 physician visits per year. Exception: Certified Emergencies. Office visits are limited to one per day, per recipient, per provider. For purposes of this limitation, a physician or physician of the same specialty and subspecialty from the same group practice are considered a single provider. Annual routine physical examinations are not covered except through EPSDT. Refer to Appendix A, EPSDT, for details. Medical examinations for such reasons as insurance policy qualifications are not covered. Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered. Medicaid requires a physician's visit once every 60 days for patients in a nursing facility. Patients in intermediate care facilities for the mentally retarded must receive a complete physical examination at least annually.
Eyecare	Eye examinations by physicians are a Medicaid covered service. Physician visits for eye care disease are counted as part of each recipient's benefit limit of 14 physician visits per year.
Foot Devices	See Chapter 14, Durable Medical Equipment (DME), for details
Gastric bypass	Covered with prior authorization approval when specific medical criteria are met. See Chapter 4, Obtaining Prior Authorization.
Hearing Aids	See Chapter 10, Audiology/Hearing Services, for details.
Hyperbaric Oxygen Therapy	Topically applied oxygen is not hyperbaric and is not covered. HBO therapy should not be a replacement for other standard successful therapeutic measure. Medical necessity for the use of hyperbaric oxygen for more than two months must be prior approved. (Chapter 4, Obtaining Prior Authorization). Refer to Chapter 19 Hospital, under Outpatient Hyperbaric Oxygen Therapy (HBO) for specific coverage information.
Hyperalimention Parental TPN IDPN IPN	Please refer to Section 28.2.9 for documentation requirements for parental, TPN, IDPN, and IPN nutrition.
Immunizations	Refer to Appendix A, EPSDT, for information regarding the Vaccines For Children (VFC) Program. Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service. Refer to Appendix H, Alabama Medicaid Physician Administered Drugs for coverage information.
Infant Resuscitation	Newborn resuscitation (procedure code 99465 on/after 01/01/09) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.
Mammography Diagnostic	Refer to Chapter 22, Independent Radiology for coverage information.
Mammography Screening	Refer to Chapter 22, Independent Radiology for coverage information.
Medical Materials and Supplies	Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

Medical Necessity	The Alabama Medicaid Agency is mandated to only reimburse for services, procedures, and surgeries that are medically necessary. Medical necessity must be documented in the recipient's medical record with supporting documentation such as: Laboratory test results, diagnostic test results, history (past attempts of management if applicable), signs and symptoms, etc. All Medicaid services are subject to retrospective review for medical necessity. EXAMPLE: Endometrial Ablation is covered by Medicaid when it is considered medically necessary and should not be performed when an alternative outcome is intended such as cessation of menses. Medical necessity must be clearly documented in the medical record.
Nerve Conduction Studies and Electromyography	Refer to Chapter 22, Independent Radiology for coverage information.
Newborn Claims	Five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital may be filed under the mother's name and number or the baby's name and number: When billing under the mother's Medicaid number, use diagnosis codes **V200 – V202 only, for normal newborn care. These diagnosis codes must be used on the claim form for consideration of payment.** 1. Routine newborn care (99460 on/after 01/01/09, 99462 on/after 01/01/09, and discharge codes 99238 or 99239). 2. Circumcision (54150 or 54160) Please note that the billing of PC 64450 is not allowed along with PC 54150 (which includes the nerve block in the description). 3. Newborn resuscitation (99465). 4. Standby services following a cesarean section or a high-risk vaginal delivery (99360). 5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99464). Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or non-delivering OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. Use CPT codes when filing claims for these five kinds of care. If these services are billed under the mother's name and number and the infant(s) are twins, indicate Twin A or Twin B in Block 19 of the claim form. Any care other than routine newborn care for a well baby, before and after the mother leaves the hospital, must be billed under the child's name and number.
Newborn Hearing Screening	Inpatient newborn hearing screenings are considered an integral part of inpatient hospital services. Please refer to Chapter 19 for Outpatient Services. Limited hearing screen codes 92586 and 92587 (CPT 2002) may be billed in an outpatient setting provided: 1) an infant was discharged prior to receiving the inpatient hearing screen, or 2) an infant was born outside a hospital or birthing center. These codes are reimbursable for audiologists, pediatricians, otolaryngologists, and EENT. Comprehensive hearing screen codes 92585/92588/92558 may be billed for: 1) infants who fail the newborn hearing screening prior to discharge from the hospital, or 2) infants/children fail a hearing screening at any time following discharge. Comprehensive hearing screenings should be performed on infants by three months of age if they failed the newborn hearing screening prior to discharge. Code 92585 is reimbursable for otolaryngologists, audiologists, pediatricians, and EENT. Code 92588 is reimbursable for otolaryngologists, audiologists, pediatricians, EENT, and neurologists.
Obstetrical Services	Refer to Section 28.2.10

Added: Nerve Conduction Studies and Electromyography

Obstetrical Ultrasounds	Medicaid recipients that are **not** participating in the Maternity Care program are allowed up to two obstetrical ultrasounds per pregnancy without prior authorization. Greater than two OB ultrasounds per pregnancy must be supported with a medical diagnosis, medical benefit of the procedure, and prior authorized. **Effective 1/1/2010**, ultrasounds for recipients participating **in** the Maternity Care Program are included in the Maternity Contract, and do not require a prior authorization. All ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure.
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.
Podiatrist Service	Covered for QMB or EPSDT referred services only. See Chapter 29, Podiatrist, for more details.
Post Surgical Visits	Routine post-surgical care in the hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Post-surgical visits cannot be billed separately the day of, or up to 90 days after surgery. For conditions unrelated to the surgical procedure bill the appropriate (E&M) procedure code with a 24 modifier appended. The diagnosis must support use of the modifier 24.
Prosthetic Devices	Internal prosthetic devices (e.g., Smith Peterson Nail or pacemaker) are a covered benefit.
Psychiatric Services	Physician visits for psychiatric services are counted as part of each recipient's benefit limit of 14 physician visits per year. Psychiatric evaluation or testing are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations are limited to one per calendar year, per provider, per recipient. Psychotherapy visits are included in the office visit limit of 14 visits per calendar year. Effective January 1, 2013, the following psychotherapy Add-on codes may be billed in conjunction with Evaluation and Management codes billed by the psychiatrist: 90833, 90836, and 90838. Psychiatric services under the Physicians' Program are confined to use with psychiatric diagnosis (290-319) and must be performed by a physician. The “must be performed by a physician” does not apply for EPSDT-referred psychiatric services. Hospital visits are not covered when billed in conjunction with psychiatric therapy on the same day. For EPSDT-referred services rendered by psychologist, see Chapter 34 for details. Psychiatric day care is not a covered benefit under the Physicians' Program. **NOTE**: For billing purposes, psychiatrist services are not limited to what psychologist bills.
Radiation Treatment Management	Radiation treatment management services do not need to be furnished on consecutive days. Up to two units may be billed on the same date of service as long as there has been a separate break in therapy sessions.
Second Opinions	Physician visits for second opinions are counted as part of each recipient's benefit limit of 14 physician visits per year. Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.
Self-inflicted injuries	Self-inflicted injuries are covered.
Sleep Studies	Covered when billed through the enrolled physician’s NPI or Outpatient hospital NPI. Medicaid does not enroll sleep study clinics. Unattended sleep studies (95806) are not covered by Medicaid. Please refer to Chapter 19, Hospital, for additional limitations.

Surgery	Cosmetic surgery is covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member. Elective surgery is covered when medically necessary. **Multiple surgeries are governed by the following rules:** When multiple or bilateral surgical procedures that add significant time or complexity are performed at the same operative session, Medicaid pays for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure. This also applies to laser surgical procedures. Additional payments will **not** be made for procedures considered to be mutually exclusive or incidental. Mutually Exclusive procedures are services that cannot reasonably be performed at the same anatomic site or same patient encounter. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g., excision of a previous scar or puncture of an ovarian cyst) are performed during the same operative session, Medicaid reimburses for the major procedure only. CPT defined Add-on codes are considered for coverage when billed with the appropriate primary procedure code. Add-on codes are not subject to rule of 50 percent reduction. Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered/billable. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated or incidental surgical procedure. Surgeons performing laparoscopic procedures on recipients where a laparoscopic procedure code (PC) has not been established should bill the most descriptive PC with modifier 22 (unusual procedural services) until the new PC is established. Unlisted CPT codes require prior authorization **before** services are rendered. Whenever unusual procedures are performed and there is no exact descriptive CPT code, AMA requires the most appropriate CPT code be utilized with a modifier 22. Procedure Code 69990 Operating Microscope may be paid separately only when submitted with the following CPT codes: 61304-61546, 61550 - 61619, 61624 - 61626, 61640-61711, 62010-62100, 63081-63308, 63704-63710, 64831, 64834-64836, 64840-64858, 64861-64870, 64885-64898, 64905-64907. Certain relatively small surgical procedure codes designated as “zero” global days may be billed in addition to an office visit. Additionally, these codes do not carry the global surgical package concept of inclusion of post-operative care. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites. Please refer to Section 28.5.3 Procedure Codes and Modifiers. Modifier 57 (Decision for Surgery), is not billable on the same day of surgery. NOTE: Surgeons are responsible for submitting hard copy hysterectomy and sterilization consent forms to HPES at PO Box 244032, Montgomery, AL 36124-4032, Attn: Medical Policy Unit / Consent Forms

Added: -4032

Surgery, Breast Reconstruction	Breast reconstruction surgery is reimbursable following a medically necessary mastectomy when performed for the removal of cancer. Breast reconstruction will also be allowed on the non-cancerous contra lateral breast for the purpose of symmetry. Medicaid does **not** reimburse for reconstruction after a prophylactic mastectomy unless evidence of breast cancer is documented in the medical record. All reconstructive procedures require prior authorization. The term "reconstruction" shall include augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Breast reconstruction surgeries are governed by the following rules: • The reconstruction follows a medically necessary mastectomy for the removal of cancer. A pathology report is required. • The recipient is eligible for Medicaid on the date of reconstruction surgery • The recipient elects reconstruction within two years of the mastectomy surgery date • Documentation of therapy completion (chemotherapy and/or radiation treatment), and Operative Report of mastectomy if reconstructive procedure is performed after mastectomy on a different date. If reconstructive procedures are to be performed on the same date as the mastectomy, the physician must send certification that radiation therapy is not planned based on current staging or treatment plan, or must document therapy completion. • For more information regarding prior authorization, please refer to Chapter 4 Obtaining Prior Authorization. For more information related to breast prosthesis, please refer to Chapter 14 Durable Medical Equipment.

Telemedicine	Effective for dates of service 1/16/2012 and thereafter, all physicians with an Alabama license, enrolled as a provider with the Alabama Medicaid Agency, regardless of location, are eligible to participate in the Telemedicine Program to provide medically necessary telemedicine services to Alabama Medicaid eligible recipients. In order to participate in the telemedicine program: a. Physicians must be enrolled with Alabama Medicaid with a specialty type of 931 (Telemedicine Service). b. Physician must submit the Telemedicine Service Agreement/Certification form which is located on the Medicaid website at: http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment/5.4.6_Web_Portal_App_Telemed_Servcs_Agree_1-5-12.pdf. c. Physician must obtain prior consent from the recipient before services are rendered, this will count as part of each recipient's benefit limit of 14 annual physician office visits currently allowed. A sample recipient consent form is located on the Medicaid website at: http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment/Fillable_Forms/5.4.6_AL_Med_Telemedicine_Recipient_Consent_Form_Fillable_6-30-11.pdf Services must be administered via an interactive audio and video telecommunications system which permits two-way communication between the distant site physician and the origination site where the recipient is located (this does not include a telephone conversation, electronic mail message, or facsimile transmission between the physician, recipient, or a consultation between two physicians). Telemedicine health care providers shall ensure that the telecommunication technology and equipment used at the recipient site, and at the physician site, is sufficient to allow the health care physician to appropriately evaluate, diagnose, and/or treat the recipient for services billed to Medicaid. Transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. The provider shall maintain appropriately trained staff, or employees, familiar with the recipient's treatment plan, immediately available in-person to the recipient receiving a telemedicine service to attend to any urgencies or emergencies that may occur during the session. The physician shall implement confidentiality protocols that include, but are not limited to: a. specifying the individuals who have access to electronic records; and b. usage of unique passwords or identifiers for each employee or other person with access to the client records; and c. ensuring a system to prevent unauthorized access, particularly via the internet; and d. ensuring a system to routinely track and permanently record access to such electronic medical information These protocols and guidelines must be available to inspection at the telemedicine site, and to the Medicaid Agency upon request. Procedure codes covered for telemedicine services include; consultations (**99241-99245, 99251-99255**), office or other outpatient visits (**99201-99205, 99211-99215**), individual psychotherapy (90832 - 90838), psychiatric diagnostic (90791 - 90792), and neurobehavioral status exam (**96116**). All procedure codes billed for telemedicine services must be billed with modifiers **GT** (via interactive audio and video telecommunications system). The Agency will **not** reimburse providers for origination site or transmission fees.

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Added: 908132-90838)

Deleted: ~~90801~~

Added: 90791-90792

Therapy	Physician visits for therapy are counted as part of each recipient's benefit limit of 14 physician visits per year. See Rule No. 560-X-6.14 for details about this benefit limit in the *Alabama Medicaid Agency Administrative Code,* Chapter 6. Physical Therapy is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician or non-physician practitioner and provided in a hospital setting. Refer to Chapter 19, Hospital, for more information. For all physical therapy services performed as a result of an EPSDT screening refer to Chapter 37, Therapy, for policy only. Group Therapy is a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally. Group Therapy is not covered when performed by a caseworker, social services worker, mental health worker, or any counseling professional other than physician. Group Therapy is included in the physician visit limit of 14 visits per year. Speech Therapy for a speech related diagnosis, such as stroke (CVA) or partial laryngectomy, is a covered benefit when prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting or in a nursing facility is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician. Family Therapy is a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation that justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is not covered when performed by a caseworker, social service worker, mental health worker, or any counseling professional other than a physician. Family Therapy is included in the physician visit limit of 14 visits per year.
Transplants	See Chapter 19, Hospitals, for transplant coverage.
Ventilation Study	Ventilation study is covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record must contain all of the following: • Graphic record • Total and timed vital capacity • Maximum breathing capacity Always indicate if the studies were performed with or without a bronchodilator.
Newborn Care Services	Well baby coverage is covered only on the initial visit, which must be provided within 8 weeks of birth. When the well-baby checkup is done, the physician should bill procedure code 99461. Diagnosis codes V20.2, V20.31 and V20.32 are acceptable to bill for routine newborn care/well baby checkup. Only one well-baby checkup can be paid per lifetime, per recipient. Refer to Appendix A, EPSDT, for information on additional preventive services.

NOTE:

For newborn hospital discharge services performed on a subsequent admission date, use code 99238. Please use code 99463 when filing claims for newborns assessed and discharged from the hospital or birthing room on the same date.

Coding Exceptions

Specific codes sets in an audit were identified with an explanation as to why they should be removed or modified in the audit process. Medicaid agrees these codes sets can be billed together as an exception to NCCI and/or CPT policy. As indicated, the multiple surgery rule will be applied.

Code Sets									***Multiple Surgery***
Procedure code 64450 is allowed with code 54160.									Yes
Tympanostomy 69436 – codes below									Yes
Allowed with 69436		21030	30545	31238	31511	31615	40819	42720	42831
11300	12052	21555	30801	31240	31515	31622	40820	42806	42835
11305	14040	21556	30802	31254	31525	31624	41010	42810	42836
11401	15120	30115	30901	31255	31526	31625	41110	42815	42870
11420	15760	30130	30903	31256	31535	31641	41115	42820	42960
11440	17000	30140	31000	31267	31540	38510	41520	42821	42961
11441	17017	30200	31020	31276	31541	38542	42140	42825	43200
11444	17250	30310	31231	31287	31575	38724	42145	42826	43202
11900	20922	30520	31237	31288	31613	40808	42200	42830	43830

28.2.3 Non-covered Services

Service	***Coverage and Conditions***
Acupuncture	Acupuncture is not covered.
After Office Hours	The following services are not covered: After office hours, services provided in a location other than the physician's office, and office services provided on an emergency basis.
Autopsies	Autopsies are not covered.
Bariatric Procedures	Considered cosmetic unless specific medical criteria are met
Biofeedback	Biofeedback is not covered.
Blood Tests	Blood tests are not covered for marriage licenses.
Casting and Supplies	Some surgical codes are considered an inclusive package of professional services and/or supplies and are not considered separately allowable or reimbursable as the fracture repair or surgical codes is inclusive of these services. An example of this would be a surgical code for a fracture repair which is inclusive of any casting and strapping services or supplies.
Cerumen Removal	CPT Code 69210 is not covered if the ear wax is not impacted and the service does not meet the criteria outlined in section 28.2.2, Covered Services.
Chiropractors	Chiropractic services are not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.
Chromosomal Studies	Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies on prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.
Dressing and Compression Wrap	Any dressing/compression wrap performed in conjunction with wound debridement is considered part of the debridement services and is not separately covered / billable.
Experimental Treatment or Surgery	Experimental treatment or surgery is not covered.

Filing Fees	Filing Fees are not covered.
Hypnosis	Hypnosis is not covered.
Laetrile Therapy	Laetrile therapy is not covered.
Mutually Exclusive Procedures	Mutually exclusive procedures are those codes that cannot reasonably be done in the same session and are considered not separately allowable or reimbursable. For example, a vaginal and abdominal hysterectomy on the same date of service.
Oxygen and Compressed Gas	Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to Chapter 14, DME, for more information.
Pulse Oximetry	Effective January 1, 2009, Non-invasive ear or pulse oximetry services (procedure codes 94760-94762) will no longer be considered separately billable/payable by Medicaid for physician and outpatient services. These procedure codes, per policy dated July 2006, are considered bundled services which are included in Evaluation and Management codes for both physician and outpatient services.
Surgery	When multiple and/or bilateral procedures are billed in conjunction with one another and meet the CPTs definition of "Format of Terminology" (bundled or subset) and/or comprehensive/component (bundled) codes, then the procedure with the highest allowed amount will be paid while the procedure with the lesser amount will not be considered for payment as the procedure is considered an integral part of the covered service. Please refer to Section 28.5.3 Procedure Codes and Modifiers. Incidental surgical procedures are defined as those codes that are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. An example of this would be lysis of adhesions during the same session as an abdominal surgery. Refer to this link, (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html for more information regarding NCCI.
Post Surgical Visits	Post-surgical hospital or office visits for conditions directly related to major surgical procedures are covered by the surgical fee. Surgical visits cannot be billed separately the day of surgery or up to 90 days after surgery. Visits by Assistant Surgeon or Surgeons are not covered.
Preventive Medicine	Medicaid does not cover preventive medicine other than those specified elsewhere, including but not limited to, EPSDT screening.
Syntocin	Syntocin is not covered.
Telephone Consultations	Telephone consultations are not covered.
Therapy	Occupational and Recreational Therapies are not covered.

28.2.4 Limitations on Services

Within each calendar year each recipient is limited to no more than a total of 14 physician visits in offices, hospital outpatient settings, nursing facilities, rural health clinics or Federally Qualified Health Centers. Visits not counted under this benefit limit will include, but not be limited to, visits for: EPSDT, prenatal care, postnatal care, and family planning. Physicians services provided in a hospital outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year. If a patient receives ancillary services in a doctor's office, by the physician or under his/her direct supervision, and the doctor submits a claim only for the ancillary services but not for the office visit, then the services provided will not be counted as a visit.

Office visits are limited to one per day per recipient per provider. For purposes of this limitation, a physician or physician of the same specialty and subspecialty from the same group practice are considered a single provider. Annual office visit benefit limits are 14 office visits per calendar year. Medicaid will continue to pay covered ancillary services (injections, lab, x-rays etc…) for recipients after they have exhausted the 14 physician office visit limitation.

For further information regarding outpatient maintenance dialysis and ESRD, refer to Chapter 35, Renal Dialysis Facility.

A new patient office visit codes shall not be paid to the same physician or same group practice for a recipient more than once in a three-year period.

Prolonged Services Direct Face-to-Face Patient Contact (Procedure Codes 99354 and 99355) in Office or Other Outpatient Setting

Requirement for Physician Presence and Documentation:

- Physicians may count **only** the duration of **direct face-to-face** contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged service codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged outpatient services, time spent reviewing charts or discussion of a patient with medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.

- Documentation is required in the medical record about the **duration** and **content** of the **medically necessary** evaluation and management service and prolonged services billed. The medical record must be appropriately and sufficiently documented by the physician to show that the physician personally furnished the direct face-to-face time with the patient specified in the CPT code definition. Time must be documented clearly in the 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.

- When the **evaluation and management** service is dominated by counseling and/or coordination of care (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.
- Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Effective July 1, 2011, Procedure Codes 99354 and 99355:

- May be billed only in conjunction with companion procedure codes 99201-99205, 99212-99215 99241-99245, 99324-99337, and 99341-99350. Effective April 1, 2012, Procedure Code 99211 is excluded from coverage with prolonged services and may not be billed.
- May not be billed with codes including the EP modifier.
- May not be billed without the above listed companion codes.

Effective January 1, 2012:

Procedure code **99354** prolonged physician services in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour and Procedure code **99355** prolonged physician services in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes will be limited to **one per recipient per provider per year**. For purposes of this limitation, a physician or physicians of the same specialty and subspecialty from the same group practice are considered a single provider. These services will be subject to post-payment review.

28.2.5 Physician Services to Hospital Inpatients

In addition to the 14 physician visits, Medicaid covers up to 16 inpatient dates of service per physician, per recipient, per calendar year. For purposes of this limitation, each specialty within a group or partnership is considered a single provider. Physician visits are limited to one per day.

When filing claims for recipients enrolled in the Patient 1st Program, please refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

Physician hospital visits are limited to one visit per day, per recipient, per provider.

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

Added: The procedure code…criteria applied) appended.

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

Added: Physician may **not**

Deleted: ~~Professional~~

Added: professional

Deleted: ~~may not be billed~~

Echocardiography (i.e., M-mode, transthoracic, complete and follow up)

Echocardiography (i.e., 2D, transesophageal)

Echocardiography (i.e., Doppler pulsed or continuous wave with spectral display, complete and follow up)

Cardiac Catheterizations

Comprehensive electrophysiologic evaluations and follow up testing

Programmed stimulation and pacing

Intra-operative epicardial and endocardial pacing and mapping

Intracardiac catheter ablations; intracardiac echocardiography

Evaluation of cardiovascular function

Plethysmography, total body and tracing

Ambulatory blood pressure monitoring

Cerebrovascular arterial studies, extremity arterial studies, venous studies, and visceral and penile studies

Circardian respiratory pattern recording (i.e., pediatric pneumogram), infant

Needle electromyography

Ischemic limb exercise test

Assessment of aphasia

Developmental testing

Neurobehavioral status exam and neuropsychological testing battery

Professional interpretations for lab and x-ray (CPT code 70000 through 80000 services) in the inpatient setting can only be billed by pathologists and radiologists. The only exception is for professional interpretations by cardiologists for catheterization or arterial studies and for select laboratory procedures by oncologists and hematologists. Professional interpretations/components done by other physicians for services in this procedure code range are included in the hospital visit if one is done. If no hospital visit is made, professional interpretation by physicians other than radiologists, pathologists, oncologists, hematologists, and cardiologists

should not be billed as these services are covered only for the above-mentioned specialties.

A physician hospital visit and hospital discharge shall not be paid to the same physician on the same day. If both are billed, only the discharge shall be paid.

Professional interpretations performed for an inpatient are counted by dates of service rather than the number of interpretation performed.

An office visit shall not be paid to the same provider or other physicians in the same group practice with the same specialty and subspecialty on the same day as an inpatient visit. If both are billed, then the **first** Procedure Code billed will be paid.

Physician consults are limited to one per day per recipient.

28.2.6 Critical Care (99291 & 99292)

When caring for a critically ill patient, for whom the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. Critical care guidelines are defined in the Current Procedural Terminology (CPT) and Provider Manual. Critical care is considered a daily global inclusive of all services directly related to critical care.

Coverage of critical care may total no more than four hours per day.

The actual time period spent in attendance at the patient's bedside or performing duties specifically related to that patient, irrespective of breaks in attendance, must be documented in the patient's medical record.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except:

- An EPSDT screening may be billed in lieu of the initial hospital care (P/C 99221, 99222, or 99223). If screening is billed, the initial hospital care cannot be billed.
- Procedure code 99082 (transportation or escort of patient) may also be billed with critical care (99291 and/or 99292 for recipients 25 months of age and older or 99466 and/or 99467 for recipients 24 months of age or less). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.

LIMITATIONS:

PROCEDURE CODES NOT BILLABLE IN ADDITION TO CRITICAL CARE (99291 & 99292):

FROM	TO	FROM	TO	FROM	TO	FROM	TO
31500	31500	43752	43757	92265	92275	95925	95937
36000	36440	51100	51100	92280	92287	99090	99091
36468	36479	51701	51702	92920	93299	99170	99199
36510	36510	62270	62270	93303	93352	99460	99463
36555	36555	71010	71020	93561	93562		
36591	36591	82800	82820	93668	93799		
36600	36680	91105	91105	93875	94799		

- Procedure codes 99291, 99292, 99466 and 99467 may be billed by the physician providing the care of the critically ill or injured patient in place of service 41, Ambulance, if care is personally rendered by the physician providing the care of the critically ill or injured patient.

28.2.7 Pediatric and Neonatal Critical Care

CPT Code	Description	Criteria
99468	Initial Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for 29 days or older, can be billed by any physician provider type
99469	Subsequent Inpatient Neonatal Critical Care, per day for the evaluation and management of a critically ill neonate, 28 days of age or less	Not valid for ages 29 days or older, can be billed by any physician provider type
99471	Initial Inpatient Pediatric Critical Care, per day for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Not valid for 28 days or less, can be billed by any physician provider type
99472	Subsequent Inpatient Pediatric Critical Care per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	Not valid for ages 28 days or less, can be billed by any physician provider type
99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	May be billed by any physician provider type for infant or child, 2 through 5 years of age
99476	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	May be billed by any physician provider type for infant or child, 2 through 5 years of age

The pediatric and neonatal critical care codes (99468-99476) include management, monitoring and treatment of the patient, including respiratory, pharmacological control of the circulatory system, enteral and parenteral nutrition, metabolic and hematologic maintenance, parent/family counseling, case management services and personal direct supervision of the health care team in the performance of their daily activities.

The following criteria should be used as guidelines for the correct reporting of neonatal and pediatric critical care codes for the critically ill neonate/infant. Only one criterion is required to be classified as critically ill.

- Respiratory support by ventilator or CPAP
- Nitric oxide or ECMO

- Prostaglandin, Indotropin of Chronotropic or Insulin infusions
- NPO with IV fluids
- Acute Dialysis (renal or peritoneal)
- Weight less than 1,250 grams
- Acute respiratory distress in a pediatric admission requiring oxygen therapy with at least daily adjustment and FIO2>35% oxygen by oxyhood.

RESTRICTIONS:

No individual procedures related to critical care may be billed in addition to procedure codes 99468-99476 except:

- Chest tube placement
- Pericardiocentesis or thoacentesis
- Intracranial taps
- Initial hospital care history and physical or EPSDT screen may be billed in conjunction with 99468. Both may not be billed. NOTE: One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.
- Standby (99360), resuscitation (99465), or attendance at delivery (99464) may be billed in addition to critical care. Only one of these codes may be billed in addition to neonatal intensive care critical care codes.

LIMITATIONS:

- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight service codes are reported once per day per recipient.
- Subsequent Hospital Care codes (99231-99233) cannot be billed on the same date of service as neonatal critical care codes (99468-99476)
- Only one unit of critical care can be billed per child per day in the same facility. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Critical care is considered to be an evaluation and management service. Although usually furnished in a critical or intensive care unit, critical care may be provided in any inpatient health care setting. Services provided which do not meet critical care criteria, should be billed under the appropriate hospital care codes. If a recipient is readmitted to the NICU/ICU, the provider must be the primary physician in order for NICU critical care codes to be billed again.
- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).

- Transfers to the pediatric unit from the NICU cannot be billed using critical care codes. Subsequent hospital care would be billed in these instances.
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as defined above. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.

28.2.8 Initial and Continuing Observation or Intensive Care Services

CPT Code	Description	Criteria
99477	Initial hospital care, per day for the evaluation and management of the neonate, 28 days of age or younger, which requires intensive observation, frequent interventions, and other intensive care services.	May only be billed by a neonatologist
99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)	May only be billed by a neonatologist
99479	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight of 1500-2500 grams)	May only be billed by a neonatologist
99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)	May only be billed by a neonatologist

These codes are used to report care subsequent to the day of admission provided by a neonatologist directing the continuing intensive care of the very low birthweight infant who no longer meets the definition of being critically ill. Low birthweight services are reported for neonates less than 2500 grams who do not meet the definition of critical care but continue to require intensive observation and frequent services and intervention only available in an intensive care setting. Services provided to these infants exceed those available in less intensive hospital areas of medical floors. These infants require intensive cardiac and respiratory monitoring, continuous and/or frequent vital signs monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring and constant observation by the health care team under direct supervision.

Restrictions:

No individual procedures related to critical care may be billed in addition to procedure codes 99478-99480 except:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps

Limitations:

- Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed. Only one unit can be billed per day per physician regardless of specialty. Medicaid pays the first claim received and denies subsequent claims (first in, first out policy).
- Global payments encompass all care and procedures that are included in the rate. Providers may not perform an EPSDT screen and refer to a partner or other physician to do procedures. All procedures that are included in the daily critical care rate, regardless of who performed them, are included in the global critical care code.
- Consultant care rendered to children for which the provider is not the primary attending physician must be billed using consultation codes. Appropriate procedures may be billed in addition to consultations. If, after the consultation the provider assumes total responsibility for care, critical care may be billed using the appropriate critical care codes as per the setting. The medical record must clearly indicate that the provider is assuming total responsibility for care of the patient and is the primary attending physician for the patient.
- Pediatric, neonatal critical care codes and intensive (non-critical) low birth weight services codes are only reported once per day per recipient.

PROCEDURE CODES NOT BILLABLE IN ADDITION TO INITIAL AND CONTINUING OBSERVATION OR INTENSIVE CARE SERVICES

FROM	TO	FROM	TO	FROM	TO	FROM	TO
31500	31579	62263	62368	94002	94004	99218	99220
36000	36830	90470	90471	94010	94772	99231	99239
43752	43761	90760	90781	95831	95857	99251	99275
51000	51010	92081	92081	95880	95882	99291	99292
51100	51102	92551	92551	96101	96125	99431	99435
51600	51798	92950	92950	96360	96379	99460	99463
53670	53675	93000	93352	99090	99091		

28.2.9 End-Stage Renal Disease (ESRD)

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services. For example, an attending physician who provides evaluation and management (E & M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E & M services for inpatient visits.

Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

Refer to Chapter 35, Renal Dialysis Facility, for further details.

Parenteral Nutrition

The Alabama Medicaid Agency may reimburse for total parenteral nutritional (TPN) solutions through the pharmacy program if the recipient meets certain requirements as listed below. TPN solutions include those used for hyperalimentation, intradialytic parenteral nutrition (IDPN), and intraperitoneal nutrition (IPN). Requirements must be met and clearly documented in the medical record for coverage of all TPN. All services rendered are subject to post payment review.

Statement of Medical Necessity

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyperalimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient's medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of the initial order and updated yearly in accordance with Medicaid billing practice.

Hyperalimentation

Medicaid covers hyperalimentation for recipients who meet certain requirements of medical necessity and documentation in the medical record is sufficient based on the following:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. The following are considered conditions which could cause insufficient absorption:
  1. Crohn's disease
  2. Obstruction secondary to stricture or neoplasm of the esophagus or stomach
  3. Loss of ability to swallow due to central nervous system disorder, where the risk of aspiration is great
  4. Short bowel syndrome secondary to massive small bowel resection
  5. Malabsorption due to enterocolic, enterovesical or enterocutaneous fistulas (TPN temporary until the repair of the fistula)
  6. Motility disorder (pseudo-obstruction)
  7. Prolonged paralytic ileus following a major surgical procedure or multiple injuries
  8. Newborn infants with catastrophic gastrointestinal anomalies such as tracheoesophageal fistulas, gastroschisis, omphalocele or massive intestinal atresia
  9. Infants and young children who fail to thrive due to systemic disease or secondary to insufficiency associated with short bowel syndrome, malabsorption or chronic idiopathic diarrhea.
- Medical record documentation must include supporting evidence that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, hyperalimentation must be given in order to meet 100% of the patient's nutritional needs.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include BUN, serum albumin, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

IDPN and IPN involves infusing hyperalimentation fluids as part of dialysis, through the vascular shunt or intraperitoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN
- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication
- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.
- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol level, and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

Restrictions

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist; these are as follows:

- Glucose
- Dextrose
- Trace Elements
- Multivitamins

28.2.10 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth by the Alabama Board of Medical Examiners. The AA must enroll with a NPI to bill the Alabama Medicaid Program. Refer to Chapter 38, Anesthesiology, for more information.

28.2.11 Obstetrical and Related Services

The following policy refers to maternity care billed as fee-for-service and not as a part of the Maternity Care program. Refer to Chapter 24, Maternity Care Program, for more details.

Physician visits for obstetrical care are counted as part of each recipient's benefit limit of 14 physician visits per year under the conditions listed below.

Maternity Care and Delivery
The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered.

NOTE:

When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician must use a "global" obstetrical code in billing.

If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of 14 physician office visits a calendar year. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

NOTE:

The date of service on the “global” OB claim must be the date of delivery.

Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

To justify billing for global antepartum care services, physicians must utilize the CPT-4 antepartum care global codes (either 4-6 visits or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's limit of 14 office visits per year.

NOTE:

Physicians who provide less than four (4) visits for antepartum care must utilize CPT-4 codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's limit of 14 physician visits a calendar year.

Billing for antepartum care services in addition to "global" care is not permissible. However, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high-risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's limit of 14 physician office visits a calendar year.

Delivery and Postpartum Care

Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within 62 days post delivery. Additional claims for routine visits during this time should not be filed.

Delivery Only

If the physician performs the delivery only, he must utilize the appropriate CPT-4 delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

Ultrasounds

Obstetrical ultrasounds are limited to two per pregnancy and one (1) per day per recipient. For patients covered under the maternity care waiver, refer to Chapter 24, Maternity Care Program. Generally, first ultrasounds are conducted to detect gestational age, multiple pregnancies, and major malformations. Second ultrasounds may be conducted to detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

Additional ultrasounds may be **prior approved** by the Alabama Medicaid Agency if a patient's documented medical condition meets any of the following criteria:

- Gestational diabetes with complications (Type 1 diabetes, vascular disease, hypertension, elevated alpha-fetoprotein values, poor patient compliance)
- Failure to gain weight, evaluation of fetal growth
- Pregnancy-induced hypertension
- Vaginal bleeding of undetermined etiology
- Coexisting adnexal mass
- Abnormal amniotic fluid volume (polyhydramnios, oligohydramnios)
- Pregnant trauma patient
- Congenital diaphragmatic hernia (CDH)
- Monitoring for special tests such as fetoscopy, amniocentesis, or cervical cerclage placement
- Assist in operations performed on the fetus in the uterus
- Detection of fetal abnormalities with other indicators or risk factors (Low human chorionic gonadotrophin (HCG) and high-unconjugated estriol (uE3) are predictive of an increased risk for Trisomy 18. Echogenic bowel grades 2 and 3 are indicative of an increased risk of cystic fibrosis and Trisomy 21)
- Determination of fetal presentation
- Suspected multiple gestation, serial evaluation of fetal growth in multiple gestation

- Suspected hydatidiform mole
- Suspected fetal death
- Suspected uterine abnormality
- Suspected abrupt placenta
- Follow-up evaluation of placental location for identified placenta previa
- Maternity Care subcontractors should contact the Primary Contractor for information regarding obstetrical ultrasounds.

To determine if a procedure requires prior authorization, providers should use the AVRS line at HP, 1(800) 727-7848. For information on diagnostic radiology procedures that require prior authorization, please refer to Chapter 22, Independent Radiology.

Emergency Services For Non-Citizens

Miscarriages

Miscarriages are not currently billable electronically. Requests concerning miscarriages for aliens who are not eligible for pregnancy or full coverage Medicaid continue to be processed manually, until further notice. Aliens, who had miscarriages, must continue to present bills timely (within three months) to the SOBRA worker, who determines eligibility; then forwards information to Central Office for manual processing. Providers will receive a check from Medicaid for miscarriages as well as other alien services approved for reimbursement.

Delivery Services Billable Through HP

Procedure code 01967 has been added to the list of codes billable through HP for medical claims.

For CMS-1500 (formerly HCFA-1500) medical claims, the following procedures are covered:

- 59409-vaginal delivery only
- 59612-vaginal only, after previous c-section
- 59514-c-section only
- 59620-c-section only, after attempted vaginal, after previous c-section
- 01960-vaginal anesthesia
- 01961-c-section anesthesia
- 01967-neuraxial labor analgesia/anesthesia
- 62319-epidurals

For UB-04 inpatient claims, the following per diem is covered:

- Up to 2 days for vaginal delivery
- Up to 4 days for c-section delivery.

Allowable diagnoses codes for CMS-1500 or UB-04:

V270 - V279	650
65100-65993	6571 - 6573

Allowable Surgical codes for UB-04 are 740-7499.

28.2.12 Vaccines For Children (VFC)

The Department of Public Health provides vaccines at no charge to Medicaid providers enrolled in the Vaccines For Children (VFC) Program as recommended by the Advisory Committee on Immunization.

Medicaid reimburses administration fees for vaccines provided free of charge through the VFC Program. The rate for the administration fee is $8.00; it is not the rate on the pricing file. Please refer to Appendix A, Well Child Check-Up, Section A.6.1 (Fees) for information regarding the use of designated VFC codes for billing immunization administration fee(s).

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

Refer to Appendix A, EPSDT, for procedure codes for VFC.

28.2.13 Lab Services

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected. The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected. Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Lab Tests Performed in Physician's Offices

When performing laboratory tests in the physician's office:

1. The Physician must be CLIA certified to perform the test,
2. The Physician must have the appropriate equipment to perform the test, and
3. The Physician's office bills for the tests performed but not the collection fee.

When specimens are sent to an outside lab:

1. The Physician's office should not bill the laboratory code, and
2. The Physician's office may bill a collection fee with a "90" modifier for blood specimens.

EXAMPLE:
Lead Levels

Procedure Code 83655 (Lead) should only be billed when the office has the equipment to perform the test. When collecting a specimen only and then sending the blood sample to an outside lab for analysis, you must bill Procedure Code 36415 with modifier 90. The utilization of procedure code 36415-90 will enable you to receive a collection and handling fee for the specimen obtained.

Procedure code 36415-90 should not be billed when lab procedures are performed in the office. The appropriate lab procedure code(s) must be billed when actually performing the lab test. Again, the correct equipment must be utilized to perform the test. These services are subject to post-payment review. Medical record documentation must support the performance and medical necessity of the laboratory test.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (e.g., finger, heal, ear stick) and Q0091-90 for collection of Pap smear specimen.

Repeat Lab Procedures

Modifier 91 may be utilized to denote a repeat clinical laboratory test performed on the same date of service for the same recipient. Providers should use modifier 91 instead of modifier 76 for repeat lab procedures.

NOTE:

A physician CANNOT bill the following pathology/laboratory procedure codes; however the above collection fee can be billed, if applicable:

82775 Galactose – 1 – phosphate uridyl transferase; quantitative
83498 Hydroxyprogesterone, 17 – d
84030 Phenylalanine (PKU) blood
84437 Thyroxine; total requiring elution (e.g., neonatal)

28.2.14 Supply Code

The procedure code 99070 is utilized by physicians to bill for supplies and materials over and above those usually included with the office visit. Examples of supplies and materials over and beyond usual supplies include elastic wraps, disposable tubing for bronchial dilating equipment or post-operative dressing changes when no office visit is allowable.

28.3 Prior Authorization and Referral Requirements

Medical care and services that require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers, e.g., organ transplants and select surgical procedures. Please refer to Chapter 4, Obtaining Prior Authorization for more information.

For information regarding Prior Authorization for MRI's, CT scans, CTA's, MRA's, and PET scans, refer to chapter 22, Independent Radiology.

Unlisted services and procedure codes are not covered by the Alabama Medicaid Agency, with the exception of Medicare crossover claims and rare instances when approval is granted prior to service provision after the agency has determined that the service is covered and that no other procedure code exists for reimbursement.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital.

28.4 Signature Requirements

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.

Services that require a physician's order 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 1st/EPSDT referral form may be considered the physician's order as long as these guidelines are met. Refer to the individual provider manual chapters for detailed description of what must be included in an order.

All entries in the medical record must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his/her entry. Authentication may include handwritten or electronic signatures, or written initials, **Stamped or copied signatures will not be accepted.**

28.5 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

Deleted: ~~The~~ copayment amount…Medicaid required copayment.

Added: The copayment amount…including crossovers is:

Added: $3.90 for procedure…for each procedure:

Added: *The following CPT…for each procedure.

Added: 90847, 90849, 90853 to Medicaid required copayment.

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an “active user letter” issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

28.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Physicians who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

28.6.1 Time Limit for Filing Claims

Medicaid requires all claims for physicians to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

28.6.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

28.6.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

Filing Claims with Modifiers

Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. It is necessary to append the appropriate anatomical modifiers to surgical codes to differentiate between multiple surgeries and sites.

Appropriate Use of Modifiers

Please refer to this CMS link for more information regarding NCCI edits: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

Modifier 24 (Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period)

The Physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E&M service. From a coding perspective, Modifier 24 is appropriate when a physician provides a surgical service related to one problem and, during the postoperative period or follow-up care for the surgery, provides and E&M service unrelated to the problem requiring the surgery.

Modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)

It may be necessary to indicate that on the day a procedure or service identified by CPT code was performed, the patient's condition required a significant, separately identifiable E&M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other non E&M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E&M services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Modifier 76 (Repeat Procedure by Same Physician)

The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure/service. From a coding perspective, modifier 76 is intended to describe the same procedure or service repeated, rather than the same procedure being performed at multiple sites.

Modifier 78 (Return to the Operating Room for a Related Procedure During the Postoperative Period)

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When the subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. Modifier 78 is not used for procedures that indicate in the code descriptor “subsequent, related or redo.”

Modifiers 80, 81, 82 and AS (Assistant-at-Surgery Modifiers)

An assistant-at-surgery serves as an additional pair hands for the operating surgeon. Assistants-at-surgery do not carry primary responsibility for or “perform distinct parts” of the surgical procedure. Assistant-at-surgery coverage is limited to fully qualified physicians and non-physician practitioner (i.e., PAs, CRNP, etc) if it is within the scope of their licenses.

- **Modifier 80** – Assistant surgeon
- **Modifier 81** – Minimum assistant surgeon
- **Modifier 82** – Assistant surgeon (when qualified resident surgeon not available)
- **Modifier AS** – Physician assistant, nurse practitioner, or clinical nurse specialist for assistant at surgery.

Modifier Q5 (Service Performed by a Substitute Physician under a Reciprocal Billing Agreement)

Under certain circumstances, the physician may need to indicate that a service was provided by a substitute physician. Modifier Q5 is reported when the regular physician arranges for a substitute physician to furnish services on an occasional reciprocal basis. Modifier Q5 should be appended after the procedure code to indicate that the service was provided by a substitute physician under a reciprocal arrangement. When appending modifier Q5, the regular provider is certifying that the services are covered services furnished by the substitute physician. The regular physician should keep a record on file of each service provided by the substitute physician and make this record available to Medicaid upon request.

Modifier Q6 (Service Furnished by a Locum Tenens Physician)

Under certain circumstances, the physician may need to indicate that a service was provided by a locum tenens physician. A locum tenens physician generally has no practice of his/her own; he/she usually moves from area to area as needed. The regular physician generally pays the substitute physician a fixed per diem amount or other fee-for-time compensation, with the locum tenens physician having a status of an independent contractor rather than of an employee. Modifier Q6 should be appended after the procedure code to indicate that the service was provided by a locum tenens physician. The regular physician should keep a record on file of each service provided by the locum tenens physician and make this record available to Medicaid upon request.

Bilateral Procedures

Effective for dates of adjudication October 1, 2006 and thereafter the procedure for billing bilateral procedures changed. In the past, (through September 30, 2006), providers were instructed to bill for bilateral procedures on one line with modifier 50. The reimbursement was adjusted to 150% of Medicaid's fee schedule.

Effective for dates of adjudication October 1, 2006 and thereafter, the new procedure is as follows:

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

Example:

Line 1: 27558 RT
27558 LT; 50 (Optional use of modifier 50)

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

NOTE:
When Medicaid payment occurs for a procedure code billed inappropriately with modifier 50, AND/OR RT (right) AND/OR LT (left), the claim will be subject to a system adjustment in payment, post payment review, and recoupment.

Procedure Codes

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

NOTE:
Unlisted procedure codes are not covered by the Agency unless the provider requested and received approval for a prior authorization before the service is rendered. The Agency will deny all requests for payment of unlisted codes after the fact.

Physician-Employed Physician Assistants (PA) and Certified Registered Nurse Practitioners (CRNP)

CRNP and PA payment will be made only for CPT codes identified in Appendix O, physician administered drugs, and laboratory services, (must be CLIA certified). EPSDT screenings will be covered only if the provider is enrolled in that program. Refer to Appendix A, EPSDT, for EPSDT program requirements.

The Physician's Assistant or CRNP can make physician required inpatient visits to nursing facilities. However, physician required inpatient visits to hospitals or other institutional settings cannot be made by a PA or CRNP. CRNP and PA services have been expanded. Please refer to Appendix O for additional information.

Global Surgical Packages

Effective for dates of adjudication 10/1/06 and thereafter, Medicaid will adopt Medicare's RVU file designation for global surgical days. In the past and through date of adjudication September 30, 2006, Medicaid has used a 62 day post op period after major surgeries.

Effective for dates of adjudication 10/1/06 and thereafter, Medicaid will use a zero, 10 day, and 90 day post op period for routine surgical care. Routine post-surgical care in the hospital or office setting for conditions directly related to surgical procedures is covered by the surgical fee. Depending on post operative period, post-surgical visits cannot be billed separately the day of, or up to 90 days after surgery.

For conditions unrelated to the surgical procedure bill the appropriate (E&M) procedure code with a 24 modifier appended. The diagnosis must support use of the modifier 24.

Claims for these services will be subject to post payment review.

Refer to this Medicare RVU file: https://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage for global surgical procedure codes Zero, 10 and 90 day(s) post operative period.

Professional and Technical Components

Some procedure codes in the 70000, 80000, 90000, and G series are a combination of a professional component and a technical component. Therefore, these codes may be billed one of three different ways; (1) as a global, (2) as a professional component, or (3) as a technical component. NOTE: Not all providers are allowed to bill any or all of the three ways to bill. Specific coverage questions should be addressed to the Provider Assistance Center.

- **Global**, the provider must own the equipment, pay the technician, review the results, and provide a written report of the findings. The procedure code is billed with no modifiers. The Global component should be billed only for the following place of service locations:
  - 11 (Office)
  - 81 (Independent Laboratory)
- **Professional component**, the provider does not own or operate the equipment. The provider reviews the results, and provides a written report of the findings. The Radiological professional component is billed by adding modifier 26 to the procedure code, and should be billed only for the following place of service locations:
  - 21 (inpatient hospital)
  - 22 (outpatient hospital)
  - 23 (emergency room - hospital)
  - 51 (inpatient psychiatric facility)
  - 61 (comprehensive inpatient rehab facility)
  - 62 (comprehensive outpatient rehab facility)
  - 65 (end-stage renal disease facility)
  - 81 (Independent Laboratory)
- **Technical component**, the provider must own the equipment, but does not review and document the results. The technical component charges are the facility's charges and are not billed separately by physicians. The technical component is billed by adding modifier TC to the procedure code. The technical component can only be billed by facilities.

28.6.4 Billing for Patient 1st Referred Service

Please refer to Chapter 39 for information regarding the Patient 1st Program and Patient 1st referrals. Please refer to Chapter 5, Filing Claims, for information regarding filing claims for a Patient 1st referral.

28.6.5 Place of Service Codes

The following place of service codes apply when filing claims for physicians:

POS	Description
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or water
51	Inpatient Psychiatric Facility
52	Psy. Fac. Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Fac./Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

28.6.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

28.6.7 Consent Forms Required Before Payments Can Be Made

NOTE:

HP will NOT pay any claims to ANY provider until a correctly completed original of the appropriate form is on file at HP. Please note, **only the surgeon** should submit consent forms to HP. All other providers should not request and or submit copies of the consent form. Multiple copies slow down the consent form review and claims payment process.

Abortions

In accordance with federal law, abortions are covered only (1) if the pregnancy is the result of an act of rape or incest; or (2) where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Please refer to Appendix E, Medicaid Forms, for a copy of the PHY-96-2 Certification and Documentation for Abortion form, which is used when the pregnancy is causing the life of the mother to be in danger. In the case of abortions performed secondary to pregnancies resulting from rape or incest, the documentation required is a letter from the recipient or provider certifying that the pregnancy resulted from rape or incest.

- The original copy of the PHY-96-2 form (for life of the mother in danger) signed by the attending physician, or the certification letter regarding rape or incest, and a copy of the medical records (history and physical, operative report and discharge summary) must be submitted to HPES, P.O. Box 244032, Montgomery, AL 36124-4032, Attn: Medical Policy Unit/Consent Forms.

Added: HPES, P.O. Box…Unit/Consent Forms.

- The second copy of the consent form or certification letter must be placed in the recipient's medical record.

All claims relating to abortions must have the above-specified documentation on file at HP prior to payment.

This documentation is not required when a recipient presents with a spontaneous abortion.

If the recipient does not qualify for payment by Medicaid and elects to have the abortion, providers may bill the recipient for the abortion as a non-covered service.

Sterilization

HP must have on file the Medicaid-approved sterilization form. Refer to Appendix C, Family Planning, for more information. Surgeons should submit hard copy sterilization consent forms to HPES, P.O. Box 244032, Montgomery, AL 36124-4032, Attn: Medical Policy Unit/Consent Forms.

Added: Surgeons should submit… Unit/Consent Forms

Sterilization by Hysterectomy

Payment is not available for a hysterectomy if:

1. **It was performed solely for the purpose of rendering an individual permanently incapable of reproducing**
2. **If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing**

NOTE:

Sterilization performed for the sole purpose of rendering a person permanently incapable of reproducing is not available to persons under twenty-one (21) years of age under the Medicaid Program.

Refer to Appendix E, Medicaid Forms, for a sample of the sterilization form.

Hysterectomy

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are not covered under Medicaid. Hysterectomies done as a medical necessity as treatment of disease can be paid for by the Medicaid funds under the physician's program.

The hysterectomy consent form was revised to include a section for unusual circumstances. This form should be used by a physician to certify a patient was already sterile when the hysterectomy was performed; a hysterectomy was performed under a life threatening situation; or a hysterectomy was performed under a period of retroactive Medicaid eligibility. In all of these circumstances, medical records must be forwarded to HP along with the hysterectomy consent form and claim(s) in order for a State review to be performed.

NOTE:

The **doctor's explanation** to the patient that the operation will make her sterile and the **doctor's and recipient's signature** must precede the operation except in the case of medical emergency. If a field is missing, contains invalid information or indicates the recipient/representative or physician signed after the date of surgery, HP will return the consent form to the provider to correct invalid information.

Added: Surgeons should submit…Unit/Consent Forms.

HP must have on file a Medicaid-approved Hysterectomy Consent Form. The revised hysterectomy consent form (form # PHY-81243) became effective January 1, 2004. Instructions for completing the consent form are on the back of the consent form. See Appendix E, Medicaid Forms, or visit our website for a sample copy of this form. Surgeons should submit hard copy hysterectomy consent forms to HPES, P.O. Box 244032, Montgomery, AL 36124-4032, Attn: Medical Policy Unit/Consent Forms.

Exceptions That Do Not Require Prior Completion of the Consent Form

In the following situations, the consent form is required and section III and IV of the consent form must be completed.

Added: III and

1. The physician who performed the hysterectomy certifies in writing that the patient was already sterile when the hysterectomy was performed; the cause of sterility must be stated in this written statement. Refer to Section IV on the consent form.
2. The physician who performed the hysterectomy certifies in writing that the hysterectomy was performed under a life-threatening emergency situation in which prior acknowledgement was not possible. This written statement must include a description of the nature of the emergency. Refer to Section IV on the consent form.
3. The hysterectomy was performed during a period of retroactive Medicaid eligibility, and the physician who performed the hysterectomy submits, in lieu of the consent form, a written statement certifying that the individual was informed before the operation that the hysterectomy would make her sterile. Refer to Section IV on the consent form.

NOTE:

Medicaid payment cannot be made for any claims for services provided in connection with an abortion, a sterilization procedure or a hysterectomy for medical reasons unless an approved consent form is on file. Please be aware consent for sterilization is different from consent for hysterectomy. See Appendix E, Medicaid Forms, for examples of each.

28.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Anesthesiology	Chapter 38
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
Alabama Medicaid Injectable Drug List	Medicaid website
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

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29

29 Podiatrist

Podiatrists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

The policy provisions for podiatrists can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 11.

29.1 Enrollment

HP enrolls podiatrists and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a podiatrist provider is added to the Medicaid system with the National Provider Identifiers provided at the time applications is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for podiatry-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Podiatrists are assigned a provider type of 14 (Podiatrist). Valid specialties for podiatrists include the following:

- Podiatry (140)
- QMB/EPSDT (600)

Enrollment Policy for Podiatrists

To participate in the Alabama Medicaid Program, podiatrists must meet the following requirements:

- Possess a current license issued to practice podiatry
- Operate within the scope of practice established by the appropriate state's Board of Podiatry

29.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Podiatry services are covered only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

For more information regarding the EPSDT program, refer to Appendix A, EPSDT.

29.3 Prior Authorization and Referral Requirements

Podiatrists may provide services for QMB recipients or to recipients referred as a result of an EPSDT screening.

For podiatry services to be paid by Medicaid for non-QMB recipients (i.e., EPSDT), the service must be medically necessary and the result of a referral from a contracted Medicaid EPSDT screening provider. Screening providers will complete and forward an Agency Referral Form (form 362), which must identify the reason for referral and serve as documentation that the services provided were the result of an EPSDT screening.

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.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 to determine whether your services require a referral from the Primary Medical Provider (PMP).

Deleted: ~~The copayment amount … and family planning.~~

29.4 Cost Sharing (Copayment)

Added: for office

The copayment amount for office visit* including crossovers is:

Added: is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

Deleted: ~~Copayment does not…and family planning.~~

Added: The copayment amount…including crossovers is:

Added: $3.90 for procedure…$10.01 and $25.00

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

Added: The following CPT…for each procedure:

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

Added: 90847, 90849, 90853…99348, 99349, 99350

If one of these CPT codes is applicable for your practice, then copay applies.

Added: If any of…then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

Added: Copayment does not…Medicaid required copayment.

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

29.5 Completing the Claim Form

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Podiatrists who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

29.5.1 Time Limit for Filing Claims

Medicaid requires all claims for podiatrists to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

29.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

29.5.3 Procedure Codes and Modifiers

Podiatry providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Podiatry CPT codes describing procedures performed on the foot and toes range from 28001 - 29909. In addition to the 28001-29909 CPT codes, podiatrists may also use the evaluation and management codes 99201-99215

and nail codes 11719-11765. Procedure code coverage, maximum units and prior authorization requirements should be checked through AVRS prior to rendering service. Refer to Appendix L, AVRS Quick Reference Guide, for more details on verifying this information.

29.5.4 Place of Service Codes

The following place of service codes apply when filing claims for podiatry services:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
54	Intermediate Care Facility/Mentally Retarded
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic

29.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

29.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

30

30 Preventive Health Education

Preventive Health Education Services are services provided by a physician or other licensed practitioner of the healing arts (within the scope of practice), or by other qualified providers, designed to prevent disease, disability, or other health conditions or their progression; to prolong life; and to promote physical and mental health and efficiency.

The purpose of these services is to reduce unintended adolescent pregnancies; decrease the rate of infant mortality; and decrease the incidence of maternal complications, low birth weight babies, and deaths among infants and small children.

The policy provisions for preventive health education services can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 50.

30.1 Enrollment

HP enrolls preventive health education providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid Agency as a preventive health educator is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for preventive health educator-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Preventive health education providers are assigned a provider type of 55 (Private Prenatal Education). The valid specialty for preventive health education providers is Preventive Health Education (183).

Enrollment Policy for Preventive Health Education Providers

Providers include clinics or other organizations that use licensed practitioners of the healing arts within the scope of practice under state law and federal regulations.

Professional instructors of the provider must meet the following qualifications (according to specialty) as listed below:

- A health educator must have graduated from an accredited four-year college or university with major course work in public health, health education, community health, or health/physical education/recreation with a concentration in health.
- A social worker must be licensed by the Alabama Board of Social Work Examiners.
- A registered nurse must be licensed by the Alabama Board of Nursing as a Registered Nurse.
- A nurse practitioner must have successfully completed a supplemental program in an area of specialization, and must be licensed by the Alabama Board of Nursing as a Registered Nurse and be issued a certificate of approval to practice as a Certified Registered Nurse Practitioner in the area of specialization.
- A nurse midwife must be licensed by the Alabama Board of Nursing as a Registered Nurse and a Certified Nurse Midwife.
- A nutritionist must be licensed as a Registered Dietitian by the American Dietetic Association.
- A nutritionist associate must have graduated from a four-year college or university with major course work in nutrition or dietetics.
- A professional counselor must be licensed by the Alabama Board of Examiners in Counseling.
- A health instructor must have a bachelor's degree with extensive experience in providing instruction in preventive health education supplemented by a training program approved by the Alabama Medicaid Agency.

In cases where there is no licensing board for the instructors listed above, the instructor must work under the personal supervision of a physician or work in a facility that provides the services under the direction of a physician, such as in a clinic or outpatient hospital. "Under the supervision of" denotes that the physician is familiar with the Medicaid approved preventive information being presented to recipients and is available to the preventive health instructor by telephone, fax, or in person at the time the instructor is providing the preventive health education service. Providers must supply Medicaid with the name and resume of the physician supervising the instructor and maintain documentation sufficient to demonstrate their availability to the instructors.

All provider instructors must have successfully completed a training program, which is designed to prepare them to provide educational services. This training program must be approved by the Alabama Medicaid Agency.

Providers must develop a specific written curriculum for their educational services, including specific course content and objectives for each class. This curriculum must be approved by the Alabama Medicaid Agency.

30.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Eligibility of recipients for preventive health education services varies according to the type of service being provided.

- Prenatal Education services are limited to pregnant Medicaid eligible females (as evidenced by physical examination or a positive pregnancy test).
- Adolescent Pregnancy Prevention Education is available to all Medicaid eligible individuals who are of childbearing age, who are not pregnant, and who are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy.

Covered Services

Preventive Health Education Services are covered when provided by a Medicaid enrolled preventive health education service provider.

Prenatal and Pregnancy Prevention Education

Prenatal Education consists of a series of classes that teach pregnant women about the process of pregnancy, healthy lifestyles, and prenatal care. These services are covered for Medicaid eligible pregnant women only. Prenatal Education visits are limited to 12 visits per recipient during each two-year period beginning with the first date of service.

Adolescent Pregnancy Prevention Education

Adolescent Pregnancy Prevention Education consists of a series of classes which teach non-pregnant adolescents (male or female) about consequences of unintended pregnancy, methods of family planning, and decision-making skills. These services are covered for all Medicaid eligible non-pregnant individuals of child bearing age who are eligible for services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy. Adolescent Pregnancy Prevention Education visits are unlimited.

Reimbursement

Reimbursement to providers is based on Medicaid's established fee schedule, not to exceed the prevailing rate in the locality for comparable services offered under comparable conditions.

30.3 Prior Authorization and Referral Requirements

Preventive health education procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

30.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by preventive health education providers.

30.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Preventive health education providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

30.5.1 Time Limit for Filing Claims

Medicaid requires all claims for preventive health education to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

30.5.2 Diagnosis Codes

Prenatal Education services are limited to diagnosis code V220 - V222. Adolescent Pregnancy Prevention Education services are limited to diagnosis code V2509.

30.5.3 Procedure Codes and Modifiers

The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Services are **limited** to the billing of the following two procedure codes:

Procedure Code	***Description***
S9445	Prenatal Education – Limited to pregnant female recipients. Limited to diagnosis code V220 - V222.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509.

30.5.4 Place of Service Codes

The following place of service code applies when filing claims for preventive health education services:

Code	***Description***
99	Other Unlisted Facility

30.5.5 Required Attachments

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

30.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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31 Private Duty Nursing

The purpose of the Private Duty Nursing Program is to provide payment for quality, safe, cost-efficient skilled nursing care to Medicaid recipients who require a minimum of four consecutive hours of continuous skilled nursing care per day. Skilled nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is medically necessary to treat or ameliorate medical conditions identified as a result of an EPSDT screening. The medical criteria herein must be present when the specified condition listed below is found. For conditions not found in the Alabama Medicaid Administrative Code, medical necessity review will be conducted by the Medicaid Medical Director. Medicaid recipients who do not meet the medical necessity requirements for the Private Duty Nursing Program have access to a variety of nursing and related community services. The Agency will make referrals to the appropriate programs based on the level of care needed.

A private duty-nursing agency is a public agency, voluntary non-profit organization, or proprietary agency that provides a minimum of four hours per day of continuous skilled nursing care in the recipient's home. Recipients eligible for in-home private duty-nursing services may be considered for services when normal life activities take the recipient outside the home.

The recipient must be under 21 years of age and referred as the result of an EPSDT screening.

NOTE:

Providers of private duty nursing services under the Technology Assisted (TA) Waiver for Adults should refer to the Alabama Medicaid Provider Manual, Chapter 107 for policy provisions.

The policy provisions for private duty-nursing providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

31.1 Enrollment

HP enrolls private duty-nursing providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A private duty nursing provider who contracts with Medicaid is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nursing-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Private duty nursing providers are assigned a provider type of *52* (Private duty nursing). The valid specialty is Private duty nursing (580).

Enrollment Policy for Nursing Providers

Private duty-nursing providers enroll as EPSDT only. Only in-state private duty-nursing providers and out-of-state providers within 30 miles of the state line qualify for participation in the Medicaid program. Private duty-nursing providers must have a RN on staff.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

31.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Nursing services must be prescribed as medically necessary by a licensed physician as a result of an EPSDT screening referral, based on the expectation that the recipient’s medical needs are adequately and safely met in the home.

The EPSDT screening is valid for up to one year. If the need for services continues beyond the valid date, a new EPSDT screening is required.

All private duty-nursing services require prior authorization. Additionally, the recipient must be under 21 years of age to qualify and must be Medicaid eligible. The recipient must require skilled nursing care which exceeds the caregiver’s ability to care for the recipient without the assistance of at least four consecutive hours of skilled nursing care.

Qualified Caregiver

Major commitment on the part of the recipient's family is mandatory to meet the recipient's needs. The primary caregiver must sign the *Private Duty Nursing Agreement for Care* form agreeing to participate in and complete training. Additional caregivers identified for training must be indicated on the *Private Duty Nursing Agreement for Care* form (Form 388). In the event that multiple caregivers exist, an adjustment in the hours approved for PDN will occur.

- The family must have at least one member capable of and willing to be trained to assist in the provision of care for the recipient in the home.
- The family must provide evidence of parental or family involvement, and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).
- Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

Hours Allowed For Continuation of Private Duty Nursing Services Under the Following Circumstances:

- Temporary Illness: Private duty nursing hours may be provided for a period up to 90 days if the primary caregiver is incapacitated due to personal illness or illness of another family member who is dependent upon the caregiver and there is no other trained caregiver available in the home. Temporary illness includes a required surgical procedure due to illness/disease, an illness which would be a danger to the child because of contagion, or an illness which is debilitating for a limited period. Medical documentation from the caregiver's attending physician is required. The number of hours approved is dependent upon the specific circumstances.
- Patient at Risk: Private duty nursing hours may be approved if the patient appears to be at risk of abuse, neglect, or exploitation in the domestic setting and a referral for investigation has been made to the appropriate state agency. The number of hours approved is dependent upon the specific circumstances.
- Sleep: Private duty nursing hours may be provided up to eight hours depending on the situation of the primary care giver. For example, a single parent with no other family support may be granted a full eight hours while two parents serving as primary caregivers may require fewer hours or only hours on an occasional basis.
- Work: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is at work plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. *A Private Duty Nursing Verification of Employment/School Attendance* form (Form 387) providing documentation of work hours must be completed.
- School: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is attending class plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. A current course selection guide published by the school, validated class schedule from school, curriculum guide and transcripts of previous courses taken must be provided along with a completed *Private Duty Nursing Verification of Employment/School Attendance form (Form 387)*. The coursework must be consistent with the requirement for obtaining a GED, college degree, or some other type of certification for employment. Courses selected must follow a logical approach with class hours being taken one after the other unless the course has been indicated by school officials as "closed".

NOTE:

The private duty-nursing program does not cover recipients receiving skilled nursing care through the home health program. Nursing care covered by Medicaid in both programs would result in duplicate reimbursements.

NOTE:

Any private duty nursing hours approved will be reduced by the number of hours of care which are provided or are available from other resources. Hours provided by sources other than Medicaid must be reported on the Private Duty Nursing Agreement for Care form (Form 388). In the event a child eligible for Medicaid is already attending or plans to attend public school, the case manager should contact the Special Education Coordinator within the appropriate school district to request that the child's Individual Education Program (IEP) committee meet to determine the student's need for related services. The names and contact information for the coordinators are on the education website at www.alsde.edu**.** The Individuals with Disabilities Education Act (IDEA) guarantees every child the right to a free, appropriate public education and related services in the least restrictive environment. The case manager may be asked to be part of the client's IEP team to facilitate the coordination of necessary related services. Related services needed in the school that are the same as services provided in the home should be closely coordinated. For example, a child needing nursing services should be evaluated and recommended for the appropriate level of care to ensure no break in services if services previously provided by Medicaid are subsequently provided by the school district. For children attending public school, the number of approved hours may be modified during the summer months and school breaks.

NOTE:

When a Private Duty Nursing (PDN) applicant is added to the PDN Program, they may be granted more PDN hours beyond what is normally approved. The purpose of the additional hours initially is to give the PDN provider time to train the qualified caregiver(s). However during the recertification period, the PDN hours may be decreased to the hours determined by the PDN criteria.

31.2.1 Criteria for Non-Ventilator-Dependent Recipients

High technology non-ventilator-dependent recipients may qualify for private duty-nursing services if they meet either of the following criteria and at least one qualified caregiver has been identified:

- Any one of the primary requisites is present.
- Two or more secondary requisites are present.

Primary Requisites

Primary requisites include, but may not be limited to, the following as qualifying criteria for nursing recipients:

- Tracheotomy –Coverage for a functioning tracheotomy requiring oxygen supplementation; and nebulizer treatments or cough assist/inexsufflator devices. Continuation of nursing services may be approved after initial certification for those periods of time when the qualified primary caregiver is away from the home for work or school or otherwise unable to provide the necessary care.
- Total Parenteral Nutrition (TPN) - Coverage up to two months for acute phase with additional certification based upon the need for continuing therapy
- Intravenous Therapy - Coverage up to two months for a single episode. The number of hours required for a single infusion must be at least four continuous hours and require monitoring and treatment by a skilled nurse. An additional period of certification may be approved based on medical necessity for continuing therapy. Additional hours may also be approved for secondary criteria requisites listed below in conjunction with the primary criteria requisites.

Secondary Requisites

Secondary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Decubitus ulcers - coverage for stage three or four ulcers
- Colostomy or ileostomy care - coverage for new or problematic cases
- Suprapubic catheter care - coverage for new or problematic cases
- Internal nasogastric or gastrostomy feedings - coverage for new or problematic cases

31.2.2 Criteria for Ventilator-Dependent Recipients

Ventilator dependent recipients may qualify for private duty-nursing services if any one of the primary requisites is present and at least one qualified caregiver has been identified.

Primary Requisites

Primary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Mechanical ventilator support is necessary for at least six hours per day and appropriate weaning steps are in progress on a continuing basis.
- Frequent ventilator checks are necessary. Frequent ventilator checks are defined as daytime versus nighttime setting changes, weaning in progress, or parameter checks a minimum of every eight hours with subsequent ventilator setting changes.
- Oxygen supplementation for ventilator dependent recipients is at or below an inspired fraction of 40 percent (Fi02 of 0.40).

31.2.3 Scope of Services

This section lists the scope of services provided by professional nurses and licensed practical nurses.

Registered Nurse Services (RN)

A registered nurse employed by a Medicaid-enrolled private duty-nursing agency may provide continuous skilled nursing services to the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization.

The RN completes an in-home assessment to determine if services may be safely and effectively administered in the home. The registered nurse establishes a nursing care plan complying with the plan of treatment.

The RN must make monthly supervisory visits to evaluate the appropriateness of services rendered by a licensed practical nurse (LPN). An RN must be on call 24 hours a day, seven days a week.

Licensed Practical Nurse Services (LPN)

The LPN may provide continuous skilled nursing services for the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization. The LPN works under the supervision of the RN.

The RN evaluates the recipient and establishes the plan of care prior to assigning recipient services to the LPN.

The Medicaid program requires that the RN on a monthly basis provides direct or indirect supervisory visits of the LPN in the home of each recipient the LPN serves. Direct supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is present. Indirect supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is not present.

Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Private Duty Nurse is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

    (a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

    (b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Private Duty Nurse.

(3) The DSP will document missed visits in the client’s files.

31.2.4 Documentation of Services

The private duty-nursing agency is responsible for establishing and maintaining a permanent medical record for each recipient including the following:

- Home Health Certification and Plan of Care form (HCFA-485) for certification and re-certification signed by the physician
- Medical Update and Patient Information form (HCFA-486)
- Private Duty Nursing Agreement for Care form (Form 388)
- Alabama Medicaid Agency Referral form (Form 362)
- Any additional physician orders
- Signature log with dates, duration of visits, types of service, and signature of the RN/LPN and the caregiver (a copy must be provided to the recipient or recipient's representative).
- Continuous progress reports
- Documentation of in-home RN visits to supervise the LPN

Medical records shall be retained for at least three years plus the current year.

Plan of Care

A plan of care must be developed and submitted with each request for service documenting the extent of nursing needs. Each professional participating in the recipient's care must carefully review the recipient's status and needs. Each discipline must formulate goals and objectives for the recipient and develop daily program components to meet these goals in the home. This plan must also include the following:

- Designation of a home care service coordinator
- Involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate
- Family access to a telephone
- A plan for monitoring and adjusting the home care plan
- A defined backup system for medical emergencies
- A plan to meet the educational needs of the recipient
- A clearly shown planned reduction of private duty hours
- Criteria and procedures for transition from private duty-nursing care, when appropriate

At each certification, the care plan will be denied, approved, or returned to request additional information. The recipient should transition to the most appropriate care when the recipient no longer meets the private duty-nursing criteria. The most appropriate care may be home care services, nursing facility placement, or the Home and Community Based Waiver Program.

31.2.5 Non-Covered Private Duty Nursing Services

When the recipient does not meet the medical need and diagnosis criteria or does not require at least four consecutive hours of continuous skilled nursing care per day, Medicaid will not cover private duty-nursing services.

Medicaid does not provide private duty-nursing services under the following circumstances:

- Observational care for behavioral, eating disorders, or for medical conditions that do not require medically necessary intervention by skilled nursing personnel
- Services not prescribed to treat or improve a condition identified as a result of an EPSDT screening
- Custodial, sitter, and respite services
- Services after the recipient is admitted to a hospital or a nursing facility
- Services after the recipient is no longer eligible for Medicaid

If the provider fails to comply with agency rules and program policies, Medicaid may recoup payments and terminate the provider contract.

Please refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 11, for detailed policy information.

31.3 Prior Authorization and Referral Requirements

All private duty-nursing services require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Private duty-nursing providers are required to submit to HP the following forms for consideration of authorization for services:

- Alabama Prior Review and Authorization Request form (Form 342)
- EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362)
- Home Health Certification and Plan of Care form (HCFA-485) for certification and recertification signed by the physician.
- Medical update and Patient Information form (HCFA-486)
- Private Duty Nursing Agreement for Care form (Form 388)
- Any additional physician orders

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

The EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362) is valid for one year from date of screening. If the recipient continues to be approved for services beyond the one year screening date, a new EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362) indicating the current screening date and appropriate information must be submitted.

Re-certification

Every three months, documentation consisting of the Home Health Certification and Plan of Care (Form CMS 485), the Medical Update and Patient Information (Form CMS 486), and two weeks of nursing record documentation must be submitted to HP to support the need for continuation of private duty-nursing services. Providers must submit re-certification requests to HP **at least** 14 days prior to the re-certification due date. Re-certifications not received timely will be approved when criteria are met based on date of receipt. The request for re-certification will be approved or denied based on Medicaid criteria. HP denies claims for services rendered after the cancellation date.

In an emergency situation where the delay of adjustment of prior authorization hours would endanger the health of the recipient, the case manager, private duty-nursing agency, or parent should initiate a change request within 24 hours of the onset of the emergency by contacting Qualis Health at (888) 213-7576. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message left at the same number or a fax sent to (888) 213-8548 will be accepted for consideration. The message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)
- NPI of Private Duty Nursing Agency
- Phone number of Private Duty Nursing Agency
- Phone number and name of case manager, if applicable
- Nature of emergency and number of hours involved
- Contact person and contact telephone number for follow-up

The Addendum to the Care Plan (HCFA-487) and a Medical Update and Patient Information Form (HCFA-486) must be received by Qualis within ten calendar days of the voice message/fax request. Form HCFA-486 should indicate the reason for the emergency request (example; "child is ill and did not report to school") giving the date and the number of hours involved. If the documentation is not received within ten calendar days, the authorized START DATE will be the Julian (receipt) date of approval. To be approved, the request must meet established guidelines and criteria as set forth in Chapter 31 of the Provider Manual. Initiation of the Emergency Procedures does not guarantee approval, but establishes the earliest start date.

31.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by private duty-nursing providers.

31.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Private duty-nursing providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. When completing the UB-04, enter type of bill 331. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form (Form 341).

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

31.5.1 Time Limit For Filing Claims

Medicaid requires all claims for private duty-nursing providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

31.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

31.5.3 Procedure Codes

Private duty-nursing providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The following revenue codes and procedure codes apply when filing claims for private duty-nursing services:

Revenue Code	*Procedure Code*	*Description*
551	S9123/Modifier EP	Private Duty Nurse/RN
551	S9124/Modifier EP	Private Duty Nurse/LPN

31.5.4 Place of Service Codes

Place of services codes do not apply when filing the UB-04 claim form.

31.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following:

- Claims With Third Party Denials

NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more details about these attachments.

31.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.7.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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32 Provider-Based Rural Health Clinics

Rural health clinics are defined as clinics located in a rural area designated by the Bureau of Census as non-urbanized and medically under-served. Rural health clinics are designed to meet the needs of those recipients who might otherwise be unable to access medical attention.

Provider based rural health clinics are clinics that are an integral part of hospital, home health agency, or nursing facility. Provider-based rural health clinics are reimbursed on an encounter rate for services provided to Medicaid recipients.

Refer to the following chapters of the *Alabama Medicaid Agency Administrative Code*:

- Chapter 59 for policy for provider-based rural health clinics
- Chapter 60 for reimbursement policy

32.1 Enrollment

HP enrolls rural health clinic providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for claims.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

NOTE:
The 10-digit NPI is required when filing a claim.

Rural health clinics are assigned a provider type of 58 and valid specialty is 185.

NOTE:

Physicians affiliated with rural health clinics are enrolled with their own NPI, which links them to the clinic. The provider type for the physician is 58 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic NPI, and are not assigned individual NPIs.

Enrollment Policy for Provider-Based Rural Health Clinics

In order to participate in the Title XIX (Medicaid) Program, and to receive Medicaid payment, a provider-based rural health clinic must:

- Receive certification for participation in the Title XVIII (Medicare) Program
- Obtain certification by the appropriate State survey agency
- Comply with the Clinical Laboratory Improvement Amendment (CLIA) testing for all laboratory sites
- Operate in accordance with applicable federal, state and local laws.

All clinics must enroll separately and execute a separate provider contract with Alabama Medicaid.

The effective date of enrollment of a provider-based rural health clinic will be the date of Medicare certification. Providers who request enrollment more than 120 days after certification are enrolled on the first day of the month the enrollment is approved.

The provider based rural health clinic must be under the medical direction of a physician. The physician must be physically present at the clinic for sufficient periods of time to provide medical care services, consultation, and supervision in accordance with Medicare regulations for rural health clinics. A *sufficient period* is defined as follows:

- No less than once every 72 hours for non-remote sites
- At least once every seven days for remote sites

Remote sites are defined as those more than 30 miles from the primary supervising physician's principal practice location.

This requirement must be accommodated except in extraordinary circumstances. The clinic must fully document any extraordinary circumstances that prevent it from meeting this requirement.

When not physically present, the physician must be available at all times through direct telecommunication for consultation, assistance with medical emergencies or patient referral.

Change of Ownership

Medicaid must be notified within 30 calendar days of the date of a PBRHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within the 30 day timeframe.

Patient 1st Requirements for Provider-Based Rural Health Clinics

- The clinic must be a licensed federally recognized RHC enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, but not limited to, patient management, 24-hour coverage, and other program requirements.
- The RHC and or site must be opened a minimum of 40 hours per week and the physician must practice at the location of 40 hours per week to be considered a Full Time Equivalent (FTE)
- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of a total patient caseload will be allowed based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension. If the clinic is solely run by mid-level practitioners, then the FTP equivalent of those mid-level personnel will be applied against the 1200 maximum caseload.
- The RHC must specify what arrangements have been made for hospital admissions. If physicians within the RHC do not have admitting privileges, then the designee must be specified. If the RHC/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.

32.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

32.2.1 Covered Services

Rural health clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

The following services are covered in the provider-based rural health clinic:

- Medically necessary diagnostic and therapeutic services and supplies that are an incident to such services or as an incident to a physician's service and that are commonly furnished in a physician's office or a physician's home visit.
- Basic laboratory services essential to the immediate diagnosis and treatment of the patient that must include but are not limited to the following six tests that must be provided directly by the rural health clinic:
  - Chemical examinations of urine by stick or tablet methods or both (including urine ketones)
  - Hemoglobin or hematocrit
  - Blood glucose
  - Examination of stool specimens for occult blood
  - Pregnancy tests
  - Primary culturing for transmittal to a certified laboratory
- Medical emergency procedures as a first response to life threatening injuries and acute illness.
- Provider based rural health services may be provided by any of the following individuals:
- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, or registered nurse

The physician, physician assistant, nurse practitioner, certified nurse midwife, or registered nurse must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department or assist at surgery (identified surgical codes only) for Medicaid reimbursement.

A nurse practitioner, physician assistant, or certified nurse midwife must furnish patient care services at least fifty (50%) percent of the time the clinic operates.

32.2.2 Reimbursement

PBRHC services are reimbursed by an all-inclusive encounter rate. All services provided for that date of service will be included in the encounter rate. If a recipient only has lab or x-rays, this will also constitute an encounter.

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Surgical procedures performed in place of service 21 (inpatient) or place of service 22 (outpatient) will be reimbursed fee-for-service.

Contacts with one or more health professionals and multiple contacts with the same health care professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

Reimbursement for an enrolled out-of-state PBRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state PBRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

NOTE:

Since PBRHC providers are reimbursed by an all inclusive encounter rate, PBRHC providers will not receive the case management fee paid to Patient 1st providers nor the capitation fee for lock in recipients.

NOTE:

The dispensing fee for birth control pills is a non-covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Effective November 1, 2009, the Plan First Contraceptive Order Form is discontinued. Plan First women will able to go to their local pharmacy to receive their contraceptive method if they choose to do so. The Plan First recipient must receive a prescription from their private provider. A 30-day supply is the maximum that may be dispensed at one time.

The Plan First recipient will still have the option of obtaining family planning services from the Alabama Department of Public Health along with oral contraceptives, the contraceptive ring, or the contraceptive patch. To receive contraceptive product from the Health Department, the Plan First-eligible patient must have been seen first by the health department. A 12 month supply of contraceptive products may be dispensed at one time.

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

NOTE:

Effective 5/1/2012, Rural Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena® – J7302

Paragard® – J7300

Implanon® – J7307

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

1st Look - The Oral Health Risk Assessment and Dental Varnishing Program

Effective January 1, 2009 Medicaid will cover the application of fluoride varnishes for children 6 months through 35 months of age who have a moderate to high caries risk based on the risk assessment by **Patient 1st medical providers and their clinical staff (RNs, PAs, Nurse Practitioners, LPNs).** This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals, a specialty indicator will be added to the provider file in order for the provider to receive reimbursement.

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

32.3 Prior Authorization and Referral Requirements

Procedure codes billed by rural health providers generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

32.4 Cost Sharing (Copayment)

Deleted: ~~is $1.00~~

Added: $3.90

Added: Native American Indians…Medicaid required copayment.

The copayment amount $3.90 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

NOTE:

Medicaid copayment is NOT a third party resource. Do not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For provider-based rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate established by Medicaid.

32.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Provider-based rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

32.5.1 Time Limit for Filing Claims

Medicaid requires all claims for provider-based rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

32.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

32.5.3 Procedure Codes and Modifiers

NOTE:

Provider based rural health provider should refer to Chapter 28, Physician, for procedure code information.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, or ear stick) and Q0091-90 for collection of Pap smear specimen.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Independent laboratory providers will not be paid for and should not submit claims for laboratory work done for them by other independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own laboratory facilities. Providers who send specimens to another independent laboratory for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
S9445	Prenatal Education (limited to 12 classes per recipient within 2-year period)
99412	Adolescent Pregnancy Prevention Education

32.5.4 Place of Service Codes

The following place of service codes apply when filing claims for provider-based rural health clinics:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

32.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

32.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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33 Psychiatric Treatment Facilities

The policy provisions for psychiatric hospitals and residential treatment facilities (RTFs) may be found in Chapter 41 of the Medicaid Administrative Code. The complete administrative code is found on the Medicaid website: www.medicaid.alabama.gov .

Psychiatric services for recipients under age 21 are covered services when provided under the following conditions:

- Under the direction of a physician
- By a psychiatric hospital enrolled as a Medicaid provider **OR**

  By a psychiatric residential treatment facility (RTF) which is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children (COA), or by another accrediting organization with comparable standards that is recognized by the State;
- Before the recipient reaches age 21
- If the recipient was receiving services immediately before he/she reached age 21, before the earlier of the following dates:
  - The date the recipient no longer requires the services
  - The date the recipient reaches age 22
  - The expiration of covered days
    - To a recipient admitted to and remaining in the facility for the course of the hospitalization
    - As certified in writing to be necessary in the setting in which it will be provided in accordance with 42 CFR 441.152.

Psychiatric hospitals and RTFs shall comply with all applicable regulations regarding the use of restraint and seclusion as cited in 42 CFR, Part 441, Subpart D, and 42 CFR, Part 483, Subpart G.

Inpatient and residential psychiatric services are unlimited if they are medically necessary and the admission and the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care provided in an acute care hospital.

Referrals from a recipient's Patient 1st Primary Medical Provider (PMP) are not required for admissions to psychiatric hospitals or RTFs.

However, hospitals and RTFs should notify the recipient's PMP of the admission within 72 hours by faxing a copy of the recipient's face sheet to the PMP. Fax numbers for all PMPs may be found in the "About Medicaid" section on the Medicaid website: www.medicaid.alabama.gov

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Ancillary services provided during the RTF stay may be billed fee-for-service if the recipient has been granted an exemption from the Patient 1st Program.

Written requests for Patient 1st exemptions should be submitted to Medicaid by the recipient's case worker or the RTF at the time of admission to the residential facility.

Requests must be submitted on the Patient 1st Medical Exemption Request found on the Medicaid website: www.medicaid.alabama.gov under the Patient 1st tab.

Written notification shall be provided to Medicaid by the caseworker or the RTF at the time of the recipient's discharge or transfer to another facility.

All correspondence regarding Patient 1st should be mailed to:

Alabama Medicaid Agency
Attention: Patient 1st Program
P.O. Box 5624
Montgomery, AL 36103-5624

33.1 Enrollment

HP enrolls psychiatric hospital providers and issues provider contracts to applicants meeting the licensure and certification requirements of the State of Alabama, the Code of Federal Regulations, the *Medicaid Administrative Code*, and the *Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychiatric hospital or RTF provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for psychiatric hospital-related claims.

Psychiatric hospitals and RTFs are assigned a provider type of 01 (Hospital). The valid specialty for psychiatric hospitals is (017) and (013) for RTFs.

Enrollment Policy for Psychiatric Hospital Providers

To participate in the Alabama Medicaid Program, psychiatric hospital providers must meet the following conditions:

- Receive certification for participation in the Medicare program
- Possess a license as an Alabama psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code. State hospitals that do not require licensing as per state law are exempt from this provision.

- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Have a distinct unit for children and adolescents
- Have a separate treatment program for children and adolescents
- Submit a written description of an acceptable utilization review plan currently in effect
- Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new provider

Psychiatric hospitals are required to submit a monthly inpatient census report to Medicaid. The census report must list the names of all Medicaid children and adolescents who are admitted to and discharged from the hospital during the calendar month. This report should also list the names of the children and adolescents who remain in the hospital during the calendar month. The census report must be received on or before the tenth of each month for the preceding month. Mail all reports to the following address: Alabama Quality Assurance Foundation or AQAF, Two Perimeter Park South, Suite 200 West, Birmingham, Alabama 35243-2337. Failure to send the required report within the specified time period will result in the

Psychiatric hospitals and RTFs may only bill for days when a recipient is on their census. If a recipient has been discharged to a general hospital, the psychiatric hospital/RTF must not bill Medicaid for those non covered days.

Enrollment Policy for Residential Treatment Facilities (RTFs)

To participate in the Alabama Medicaid program, RTFs must meet the following conditions:

- Be accredited by JCAHO, CARF, COA, or be certified as an Alabama RTF in accordance with standards promulgated by the Alabama Department of Human Resources (DHR), the Department of Mental Health/Mental Retardation (DMH/MR), or the Department of Youth Services (DYS), or the Department of Children's Services (DCA). Upon enrollment and each time the RTF is recertified a copy of the certification letter must be sent to Medicaid within forty-five business days.
- Be in compliance with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Execute a contract or placement agreement with DHR, DMH/MR, DYS, or DCA to provide residential psychiatric treatment services in the State of Alabama
- Execute a provider agreement with Alabama Medicaid to participate in the Medicaid program;
- Submit a written description of an acceptable UR plan currently in effect
- Submit a written attestation of compliance with the requirements of 42 CFR, Part 483, Subpart G, regarding the reporting of serious occurrences and the use of restraint and seclusion upon enrollment and yearly on or before July 21;
- Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21

All correspondence regarding application by Alabama RTFs for participation in the Medicaid program should be mailed to:

Alabama Medicaid Agency
Attention: Institutional Services
PO Box 5624
Montgomery, AL 36103.

33.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

For purposes of this chapter, an inpatient is a person admitted to a psychiatric facility for bed occupancy for purposes of receiving inpatient or residential psychiatric services.

The number of days of care charged to a recipient for inpatient psychiatric services is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used to report days of care for the recipients, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid covers the day of admission, but not the day of discharge.

When a recipient is discharged and admitted to the same hospital on the same date of service, the hospital should completely discharge the recipient and then readmit on separate UB-04's (even if the readmission was for the same diagnosis).

33.2.1 Therapeutic Visits

Therapeutic visits away from the psychiatric hospital to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. An admission to a general hospital does not count as a therapeutic visit. Therapeutic visits are subject to the following limitations:

- No more than three days in duration
- No more than two visits per 60 calendar days per admission, per recipient

Therapeutic visit records will be reviewed retrospectively by Medicaid. Medicaid will recoup payments from providers who receive payments for therapeutic visits in excess of the amount as described above. This policy applies only to visits away from the psychiatric hospital. Visits away from the RTF are not limited by this policy.

33.3 Certification of Need for Inpatient and Residential Services

Providers should refer to Chapter 41 of the Medicaid Administrative Code for complete instructions on documenting the certification of need for inpatient or residential treatment services. Providers will find instructions for requesting prior authorization for inpatient hospital admissions and continued stays. Instructions for documenting emergency and non-emergency admissions to RTFs will also be found in Chapter 41.

All entries in the medical record must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

Reimbursement

Medicaid pays for inpatient services provided by psychiatric hospitals according to the per diem rate established for the hospital. The per diem rate is based on the Medicaid cost report and the provisions documented in the *Medicaid Administrative Code,* Chapter 23.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive one copy of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

If a uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100.00 per day for each calendar day after the due date.

Medicaid pays for residential treatment services provided by RTFs according to the per diem rate established in the placement agreement between the RTF and the contracting state agency (DHR, DYS, DMH, DCA).

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs)

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

OPPCs include but are not limited to the following; surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient.

Non- payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC 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 PPC must result in significant harm. The OPPCs 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 30 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 OPPCs 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 a PPC.

Reporting Other Provider-Preventable Conditions (OPPCs).

The following OPPCs must be reported to Medicaid by encrypted emailing of the required information to:*mailto:AdverseEvents@medicaid.alabama.gov*.

Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include but are not limited to:

- 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.medicaid.alabama.gov under Programs/Medical Services/Hospital Services although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

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

Psychiatric hospitals and RTF's should use the POA indicator on claims for these HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. 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 . 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:

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	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation -Intracranial Injury -Crushing Injury -Burn -Electric Shock	Codes within these ranges on the CC/MCC list: 800-829.1 830-839.9 850-854.1 925-929.9 940-949.5 991-994.9
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 psychiatric hospital or RTF 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.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

No reduction in payment for a PPC will be imposed on a hospital provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Psychiatric hospitals and RTF's are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC. In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

It is the responsibility of the psychiatric hospital or RTF 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.

It is the psychiatric hospital or RTF'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.

33.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by inpatient psychiatric hospitals or RTFs.

33.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Psychiatric hospitals and RTFs billing Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

33.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

33.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

33.5.3 Revenue Codes

Refer to the Alabama UB-04 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

33.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04claim form.

33.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with Third Party Denials.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

33.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Institutional Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

34

34 Psychologists

Licensed psychologists are enrolled only for services provided to QMB recipients or to recipients under the age of 21 referred as a result of an EPSDT screening.

The policy provisions for psychologists can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

34.1 Enrollment

HP enrolls Psychology providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychology provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for psychology-related claims.

NOTE:
All ten digits are required when filing a claim.

Psychology providers are assigned a provider type of 54 (Psychologist). Valid specialties for psychology providers include the following:

- Psychology (112)
- QMB/EPSDT (600)

Enrollment Policy for Psychology Providers

Psychologists must meet the following requirements for participation in Medicaid:

- Possess a doctoral degree in psychology from an accredited school or department of psychology
- Have a current license issued by the Alabama Board of Psychology to practice as a psychologist
- Operate within the scope of practice as established by the Alabama Board of Psychology

Minimum Qualifications for Psychology Providers Professional Staff

Medicaid reimbursement for allied mental health professional staff working for or supervised by Medicaid enrolled psychologists may be billed as follows:

- When services are directly provided by a professional counselor licensed under Alabama law (e.g. LPC, ALC) a modifier **U6** must be appended to the appropriate procedure code.
- When services are directly provided by a marriage and family therapist (LMFT) licensed under Alabama law a modifier **U7** must be appended to the appropriate procedure code.
- When services are directly provided by a certified social worker (LCSW) licensed under Alabama law, a modifier **AJ** must be appended to the appropriate procedure code.
- When services are provided directly by 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,
    - a modifier **HO** must be appended to the appropriate procedure code.
- When services are provided directly by a licensed psychological technician, only procedure codes 96102 or 96119 may be billed.

NOTE:

Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service description.

Psychologists who delegate work to employees take reasonable steps to (1) avoid delegating such work to persons who have a multiple relationship with those being served that would likely lead to exploitation or loss of objectivity; (2) authorize only those responsibilities that such persons can be expected to perform competently on the basis of their education, training, or experience, either independently or with the level of supervision being provided; and (3) see that such persons perform these services competently. {Please refer to Section 34-26-61 from the **Code of Alabama Governing Psychologists**, Duties – Supervisors, for more information and guidance; excluding #8, 9, and 10 under section (a)}.

For the supervision of licensed psychological technicians please follow the guidelines as set forth in the **Code of Alabama Governing Psychologists,** Section 34-26-62 Duties – Supervisees and Section 34-26-64 Supervision requirements.

Effective with dates of service July 1, 2010 and thereafter, the guidance for allied mental health professionals working under the direction of, or supervised by, a psychologist has been modified. The psychologist does not have to be present in the office when the practitioner is providing the service; however, the psychologist must be readily accessible by phone or pager and able to return to the office if the recipient's condition requires it.

Practitioners must follow the guidelines below for services provided "incident to" the psychologist:

- The psychologist must be able to provide evidence of management of the patient's care through, at a minimum, review of the intake notes and diagnostic impression within 30 days of the initial intake. Evidence of management of care includes:

  1) signing off on the intake notes and diagnostic impression,

  2) signing off on treatment plans,

  3) at least an annual review of the allied mental health professionals' performance, and

  4) signing off on any assessment report.

- The psychologist must employ the allied mental health professional **or** the professional must be employed by the same entity that employs the psychologist.

In addition to the requirements outlined above, effective July 1, 2012, psychologists and the allied mental health professional(s) working for or with them must have an Alabama Medicaid Agency Supervision Contract on file with the Agency.

- The Supervision Contract must be completed for each allied mental health professional billing for services under a psychologist's NPI.
- A fillable or printable version of this form can be downloaded at the following link: http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.9.2_Clinical_Psychologists.aspx
- Please submit the completed contract via fax at: (334) 353-2296 or via e-mail at: contracts@medicaid.alabama.gov
- Any claims submitted on or after dates of service July 1, 2012, that do not have a corresponding Supervision Contract on file will be subject to recoupment on post payment review.

Supervision

Supervision is defined as the overview, monitoring and directing of the activities of another where all of the following are present: a) Immediate availability by person or phone b) Regular and periodic review of records, work and activities and c) Established procedures (protocols). Supervision is **not** consultation.

For the supervision of allied mental health professionals, please follow the guidelines as set forth below:

The supervisor is the psychologist (*the psychologist will herein be referred to as the supervisor*).

The supervisee is any of the allied mental health professionals listed under the "Minimum Qualification for Psychology Providers Professional Staff" section.

A licensee who has less than 10 years of experience shall meet individually and in person with his or her supervisor for a minimum of 2 hours a month.

A licensee who has 10 or more years of experience shall meet individually and in person with his or her supervisor for a minimum of 1 hour a month.

The supervisor, in most instances, will take full legal responsibility. This means the **supervisor**:

- Is accountable to the authorizing body for the activity (i.e. license board, Alabama Medicaid Agency).
- Has responsibility to the supervisee – providing necessary resources, including training and additional information, and, at time, the setting to do the work.
- Is accountable to the clients served in the context of the supervisory relationship. The supervisor must be easily available for emergencies, meet face to face (with the supervisee) on a regular basis (SKYPE and other telecommunications are not acceptable at this time) and have access to records and work materials (i.e. computer, phone, fax, reference books etc).

- Has established ***written*** procedures (protocols) for usual, unforeseen or high-risk situations including planned absences such as vacation coverage, maternity leave etc.
- Will be required to document dates and times of supervision, including when record reviews are done, and basic information about the clients discussed or reviewed.

34.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for psychology providers.

Psychology services are only covered for QMB recipients or for recipients referred directly as a result of an EPSDT screening.

NOTE:

Psychology providers can bill only those procedures listed in Section 34.5.3, Procedure Codes and Modifiers. Only the diagnosis codes within the range of 290-316 are covered for treatment services under this program. Mental retardation diagnosis codes (317-319) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120 even if the resulting diagnosis is mental retardation.

NOTE:

Codes 90832, 90832+90785, 90834, 90834+90785, 90837, 90837+90785, 90846, 90847, 90849, and 90853 may be billed on a weekly basis; although limited to no more than 52 max units per year (combined).

***Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in the group above as per CPT guidelines.**

The Alabama Medicaid Agency will not cover the following therapies:

- Equine assisted psychotherapy
- Biofeedback therapy
- Neurobiofeedback therapy
- Sleep therapy
- Dance therapy
- Music therapy
- Art therapy

Client Intake

An intake evaluation must be performed for each client considered for initial entry into any course of covered services.

The intake evaluation process shall result in a determination of the client's need for psychological services based upon an assessment that must include relevant information from among the following areas:

- Family history
- Educational history
- Medical history
- Educational/vocational history
- Psychiatric treatment history
- Legal history
- Substance abuse history
- Mental status exam
- Summary of the significant problems the client is experiencing

Treatment Planning

The intake evaluation process shall result in the development of a written treatment plan completed by the fifth client visit.

The treatment plan shall:

- Identify the clinical issues that will be the focus of treatment
- Specify those services necessary to meet the client's needs
- Include referrals as appropriate for needed services
- Identify expected outcomes toward which the client and therapist will work to have an effect on the specific clinical issues
- Be approved in writing by a psychologist licensed in the state of Alabama
- The (initial) Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it. Unless clinically contraindicated, the recipient will sign or mark the treatment plan to document the recipients participation in developing /revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent, foster parent or legal guardian must sign the treatment plan.

Services must be specified in the treatment plan in order to be paid by Medicaid. Changes to the treatment plan must be approved by the psychologist licensed in the state of Alabama.

The psychologist must review the treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. This review shall be documented in the client's clinical record by notation on the treatment plan. This review shall note the treatment plan has been reviewed and updated or continued without change.

Treatment plan review is not a face-to-face service, therefore the recipient/ or legally responsible person signature is not required. Only the reviewing psychologist signatures or initials and dates are neccessary.

Service Documentation

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested shall include, at a minimum, the following:

- The identification of the specific services rendered
- The date and the amount of time (time started and time ended--- excluding time spent for interpretation of tests) that the services were rendered
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed
- All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

The list of required documentation described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed.

Additional Information

To further clarify service documentation questions/issues, please note the following:

Documentation

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes should not be ***preprinted*** or predated.
- The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be appropriate to meet the goals. There should be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.
- The Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. A stamped signature is not acceptable.
- If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. There must also be a written policy for documentation method in case of computer failure/power outage.

Corrections

- White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

Communication

- It is the responsibility of the provider to ensure that the primary care physician has been made aware of treatment plan goals by the fifth recipient visit, annually prior to EPSDT renewal; and, when requesting more than one therapy session per week. Documentation of communication will be required i.e. treatment note, fax confirmation sheet.

34.3 Prior Authorization and Referral Requirements

Psychology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

A completed Referral for Services Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

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.

34.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

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

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

If one of these CPT codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

Deleted: ~~Copayment does not…Medicaid required copayment.~~

Added: The copayment amount…including crossovers is:

Added: $3.90 for procedure codes… between $10.01 and $25.00

Added: * The following… for each procedure:

Added: 90847, 90849, 90853…99348, 99349, 99350

Added: If one of…then copay applies.

Added: Copayment does not…Medicaid required copayment

Added: The provider may…(copayment) amount imposed.

34.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Psychology providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

34.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Psychology to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

34.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the diagnosis codes within the range of 290-316 are covered for services under this program.

34.5.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for psychologist services. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes listed in this section are covered under this program. Some codes are covered for QMB recipients only. Check the guidelines following this grid.

CPT Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90791	Psychiatric diagnostic evaluation	1	1	1
90791 +90785	Psychiatric diagnostic evaluation with medical services	1	1	1
90837	Psychotherapy-60 minutes (53+*) with patient and/or family member	2, 3	1	This group of procedure codes may be billed on a weekly basis; although limited to no more than 52 max units per year total (combined)
90837 +90785	Psychotherapy, 60 minutes (53+*) with patient and/or family member with interactive complexity services	2, 3	1	
90832	Psychotherapy, 30 minutes (16-37*) with patient and/or family member	3, 9	1	
90834	Psychotherapy, 45 minutes (38-52*) with patient and/or family member	3, 9	1	
90832 +90785	Individual psychotherapy, 30 minutes (16-37*) with patient and/or family member with interactive complexity services	3, 9	1	
90834 +90785	Psychotherapy, 45 minutes (38-52*) with patient and/or family member with interactive complexity services	3, 9	1	*Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT guidelines.
90846	Family psychotherapy (without the patient present)	4, 9		
90847	Family medical psychotherapy (conjoint psychotherapy) with patient present	4, 9	1	

CPT Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90849	Multiple-family group psychotherapy	4, 9	1	
90853	Group psychotherapy (other than of a multiple-family group)	5, 9	1	
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorshach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	6*,7	5*	These procedure codes may be billed separately or in any combination for no more than 5 units total annually as per CPT guidelines.
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAID), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	6*,7	5*	
96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report.	6*,7, 8	5*	
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.	7, 10	5	
96118	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Bettery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.	7*	5*	These procedure codes may be billed separately or in any combination for no more than 5 units total annually as per CPT guidelines.
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Bettery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face	7*	5*	

CPT Code	Description	See Note	Daily Max	Annual Max
96120	Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report	7*, 8	5*	

Individual psychotherapy codes should be used only when the focus of the treatment encounter involves psychotherapy. Psychotherapy codes should not be used as generic psychiatric service codes.

Deleted: ~~Effective Dates of…the psychologist only.~~

Guidelines for Covered Procedure Codes:

1. Codes 90791 and ~~-~~90791+90785 have a combined annual max limitation of 1.
2. Please note 90837 / 90837+90785 are now the codes to be used to reflect 60 minutes of face-to-face time, and is included in the 52 unit annual max limitation.
3. Medicaid will not accept psychiatric therapy procedure codes 90832-90837 being billed on the same date of service as an E&M service by the same physician or mental health professional group.
4. Procedure codes 90847 and 90849 are used to describe family participation in the treatment process of the client. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions for multiple families when similar dynamics are occurring due to a commonality of problems in the family members in treatment. Group therapy must be led by a clinical psychologist licensed in the state of Alabama.
5. Procedure code 90853 is used when psychotherapy is administered in a group setting with a trained group leader in charge of several clients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. Group therapy must be led by a clinical psychologist licensed in the state of Alabama.
6. Procedure code 96101-96103 includes the administration, interpretation, and scoring of the tests mentioned in the CPT description and other medically accepted tests for evaluation of intellectual strengths, psychopathology, mental health risks, and other factors influencing treatment and prognosis. The clinical record must indicate the presence of mental illness or signs of mental illness for which psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The record must show the tests performed, scoring and interpretation, as well as the time involved (time started and time ended---excluding time spent for interpretation of tests). The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing (at this time). 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. Procedure codes 96101 and 96102 can be billed separately or in combination with code 96103 for **no more than** five hours per year (as per CPT guidelines). The units of measure for testing codes 96101 – 96103 has been

changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore 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. (*under daily max=combination of the codes).

Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary.

7. Mental retardation diagnosis codes (317-319) are not covered for treatment services; however, Medicaid will cover diagnostic testin*g,* status exam (96101-96103, 96116 and 96118-96120), even if the resulting diagnosis is mental retardation. The record must show the tests performed, scoring and interpretation, as well as the time involved (time started and time ended---excluding time spent for interpretation of tests). The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing at this time. Billing should document 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. Procedure codes 96118 and 96119 can be billed separately or in combination with code 96120 for **no more than** five hours per year (as per CPT guidelines). The units of measure for testing codes 96118 – 96120 has been changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore 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. (*under daily max=combination of the codes)

   Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary.

8. Codes 96103 and 96120 describe psychological/neuropsychological testing by a computer; **including** time for the qualified healthcare professional's interpretation and reporting. These codes are billed only once as one service regardless of the number of tests taken or time spent by the recipient completing the test. The computer code is used only when the recipient is taking a computer-based test unassisted, but the provider who interprets the report must be available during the time the recipient is taking the test. These codes cannot be billed if the computer is used only to score tests.

NOTE:

When **testing** is administered by a computer, the time that the qualified healthcare professional spends interpreting and reporting the results of each individual **test** is already included in each of these codes, scoring and/or test interpretation is not a separately billable service. For paper-and-pencil tests, the psychologist should bill appropriately for any other service provided.

9. These procedure codes may be used in any combination for no more than 52 units total annually. Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT guidelines. For exceptional circumstances where more than 52 units will be needed, consideration for request must be submitted.
10. Procedure Code 96116 is intended to describe the performance of gathering information to provide an important first analysis of brain dysfunction and progression and changes in the symptoms over time. This exam must include screening for impairments in acquired knowledge, attention, language, learning, memory, problem solving, and visual-spatial abilities.

For consideration of lifting the maximum cap on weekly unit limitations, submit a cover letter, documentation of medical necessity **and** the exceptional circumstance (i.e. how the recipient is an eminent danger to self or others and/or is at risk for hospitalization or decompensation) along with the claim, related progress note(s) and cover letter to the following address:

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

A sample Psychologist Override Request form (that can be used in lieu of a cover letter) 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

Use of Modifiers

When one of the following disciplines is the performing provider, please append the following modifiers:

Modifier	***Allied Mental Health Professional***
U6	Licensed Professional Counselor (LPC) or Associate Licensed Counselor (ALC)
U7	Licensed Marriage and Family Therapist (LMFT)
AJ	Licensed Certified Social Worker
HO	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.

Codes billed with the above modifiers will be reimbursed at 75% of the allowable amount.

Services performed by an allied mental health professional but not billed with the modifier will be subject to recoupment on post payment review.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible psychologist (and/or allied professional mental health staff) staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.-This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible psychologist (and/or allied professional mental health staff) staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (*http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html*) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly.

NOTE:

Procedure codes 90862, pharmacologic management, and 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes, **are covered for physicians only** and may not be performed or billed by psychologists.

34.5.4 Place of Service Codes

The following place of service codes apply when filing claims for psychology services:

POS Code	*Description*
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
72	Rural Health Clinic
99	Other Unlisted Facility

34.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

34.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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35

35 Renal Dialysis Facility

End Stage Renal Disease (ESRD) services are outpatient maintenance services provided by a freestanding ESRD facility or hospital-based renal dialysis center.

The policy provisions for Renal Dialysis Facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 24.

35.1 Enrollment

HP enrolls Renal Dialysis Facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a renal dialysis provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for dialysis-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Renal Dialysis Facility providers are assigned a provider type of 30 (Renal Dialysis Facility). The valid specialty for Renal Dialysis Facility providers is Hemodialysis (300).

Enrollment Policy for Renal Dialysis Facility Providers

To participate in Medicaid, End Stage Renal Disease (ESRD) facilities/centers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authority

Satellites and sub-units of facilities or centers must be separately approved and contracted with Medicaid.

35.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Medicaid covers maintenance dialysis treatments when they are provided by a Medicaid-enrolled hospital-based renal dialysis center or a freestanding ESRD facility. The maintenance dialysis treatments do not count against the routine outpatient visit limit.

Hemodialysis is limited to 156 sessions per year, which provides three sessions per week.

Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuing Cycling Peritoneal Dialysis (CCPD) are furnished on a continuous basis, not in discrete sessions, and will be paid a daily rate, not on a per treatment basis. Providers are to report the number of days in the units field on the claim.

The daily IPD or CAPD/CCPD payment does not depend upon the number of exchanges of dialysate fluid per day (typically 3-5) or the actual number of days per week that the patient undergoes dialysis. The daily rate is based on the equivalency of one week of IPD or CAPD/CCPD to one week of hemodialysis, regardless of the actual number of dialysis days or exchanges in that week.

Reimbursement will be based on a composite rate consisting of the following elements of dialysis treatment:

- Overhead costs
- Personnel services, such as administrative services, registered nurse, licensed practical nurse, technician, social worker, and dietician
- Equipment and supplies
- Use of a dialysis machine
- Maintenance of the dialysis machine
- ESRD-related laboratory tests
- Biologicals and certain injectable drugs, such as heparin and its antidote

NOTE:

Dialysis facilities that have a physician who performs EKGs on-site can apply to enroll the physician with payment going to the facility. The CPT-4 procedure codes for EKG tracing and interpretation may be billed using the physician NPI on the CMS-1500 claim form.

Laboratory Services

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. When any of these tests are performed at a frequency greater than specified below, the additional tests are separately billable and are covered only if they are medically necessary and billed directly by the actual provider of the service. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

Hemodialysis

The following table lists Hemodialysis tests and frequency of coverage:

Frequency	*Covered Tests*
Per treatment	All hematocrit and clotting time tests furnished incidentally to dialysis treatments.
Weekly	Prothrombin time for patients on anticoagulant therapy; serum creatinine, BUN.
Monthly	Alkaline Phosphates LDH Serum Biocarbonate Serum Calcium Serum Chloride Serum Phosphorous Serum Potassium SGOT Total Protein

Continuous Ambulatory Peritoneal Dialysis (CAPD)

The following table lists CAPD tests and frequency of coverage.

Frequency	*Covered Tests*	
Monthly	BUN	Total Protein
	Creatinine	Albumin
	Sodium	Alkaline Phosphatose
	Potassium	LDH
	CO2	SGOT
	Calcium	HCT
	Magnesium	Hgb
	Phosphate	Dialysis Protein

All laboratory testing sites providing services to Medicaid recipients, either directly by provider or through contract, must be certified by Clinical Laboratory Improvement Amendments (CLIA) that they provide the required level of complexity for testing. Providers are responsible for assuring Medicaid that they strictly adhere to all CLIA regulations and for providing Medicaid waiver certification numbers as applicable.

Laboratories that do not meet CLIA certification standards are not eligible for reimbursement for laboratory services from Medicaid.

Ancillary Services

The actual provider of services must bill take home drugs that are medically necessary under the pharmacy program.

Routine parenteral items are included in the facility composite rate and may not be billed separately.

Non-routine injectables administered by the facility may be billed by the facility actually providing this service. Non-routine injectables are defined as those given to improve an acute condition such as arrhythmia or infection.

Routine drugs or injectables administered in conjunction with dialysis procedures are included in the facility's composite rate and shall not be billed separately. These include but are not limited to the following:

- Heparin
- Glucose
- Protamine
- Dextrose
- Mannitol
- Antiarrythmics
- Saline
- Antihistamines
- Pressor drugs
- Antihypertensives
- Trace elements
- Multivitamins

The administration fee for injectables is included in the facility's composite rate and must not be billed separately under a physician NPI.

The following procedures are non-routine and must be billed by the actual provider of service:

Procedure Code	***Description/Limits***
76061	Bone Survey - annually (roentgenographic method or photon absorptrometric procedure for bone mineral analysis)
71020	Chest X-ray - every six months
95900	Nerve Conductor Velocity Test (Peroneal NCV) - every three months
93000	EKG - every three months

Intradialytic Parenteral Nutrition (IDPN) and Intraperitoneal Nutrition (IPN)

Requirements must be met and clearly documented in the medical record for coverage of IDPN and/or IPN. All services rendered are subject to post payment review.

The ordering physician will be responsible for writing a statement of medical necessity. This statement shall certify that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract either hyper-alimentation or IDPN/IPN must be given for 100% of nutritional needs. The original signed statement of medical necessity must be kept in the patient’s medical record. This certification statement must be written or stamped on the prescription or reproduced on a form accompanying the prescription. The statement must be signed and dated by the certifying physician at the time of the initial order and updated yearly in accordance with Medicaid billing practice.

IDPN and IPN involves infusing hyper-alimentation fluids as part of dialysis through the vascular shunt or intra-peritoneally to normalize the amounts of albumin, glucose, and other nutrients in the blood stream to decrease morbidity and mortality associated with protein calorie malnutrition. IDPN and IPN solutions are considered **not covered** for the recipient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to the following:

- If IDPN or IPN is offered as an addition to regularly scheduled infusions of TPN
- If the recipient would not qualify as a candidate for TPN
- A swallowing disorder
- A temporary defect in gastric emptying such as a metabolic or electrolyte disorder
- A psychological disorder, such as depression, impairing food intake
- A metabolic disorder inducing anorexia, such as cancer
- A physical disorder impairing food intake, such as dyspnea or severe pulmonary or cardiac disease
- A side effect of medication
- Renal failure and/or dialysis

The following requirements must be met in order to bill for IDPN or IPN solutions:

- Documentation in the medical record must validate the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight.
- Documentation must include that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, IDPN or IPN must be given in order to meet 100% of the patient's nutritional needs.
- Infusions must be vital to the nutritional status of the recipient and not supplemental to a deficient diet or deficiencies caused by dialysis.
- Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly documented in the medical record. This would include, but is not limited to; creatinine (predialysis), serum albumin (predialysis), a low or declining serum cholesterol and phosphorus. Medical records must document inability to maintain weight during a trial of at least four weeks of enteral feeding.

A few solutions used in TPN preparation are considered payable as part of the composite rate for dialysis and should not be billed separately by the pharmacist. These are glucose, dextrose, trace elements and multivitamins.

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 1evel 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.

Physician Services

Physician services rendered to each outpatient maintenance dialysis patient provided during a full month shall be billed on a monthly capitation basis using the appropriate procedure code by age as outlined in the CPT. Monthly maintenance dialysis payment (i.e., uninterrupted maintenance dialysis) is comprehensive and covers most of a physician's services whether a patient dialyzes at home or in an approved ESRD outpatient facility. Dialysis procedures are allowed in addition to the monthly maintenance dialysis payment. In general, the Agency follows Medicare guidelines related to monthly capitation payments for physicians.

Physician services included in the monthly capitation payment for ESRD related services include, but are not limited to:

- Assessment and determination of the need for outpatient chronic dialysis therapy
- Assessment and determination of the type of dialysis access and dialyzing cycle,
- Management of the dialysis visits including outpatient visits for evaluation and management, management during the dialysis, and telephone calls.
- Assessment and determination if a recipient meets preliminary criteria as a renal transplant candidate including discussions with family members
- Assessment for a specified diet and nutritional supplementation for the control of chronic renal failure, including specifying quantity of total protein, sodium, potassium, amount of fluids, types of anemia and appropriate treatments, type of arthropathy or neuropathy and appropriate treatment or referral, estimated ideal dry weight, etc. Assessment for diabetic patient's diet and caloric intake is included also.
- Prescribing the parameters of intradialytic management including anticoagulant, dialysis blood flow rates and temperature, duration and frequency of treatments, etc.

The monthly capitation payment is limited to once per month, per recipient, per provider.

The following services are not covered by the monthly capitation payment (MCP) for the attending dialysis physicians and are reimbursed in accordance with usual and customary charge rules:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these service, For example, an attending physician who provides evaluation and management (E&M) services for a renal patient in an inpatient setting may bill appropriate CPT hemodialysis procedures in lieu of certain other E&M services for inpatient visits.
- Nonrenal related physician services furnished by the physician providing renal care or by another physician. (These services may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.) For example, physician services rendered to hospitalized inpatient recipients who require dialysis but are not receiving dialysis on that day may use the appropriate procedure code as described in the CPT.

Physician services are allowed for outpatient maintenance dialysis patients not performed as prescribed during a full month or interruptedly. An example of interrupted monthly outpatient dialysis maintenance is preceding and/or following the period of hospitalization.

The CPT codes described by age for physicians rendering outpatient dialysis services that are interrupted during a full month should be billed on a per day basis. These codes should be billed for the days of the month in which the outpatient ESRD related services were performed.

Single or repeated physician assessments are allowed for hemodialysis or dialysis procedures other than hemodialysis. These services are comprehensive and include assessment and management related to the patient's renal dialysis. Please utilize the most descriptive and appropriate CPT dialysis procedure when billing for single or repeated physician evaluation(s).

Dialysis training is a covered service when billed by an approved ESRD facility.

35.3 Prior Authorization and Referral Requirements

Dialysis procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

35.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Renal Dialysis Facility providers.

35.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Renal Dialysis Facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

35.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Renal Dialysis Facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

35.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists Medicaid required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

35.5.3 Procedure Codes, Revenue Codes, and Modifiers

Medicare Crossover Claims: 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,<10,000 635, >or = 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		A4657, A4913 (IV)	Supply/Admin
771		Appropriate vaccine HCPCS	Vaccine

Straight Medicaid Claims: 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,<10,000 635, >or = 10,000		Q4081	Injection epogen
636		J0882	Darbopoetin alfa, injection
636		Injectable Codes	See Alabama Medicaid website www.medicaid.alabama.gov for the Injectable Drug Listing

35.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

35.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

35.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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36 Rural Health Clinics/Independent

Rural health clinics are defined as clinics located in a rural area designated by the Bureau of Census as non-urbanized and medically under-served. Rural health clinics are designed to meet the needs of those recipients who might otherwise be unable to access medical attention.

Independent rural health clinics are physician-owned. These clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by Medicaid.

Reimbursement for an enrolled out-of-state IRHC will be the lesser of the encounter rate established by the Medicaid Department of the out-of-state IRHC or the average encounter rate established by Alabama Medicaid for in-state facilities.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 8, for policy provisions for independent rural health clinic providers

36.1 Enrollment

HP enrolls rural health clinic providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for claims.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

NOTE:
The 10-digit NPI is required when filing a claim.

Rural health clinics are assigned a provider type of 58 and specialty of 081.

NOTE:

Physicians affiliated with rural health clinics are enrolled with a NPI, which links them to the clinic. The provider type for the physician is 58 (Rural Health Clinic). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the rural health clinic, such as physician assistants or nurse practitioners, bill using the clinic's NPI, and are not assigned individual NPIs.

Enrollment Policy for Independent Rural Health Clinics

To participate in the Alabama Medicaid Program, independent rural health clinic (IRHC) providers must meet the following requirements:

- Submit a copy of the following documentation of Medicare certification: the Centers for Medicare and Medicaid Services (CMS) letter assigning the NPI.
- Submit a copy of the clinics budgeted cost report to Medicaid Alternative Services program to establish the reimbursement rate.
- Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.
- Operate in accordance with applicable federal, state, and local laws.

The effective date of enrollment of an independent rural health clinic will be the date of Medicare certification. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by Medicaid's Fiscal Agent.

Change of Ownership

Medicaid must be notified within 30 calendar days of the date of an IRHC ownership change. The existing contract is automatically assigned to the new owner, and the new owner is required to execute a new contract with Medicaid within 30 calendar days after notification of the change of ownership. If the new owner fails to execute a contract with Medicaid within this time period, the contract shall terminate.

The new owner may choose to accept the established reimbursement rate or submit a budgeted cost report to the Medicaid Agency and must submit his choice in writing to Medicaid's Provider Audit Program within the 30 day timeframe.

Patient 1st Requirements for Independent Rural Health Clinics

- The clinic must be a licensed federally recognized RHC enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The administrator must sign a clinic PMP agreement that delineates program requirements including, but not limited to, patient management, 24-hour coverage, and other program requirements.
- The RHC and or site must be opened a minimum of 40 hours per week and the physician must practice at the location of 40 hours per week to be considered a Full Time Equivalent (FTE)

- In order to be considered to carry a caseload, the physician must be a minimum of a Full Time Physician (FTP). If a physician is less than a FTP, a percentage of a total patient caseload will be allowed based on on-site availability.
- The number of physicians and/or mid-levels and their FTP status will determine caseloads. FTP physicians may have a maximum caseload of 1200 patients.
- Mid-level participation will allow a caseload to be extended by 400 additional patients. Only two mid-levels per physician will be allowed and a mid-level may only be counted once in a caseload extension. If the clinic is run solely by mid-level practitioners, then the FTP equivalent of those mid-level personnel will be applied against the 1200 maximum caseload.
- The RHC must specify what arrangements have been made for hospital admissions. If physicians within the RHC do not have admitting privileges, then the designee must be specified. If the RHC/physician does not have a designee, then the enrollment form must contain documentation as to what is done to arrange these services for non-**Patient 1st** enrollees including a written statement from the hospital.
- All physicians and mid-levels practicing in the clinic and their FTP status which are to be considered for purposes of the **Patient 1st** Program should be listed on the enrollment form.
- Patient 1st caseloads will be assigned to the IRHC assigned provider number (legacy numbers 541xxxxxx) and not the regular Medicaid Provider number assigned used to bill for lab and X-Ray services

NOTE:

Since IRHC providers are reimbursed by an all inclusive encounter rate, IRHC providers will not receive the case management fee paid to Patient 1st providers nor the capitation fee for lock in recipients.

36.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

36.2.1 Covered Services

Rural health clinic visits and inpatient physician services are subject to the same routine benefit limitations as for physicians. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 6, for details.

Independent rural health clinic services are reimbursable if they are provided by any of the following individuals:

- Physician
- Physician assistant, nurse practitioner, certified nurse midwife, registered nurse, or clinical social worker as an incident to a physician's service

The physician, physician assistant, nurse practitioner, certified nurse midwife, registered nurse or clinical social worker must conform to all state requirements regarding the scope or conditions of their practice.

The CRNP can make physician-required visits to nursing facilities. However, a CRNP cannot make physician required inpatient visits to hospitals or other institutional settings to qualify for payment to the physician or to satisfy current regulations as physician visits. The PA or CRNP may provide low complexity or straightforward medical decision-making services in the emergency department for Medicaid reimbursement.

A nurse practitioner, physician assistant, or certified nurse midwife must be available to furnish patient care at least fifty (50%) percent of the time the clinic operates

The Independent Rural Health Clinic must be under the medical direction of a physician. Except in extraordinary circumstances, the physician must be physically present for sufficient periods of times, at least every 72 hours for non-remote sites and every seven (7) days for remote sites (a remote site being defined as a site more than 30 miles away from the primary supervising physician's principal practice location), to provide medical care services, consultation, and supervision in accordance with Medicare regulations for Rural Health Clinics. When not physically present, the physician must be available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances must be documented in the records of the clinic. (an Administrative Code Change is in the process of changing these guidelines.

Services covered under the independent rural health clinic program are any medical service typically furnished by a physician in an office or in a physician home visit. Limits are the same as for the Physician Program.

NOTE:

The dispensing fee for birth control pills is a non covered service and Medicaid's Fiscal Agent will deny any claim submitted with procedure code Z5440 or S4993.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Effective November 1, 2009, the Plan First Contraceptive Order Form is discontinued. Plan First women will able to go to their local pharmacy to receive their contraceptive method if they choose to do so. The Plan First recipient must receive a prescription from their private provider. A 30-day supply is the maximum that may be dispensed at one time.

The Plan First recipient will still have the option of obtaining family planning services from the Alabama Department of Public Health along with oral contraceptives, the contraceptive ring, or the contraceptive patch. To receive contraceptive product from the Health Department, the Plan First-eligible patient must have been seen first by the health department. A 12 month supply of contraceptive products may be dispensed at one time.

NOTE:

A comparable oral contraceptive may be issued when a brand name is not available.

Contraceptive counseling will be provided to all patients by the health department. Patients who have not received a risk assessment for care coordination will be offered this service at time of contraceptive pick up.

For additional Plan First information and guidelines please refer to Medicaid's Provider Manual's Appendix C.

NOTE:

Effective 5/1/2012, Federally Qualified Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena ® - J7302__

Paragard ® – J7300

Implanon ® - J7307

1st Look- The Oral Health Risk Assessment and Dental Varnishing Program

Effective January 1, 2009 Medicaid will cover the application of fluoride varnishes for children 6 months through 35 months of age who have a moderate to high caries risk based on the risk assessment by **Patient 1st medical providers and their clinical staff (RNs, PAs, Nurse Practitioners, LPNs).** This assessment and varnish program is to be incorporated into the well child visit and be part of the comprehensive care in a medical home. The medical provider and staff must be trained in oral health risk assessment, anticipatory guidance and fluoride varnish application. This training includes oral health risk assessment, education on performing anticipatory guidance/counseling, demonstration of fluoride varnish application and the provision of information on recommendations for a dental home. Upon completion of the oral health risk assessment training program for pediatricians and other child health professionals, a specialty indicator will be added to the provider file. For Independent Rural Health Centers reimbursement for these services will be included in the office visit and will not be paid separately.

For additional Oral Health Risk Assessment and Dental Varnishing information and guidelines please refer to Medicaid's Provider Manual's Dental Chapter 13.

36.3 Prior Authorization and Referral Requirements

Procedure codes billed by rural health providers generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

36.4 Cost Sharing (Copayment)

Deleted: ~~$1.00~~

Added: $3.90

Added: Native American Indians…Medicaid required copayment.

The copayment amount $3.90 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

Providers may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

NOTE:

Medicaid copayment is NOT a third party resource. Does not record copayment on the CMS-1500 claim form.

Medicare Deductible and Coinsurance

For independent rural health clinic services, Medicaid pays the Medicare deductible and coinsurance up to the encounter rate, established by Medicaid. Please refer to Chapter 5, Filing Claims, for additional information.

36.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Independent rural health clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

36.5.1 Time Limit for Filing Claims

Medicaid requires all claims for independent rural health clinics to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

36.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

36.5.3 Procedure Codes and Modifiers

Services of the independent rural health clinics are limited to the procedures listed below. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Encounters are all-inclusive. All services provided for the encounter are included in the reimbursement rate for the encounter.

Encounters are face-to-face contacts between a patient and a health professional for medically necessary services.

Visits to a nursing home will be billed using the clinic visit procedure code 99211-SE with the appropriate nursing home place of service. These visits will count against the allowed 14 office visits per year.

Contacts with one or more health professionals and multiple contacts with the same health care professional that take place on the same day at a single location constitute a single encounter, unless the patient later suffers illness or injury requiring additional diagnosis or treatment.

The only exception to all-inclusive encounters is claims for laboratory services and for the technical component for EKG's and radiology services. Rural Health Clinic providers should use their regular NPI.

Clinic Visit

Procedure Code	*Description*
99211-SE	Medical Encounter

Inpatient Hospital

Procedure Code	*Description*
99231-SE	Inpatient Hospital Encounter

EPSDT Codes

Procedure Code	*Description*
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Initial EPSDT, Normal, under 1 year of age Initial EPSDT, Normal, 1-4 years of age Initial EPSDT, Normal, 5-11 years of age Initial EPSDT, Normal, 12-17 years of age Initial EPSDT, Normal, 18-20 years of age
99381-EP 99382-EP 99383-EP 99384-EP 99385-EP	Initial EPSDT, abnormal, under 1 year of age Initial EPSDT, abnormal, 1-4 years of age Initial EPSDT, abnormal, 5-11 years of age Initial EPSDT, abnormal, 12-17 years of age Initial EPSDT, abnormal, 18-20 years of age
99391-EP 99392-EP 99393-EP 99394-EP 99395-EP	Periodic EPSDT, normal, under 1 year of age Periodic EPSDT, normal, 1-4 years of age Periodic EPSDT, normal, 5-11 years of age Periodic EPSDT, normal, 12-17 years of age Periodic EPSDT, normal, 18-20 years of age
99391-EP 99392-EP 99393-EP 99394-EP 99395-EP	Periodic EPSDT, abnormal, under 1 year of age Periodic EPSDT, abnormal, 1-4 years of age Periodic EPSDT, abnormal, 5-11 years of age Periodic EPSDT, abnormal, 12-17 years of age Periodic EPSDT, abnormal, 18-20 years of age
99173-EP	EPSDT Vision Screen
92551-EP	EPSDT Hearing Screen
96110	Development Testing; limited; with interpretation and report (refer to Appendix A of the provider manual for specific guidelines)

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

The new interperiodic screening codes will count against office visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child's primary insurance must be billed first, and then Medicaid as the payor of last resort.

See Appendix A for additional information regarding EPSDT Screening.

NOTE:

EPSDT vision and hearing screenings are performed in conjunction with a complete comprehensive screen and are limited to one per year for children 5-20 years of age.

Family Planning Codes

Procedure Code	*Description*
11975	Implant Insertion (limited to one per 365 days) Deleted as of 6-1-03
11976	Implant Removal (limited to one per 365 days)
11976	Implant Removal (limited to one per 365 days)
58300	IUD Insertion
58301	IUD Removal
99401	HIV Pre-Test Counseling (Must be billed in conjunction with a family planning visit) - Limited to two per recipient per calendar year.
99402	HIV Post-Test Counseling (Must be billed in conjunction with a family planning visit) - Limited to two per recipient per calendar year.
J1055	Depo-Provera Shots 150 mg/ml, limited to one injection every 70 days
J1056	Medroxyprogesterone Acetate/Estradiol Cypionate
J7302	Levonorgestrel-releasing Intrauterine Contraceptive System
99205-FP	Initial Visit (limited to one per recipient per family planning provider)
99214-FP	Annual Visit (limited to one per recipient per calendar year)
99213-FP	Periodic Visit (limited to four services per calendar year)
99347-FP	Home Visit
99212-FP	Extended Family Planning Counseling (limited to one service during 60-day post-partum period)
S4989	Hormonal IUD (Progestesert)
J7300	Mechanical IUD (Paragard)

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
S9445	Prenatal Education (limited to 12 classes per recipient within 2-year period)
99412	Adolescent Pregnancy Prevention Education

NOTE:

Medical encounter (99211-SE) counts against the physician yearly benefit limitations. More than one encounter may not be billed on the same date of service.

36.5.4 Place of Service Codes

The following place of service codes apply when filing claims for independent rural health clinics:

POS Code	*Description*
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility

36.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

36.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Family Planning	Appendix C
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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37 Therapy (Occupational, Physical, and Speech)

This chapter regarding therapy services is specifically designed for therapy providers who meet **either** of the following criteria:

- Provider receives a referral as a result of an EPSDT screening exam and possesses a Patient 1st/EPSDT Referral form (Form 362) as a result of an abnormality discovered during the EPSDT exam
- Provider treats QMB recipients

Physical therapy is also covered for acute conditions in a hospital outpatient setting for non-EPSDT recipients. For more information regarding this, refer to Chapter 19, Hospital.

The policy provisions for therapy providers can be found in the *Alabama* Medicaid Agency Administrative Code, Chapter 11.

37.1 Enrollment

HP enrolls therapy providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative C*ode, and the *Alabama Medicaid Provider Manual*.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a therapy provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for therapy-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Therapy providers are assigned a provider type of 17 (Therapy). Valid specialties for therapy providers include the following:

- Occupational Therapy (171)
- Physical Therapy (170)
- QMB/EPSDT (600)
- Speech Therapy (173)

Therapists that enroll independently and have their own NPI bill on a CMS-1500 claim form as an EPSDT/QMB-only provider. Refer to Chapter 19, Hospital, for billing information for therapists enrolled by a hospital.

Enrollment Policy for Therapy Providers

Services provided must be ordered by a physician or a non-physician practitioner for an identified condition(s) noted during the EPSDT screening and provided by or under:

- For physical therapy services, a qualified physical therapist
- For occupational therapy (OT) services, the direct supervision of a qualified occupational therapist
- The supervision of a qualified speech therapist

A qualified Speech Therapist must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology.

A qualified occupational therapist must be licensed by the Alabama State Board of Occupational Therapy.

A qualified physical therapist must be licensed by the Alabama Board of Physical Therapy.

37.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Services provided to Medicaid-eligible children by those working under the direction of licensed, enrolled speech therapists, occupational therapists or physical therapists are subject to the following conditions:

- The person providing the service must meet the minimum qualifications established by state laws and Medicaid regulations.
- A supervising provider must employ the person providing the service.
- The case record must identify the person providing the service.
- The supervising therapist must assume full professional responsibility for services provided and bill for such services.
- The supervising provider must assure that services are medically necessary and are rendered in a medically appropriate manner.
- Services must be ordered by a physician or a non-physician practitioner.

For more information about the Plan of Treatment required for therapy services, refer to Appendix A, EPSDT.

Only procedures identified in Section 37.5.3, Procedure Codes and Modifiers, are reimbursable.

Speech Therapists (ST-Speech Language Pathologist)

Speech therapy services must be provided by or under the direct supervision of a qualified speech therapist. Services are limited to those procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers.

Speech therapy assistants must be employed by a speech therapist, have a bachelor's degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. Assistants are only allowed to provide services commensurate with their education, training, and experience. They may not evaluate speech, language, or hearing; interpret measurements of speech language or hearing; make recommendations regarding programming and hearing aid selection; counsel patients; or sign test reports or other documentation regarding the practice of speech pathology. Assistants must work under the direct supervision of a licensed speech pathologist.

Direct supervision requires the physical presence of the licensed speech pathologist in the same facility at all time when the assistant is performing assigned clinical responsibilities. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

NOTE:

Speech therapy services must be ordered by a physician and must be provided by or under the direct supervision of a qualified speech therapist.

Occupational Therapists (OT)

Occupational therapy services must be provided by or under the direct supervision of a qualified occupational therapist.

Services are limited to those procedures identified in Section 37.5.3, Procedure Codes and Modifiers. Some codes may require prior authorization before services are rendered. Medicaid does not cover recreational activities, such as movies, bowling, or skating.

Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth visit. Each supervisory visit must be documented and signed by the OT making the visit. Supervision for non-certified limited permit holders shall consist of one-to-one, on-site supervision a minimum of 50% of direct patient time by an OT who holds a current license. The OT must document supervising visits. The supervising OT ensures that the assistant is assigned only duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Occupational therapy aides employed by the OT may perform only routine duties under the direct, on-site supervision of the OT. Care rendered by an OT aide may not be charged as occupational therapy.

Physical Therapists (PT)

Services provided must be provided by or under the supervision of a qualified physical therapist.

Physical therapy assistants may provide service only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy, and must be an employee of the supervising PT. The PT assistant must only be assigned duties and responsibilities for which the assistant has been specifically educated and which the assistant is qualified to perform.

Licensed certified physical therapist assistants (PTA) are covered providers when working under the direction of a Preferred Physical Therapist with the following provisions:

- The Physical Therapist must interpret the physician's referral.
- The Physical Therapist must perform the initial evaluation.
- The Physical Therapist must develop the treatment plan and program, including long and short-term goals.
- The Physical Therapist must identify and document precautions, special problems, contraindications, goals, anticipated progress and plans for reevaluation.
- The Physical Therapist must reevaluate the patient and adjust the treatment plan, perform the final evaluation and discharge planning.
- The Physical Therapist must implement (perform the first treatment) and supervise the treatment program
- The Physical Therapist must co-sign each treatment note written by the PTA.
- The Physical Therapist must indicate he/she has directed the care of the patient and agrees with the documentation as written by the PTA for each treatment note.

Long Term Therapy Services:

- Therapeutic goals must meet at least one of the following characteristics: prevent deterioration and sustain function; provide interventions that enable the beneficiary to live at their highest level of independence in the case of a chronic or progressive disability; and/or provide treatment interventions for a beneficiary who is progressing, but not at a rate comparable to the expectations of restorative care.

Maintenance Services:

- A repetitive service that does not require the knowledge or expertise of a qualified practitioner and that does not meet the requirements for covered restorative therapy and/or long term therapy services. Maintenance services begin when the therapeutic goals of a treatment plan have been achieved or when no additional medical benefit is apparent or expected.

The Physical Therapist must render the hands-on treatment, write and sign the treatment note at a minimum of every sixth visit.

Only procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers, are valid procedure codes and reimbursable for physical therapy services.

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 Pt. 1st/EPSDT referral form may be considered as the physicians' order if these guidelines are met.

NOTE:

To determine if a procedure code requires prior authorization, use the Automated Voice Response System (AVRS).

37.3 Prior Authorization and Referral Requirements

Therapy procedure codes generally do not require prior authorization. Any service that is warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

If the EPSDT screening provider wants to render treatment services himself, the provider completes a self-referral.

After receiving a screening referral form, Medicaid providers may seek reimbursement for medically necessary services to treat or improve the defects, illnesses, or conditions identified on the referral form. The consulting provider completes the corresponding portion of this form and returns a copy to the screening provider. If services or treatment from additional providers is indicated, a copy of the referral form must be sent to those providers for their medical records. A completed Referral for Services Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for the referral.

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.

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 Pt. 1st/EPSDT referral form may be considered as the physicians' order if these guidelines are met.

37.4 Cost Sharing (Copayment)

Copayment does not apply to therapy services.

37.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Therapy providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

Therapy services are billed using the CMS-1500 claim form. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

37.5.1 Time Limit for Filing Claims

Medicaid requires all claims for therapy services to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

37.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

37.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Speech Therapy

Speech therapy providers are limited to the procedure codes listed below:

Procedure Code	*Description*	*Requires a Prior Authorization*
92506	Evaluation of speech, language, voice, communications, and/or auditory processing	No
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	No
92508	Group, two or more individuals	No
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	Yes
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes	Yes
92609	Therapeutic services for the use of speech-generating device, including programming and modification See Note Box Below.	Yes
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.	No

NOTE:

For procedure code 92609, documentation must support that Augmentative Communication Device (ACD) has been purchased by Medicaid. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Physical Therapy

Physical therapy providers are limited to the procedure codes and limits listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Procedure Code	*Physical Therapy*	*See Note*	*Max Units Per Day*	*Requires Prior Authorization*
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report		1	No
95832	Muscle Testing Manual		1	No
95833	Total evaluation of body, excluding hands		1	No
95834	Total evaluation of body, including hands		1	No
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)		10	No
95852	ROM measurements and report		1	No

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
	(separate procedure);hand, with or without comparison with normal side			
97001	Physical therapy evaluation		1	No
97002	Physical therapy reevaluation		1	No
97010	Application of a modality to one or more areas; hot or cold packs	1, 3, 5	1	No
97012	Traction, mechanical	1, 5	1	No
97014	Electrical stimulation, unattended	1, 2	4	No
97016	Vasopneumatic device	1 , 5	1	No
97018	Paraffin bath	1, 3, 5	1	No
97022	Whirlpool	3	1	No
97024	Diathermy	1, 5	1	No
97026	Infrared	1, 5	1	No
97028	Ultraviolet		1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No
97033	Iontophoresis, each 15 minutes	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3, 5	1	No
97113	Aquatic therapy with therapeutic exercises	5	1	No
97116	Gait training (includes stair climbing)	5	1	No
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).	3, 5	1	No
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	5	1	No
97150	Therapeutic procedure(s), group (2 or more individuals)	5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97532	Development of cognitive skills to		4	No

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Requires Prior Authorization***
	improve attention, memory, problem solving, (includes compensatory training) direct (one on one) patient contact by the provider, each 15 minutes			
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on one) patient contact by the provider, each 15 minutes		4	No
97535	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment), direct one on one contact by provider each 15 minutes.	3, 5	4	Yes
97542	Wheelchair management/propulsion training, each 15 minutes	3, 5	4	No
97597	Removal of devitalized tissue From wounds		1	No
97598	Removal of devitalized tissue From wounds		8	No
97750	Physical performance test or measurement, (e.g., muscoloskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3, 5	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service.)

2. 97014 cannot be billed on same date of service as procedure code 20974, 20975 or 20982.

3. When a physical therapist and an occupational therapist perform the same procedure for the same recipient for the same day of service, the maximum units reimbursed by Medicaid will be the daily limit allowed for procedure, not the maximum units allowed for both providers.

4. 97760 should not be reported with 97116 for the same extremity.

5. Procedures 97010, 97012, 97016, 97018, 97024, 97026 (therapy procedures) must be billed with one of the following codes: 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97530, 97535, or 97542 (therapeutic treatment).

Occupational Therapy

Occupational therapy providers are limited to the procedure codes and limits listed below. These procedure codes cannot be span billed and must be submitted for each date of service provided. Documentation by therapist in medical record must support number of units billed on claim.

Medicaid **does not** cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Individual occupational therapy services are limited to the following codes:

Code	***Description***	***See PT Note Above***	***Max Units Per Day***	***Requires a Prior Authorization***
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour, both face-to-face time administering tests to the patient and time interpreting test results and preparing the report.		1	No
97003	Occupational therapy evaluation		1	No
97004	Occupational therapy re-evaluation		1	No
97010	Application of a modality to one or more areas; hot or cold packs	1, 3, 5	1	No
97018	Paraffin bath	1, 3, 5	1	No
97022	Whirlpool	3	1	No
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	No

Code	***Description***	***See Note Above***	***Max Units Per Day***	***Requires a Prior Authorization***
97033	Iontophoresis, each 15 minutes (Deleted 1-1-99)	3	4	No
97034	Contrast baths, each 15 minutes	3	4	No
97035	Ultrasound, each 15 minutes	3	4	No
97036	Hubbard tank, each 15 minutes	3	4	No
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3, 5	4	No
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense posture, and proprioception	3, 5	1	No
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	3, 5	1	No
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes	3, 5	4	No
97535	Self care / home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of adaptive equipment) direct one on one contact by provider, each 15 minutes.	3, 5	4	Yes
97542	Wheelchair management /propulsion training, each 15 minutes	3, 5	4	No
97597	Removal of devitalized tissue from wounds		1	No
97598	Removal of devitalized tissue from wounds		8	No
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes	3	12	No
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	3	4	No
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes	3	4	No
97762	Checkout for orthotic/prosthetic, use, established patient, each 15 minutes	3	4	No

NOTE:

Refer to Chapter 14, Durable Medical Equipment, for L codes.

Refer to Chapter 108, Early Intervention Services for therapy delivered to infants/children enrolled in Alabama's Early Intervention System (AEIS).

37.5.4 Place of Service Codes

The following place of service codes apply when filing claims for therapy services:

POS Code	*Description*
11	Office

37.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

37.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
EPSDT	Appendix A
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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38 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid.

The policy provisions for anesthesia can be found in the Alabama Medicaid Agency Administrative Code, Chapter 6.

38.1 Enrollment

HP enrolls anesthesiologists, Certified Registered Nurse Anesthetists (CRNA) and Anesthesiology Assistants (AA) and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

HP also enrolls Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician or hospital.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an anesthesiologist, CRNA, or AA provider is added to the Medicaid systems with the NPIs provided at the time application is made. Appropriate specialty codes are assigned to enable the provider to submit requests and receive reimbursements for anesthesia-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Anesthesiologists are assigned a provider type of 31 (Physician). CRNAs and AAs are assigned a provider type of 09(Anesthesiology). Valid specialties for the above include the following:

- Anesthesiology (311)
- Anesthesiology Assistant (101)
- CRNA (094)

Enrollment Policy for Anesthesiology Providers

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program.

In addition to the completed application, the following information for Anesthesiologist Assistants must be submitted and approved before the enrollment process can be initiated:

- Copy of current state license
- Copy of current certifications (CRNA or AA)

38.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth in the Alabama Board of Medical Examiners. The AA must enroll and receive a NPI to bill the Alabama Medicaid Program. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist

Administration of anesthesia by a self-employed CRNA is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll and receive a NPI to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units.

For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. The definition of medical direction is an anesthesiologist medically directing four concurrent cases (CRNA/AA) or less. In order to bill for medical direction, the anesthesiologist must be immediately physically available at all times. Addressing an emergency of short duration, or rendering the requisite CRNA or AA direction activities (listed below in a. through g.), within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist’s personal continuing involvement in a particular case, medical direction ceases to be available in all other cases.

In order for the anesthesiologist to be reimbursed for medical direction activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities:

- Performs a pre-anesthesia examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies

- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual
- Monitors the course of anesthesia administration at frequent intervals
- Remains immediately physically available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

A necessary task or medical procedure may be executed while concurrently medically directing CRNAs or AAs only if the task or procedure is one which may be: (1) immediately interruptible without compromising the wellbeing, quality of care, or health of the recipient and (2) is executed in an area close enough to the operating rooms where the CRNAs and AAs are being medically directed and that will permit the physician to remain in compliance with the requirements of being immediately physically available. Examples of an “area close enough to the operating rooms” are the Post-Anesthesia Care Unit (PACU) or receiving room. A task or procedure that may be stopped instantly is defined as one of limited difficulty and brief duration so that if it is stopped instantly, it would not interfere with the quality of care, wellbeing, or health of the recipient. There are two exceptions to the above:

1. acting in response to urgencies of short duration or medical emergencies (e.g., ACLS provision, intubation, starting difficult intravenous (IV) lines that without them would reduce the recipient’s quality of care, etc.)
2. labor epidural placement and management

The execution of a trigger point injection or an epidural steroid injection while medically directing is permissible when requested by another physician. The 1:4 ratio should be maintained while the trigger point injection or the epidural steroid injection is being executed. The consult for the execution of the aforementioned may serve as the second, third, or fourth simultaneous case. Therefore the execution of these limited pain services is disallowed while medically directing four simultaneous anesthetics. The ability to respond to urgent or emergent needs in the hospital (operating room, labor and delivery room, or anywhere in the hospital where his/her responsibility lies) may not be decreased at any time and is the responsibility of the anesthesiologist who is medically directing. The intent of this exception is to allow for provision of commonly requested procedures and to improve effectiveness. However, this exception does not include consults to diagnose. Diagnosis of chronic pain and treatment of complex problems is not allowed while simultaneously medically directing CRNAs and AAs.

Global Anesthesia Definition

The Agency has identified certain procedures to be included in the global payment for the anesthesia services. These procedures include but are not limited to the following: general anesthesia, regional anesthesia, local anesthesia, supplementation of local anesthesia, and other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure.

Anesthesia services include:

- All customary preoperative and postoperative visits,
- Local anesthesia during surgery,
- The anesthesia care during the procedure,
- The administration of any fluids deemed necessary by the attending physician, and any usual monitory procedures

Interpretation of non-invasive monitoring to include EKG, temperature, blood pressure, pulse, breathing, electroencephalogram and other neurological monitoring,

Monitoring of left ventricular or valve function via transesophageal echocardiogram,

Maintenance of open airway and ventilatory measurements and monitoring,

Oximetry, capnography and mass spectrometry.

Monitoring all fluids used during cold cardioplegia through non-invasive means. Additional claims for such services should not be submitted.

Placement of lines such as arterial catheterizations and insertion and placement of pulmonary artery catheters (e.g., Swan-Ganz) for monitoring will no longer be included in the global anesthesia reimbursement when billed with other procedures but will be allowed to be billed using the same guidelines outlined in this chapter under “Special Situations for Anesthesia”. The time of placement of invasive monitors and who placed them should be documented in the medical record. Verification of anesthesia time units may be subject to post-payment audits. Billing for anesthesia time while placing invasive monitors is not allowed unless the patient required general anesthesia for placement.

The time anesthesia starts is at the beginning of induction via the injection or inhalation of an anesthetic drug or gas and ends at the time the recipient is transferred to the recovery room or post anesthesia care unit (PACU). Induction is defined as the time interval between the initial injection or inhalation of an anesthetic drug or gas until the optimum level of anesthesia is reached. The recipient must be prepared by the anesthesiologist prior to induction and must be assessed by the anesthesiologist immediately after the surgical procedure. Up to 15 minutes are allowed for the preparation of anesthesia, and up to 15 minutes are allowed after the operation (for transfer of the recipient to the receiving room, recovery room, or PACU). It is inappropriate to bill for anesthesia time while the patient is receiving blood products or antibiotics in the holding area or waiting in a holding area, or waiting in the operating room more than 15 minutes prior to induction.

Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e., pudendal block or paracervical block) is considered part of the obstetrical coverage. Additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia is billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

When an epidural is performed as part of maternity labor/delivery by a resident, modifiers **AA** and **GC** must be billed along with the procedure code to identify the service is administered under the direction of a physician **(AA**), and performed by the resident **(GC).** When the epidural is performed by a physician in the absence of a resident, use modifier **AA** only.

When a medical procedure is a non-covered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a non-covered service.

A primary anesthesia procedure is included in the procedure code range of 00100-01997 as noted in the Relative Value Guide.

NOTE:

Medical record documentation should clearly support and reflect physician services. Post-payment reviews may be performed.

Special Situations for Anesthesia

If two procedures of equal unit value are billed, the first procedure will be paid and the second one will deny because the subsequent procedure is included in the primary anesthesia charge.

If two procedures are billed with different unit values, the procedure with the greatest unit value will pay and the other procedure will deny because the subsequent procedure is included in primary anesthesia charge.

The anesthetic agent for nerve blocks (CPT codes 64400-64530) is included in the reimbursement fee for the performance or administration of the nerve block. No additional procedures should be filed for the nerve block medication.

Anesthesia for CAT Scans or MRI/MRA Procedures is not covered for anesthesiologists. The attending/admitting physician is responsible for ordering the necessary measure(s) to ensure the patient is prepared for these tests.

Monitored Anesthesia Care is a covered service.

Medicaid does not cover physical status modifiers.

Qualifying factors may be billed in addition to anesthesia codes if applicable. See Section 38.5.3 for more information.

Standby anesthesia is not payable under Medicaid.

Consultations

A consultation for anesthesia performed on the day of or days before a procedure is considered part of the global procedure and is not a separately reimbursable item.

There are two exceptions to the above as outlined below.

- A recipient with chronic intractable pain receives a consult from an anesthesiologist for the chronic intractable pain, or
- A recipient receives a consult from an anesthesiologist to have an anesthesia procedure performed but ends up not receiving the anesthesia, e.g., the surgery is canceled due to complications.

Post-Operative Pain Management and Epidural Catheters

Surgeons routinely provide necessary post-operative pain management services and are reimbursed for these services through the global surgery fee. The surgeon should manage post-operative pain except under extraordinary circumstances. Procedures involving major intra-abdominal, vascular and orthopedic, and intrathoracic procedures will be covered for post-operative pain management by an anesthesiologist when medically indicated. Postoperative pain management services is not covered by non-physicians.

The definition for post-operative pain management is the management of a recipient's pain beyond, or separate from, the recovery room or operating room. The separately identifiable physician-recipient encounter and management should occur outside the intraoperative area. A separately identifiable physician-recipient encounter reflecting the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications should be clearly reflected in the medical record documentation.

No additional payment is allowed for an injection of Duramorph or other analgesic agents as a boost at the end of an anesthesia procedure (using the same catheter used for the epidural or spinal anesthesia) without a separately identifiable physician-recipient encounter including the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications. However, if there is a separately identifiable physician-recipient encounter on subsequent post-op days, where the physician provides post-operative analgesic orders and manages post-operative analgesic complications, daily management of epidural or subarachnoid drug administration may be billed.

If a recipient receives general anesthesia and consequently requires additional pain control such as an epidural injection or an epidural catheter placement on the same day as the general anesthesia, the single injection or catheter placement will be reimbursed at one-half of the allowable. However, catheter placement and daily management of an epidural catheter is not allowed on the same date of service. When the physician provides a separately identifiable physician-recipient encounter to manage and evaluate the catheter and it is reflected in the medical record, this coverage is satisfactory for a reasonable period of time over the consecutive post-operative days.

Patient Controlled Analgesia

Patient controlled analgesia (PCA) services are reimbursable when they are administered by an anesthesiologist and are performed for the control of post-operative pain. A separately identifiable physician-recipient encounter should be reflected in the medical record documentation. PCA pumps are usually administered through an intravenous (IV) line or the PCA pump is connected to an epidural catheter line.

When an anesthesiologist provides the management of the PCA pump through an IV line, the anesthesiologist will be allowed a total of four units and will be considered a global payment for the management regardless of the number of days the recipient remains on the pump. Use procedure code 96522 for daily hospital management of intravenous patient-controlled analgesia.

The anesthesiologist should use the appropriate procedure code(s) when filing claims for a single injection or for an injection including catheter placement (epidural, subarachnoid, cervical, thoracic, lumbar, or sacral) when the PCA pump is connected to an epidural line. Placement of the epidural catheter and daily management of a subarachnoid or epidural catheter is not reimbursable on the same date of service. Daily management of a subarachnoid or epidural catheter is reimbursable on subsequent days. Delivery of pain medication through intermittent injections, a regular infusion, or by a PCA pump is included in the management of an epidural line whether a registered nurse or a physician administers it. Additional units for a PCA pump that is connected to an epidural line is not separately reimbursable.

The global surgical reimbursement fee to the surgeon includes the management of a PCA pump for post-operative pain control and is not a separately reimbursable item. Similarly, a physician's global medical service reimbursement includes the management of a PCA pump for recipients with chronic pain control or terminal cancer and is not separately reimbursable.

Intractable Pain and Epidural Catheters

Some forms of conventional therapy such as oral medication, physical therapy, or a TENS unit may not relieve recipients with intractable pain. Placement of an epidural catheter may be allowed when medically necessary for recipients with intractable pain. Reimbursement for daily management is allowed when it is medically necessary and is a separately identifiable physician-recipient encounter is clearly documented in the medical record by the anesthesiologist. Placement of an epidural catheter and daily management of an epidural catheter is not reimbursable on the same date of service.

38.3 Prior Authorization and Referral Requirements

Anesthesiology procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

NOTE:

Consults performed in the inpatient hospital setting do not require a Patient 1st referral. Consults performed in a setting other than inpatient hospital require a Patient 1st referral.

38.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Anesthesiologists, Certified Registered Nurse Anesthetists or Anesthesiology Assistants.

38.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

38.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Anesthesiologists, CRNAs and AAs to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

38.5.2 Diagnosis Codes

The International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

38.5.3 Procedure Codes and Modifiers

Anesthesia providers are required to utilize the appropriate anesthesia code identified in the current Relative Value Guide published by the American Society of Anesthesiologists. Time in attendance should be billed by listing **total minutes** of anesthesia time in block 24G of the CMS-1500 claim form. Type of service “7” should be used for billing anesthesia codes (00100-01997). The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers. Effective October 1, 2004 to bill for code 90784, bill the first line item with the code and one unit. Bill the second line item with code 90784 with modifier 76 (repeat procedure) and 3 units.

HP will calculate total units by dividing the total minutes (reported in block 24G) by 15, rounding up to the next whole number, and adding the time units to the auto-loaded base unit values. The base unit values are derived from the ASARVG for CPT-4 anesthesia codes.

The number of qualifying factor units is multiplied by the price allowed for anesthesia services. For more information regarding qualifying factors, see the next section of this manual.

Qualifying Factors

Beginning June 14, 2002, qualifying factors will be reimbursable. Qualifying factors allow for anesthesia services provided under complicated situations depending on irregular factors (ex: abnormal risk factors, significant operative conditions). The qualifying procedures would be reported in conjunction with the anesthesia procedure code on a separate line item using 1 unit of service.

The qualifying procedure codes are indicated below.

Procedure Code	Description	Units
99100	Anesthesia for recipient with farthest ages, over seventy and under one year	1
99116	Complication of anesthesia by utilization of total body hypothermia	1
99135	Complication of anesthesia by utilization of controlled hypotension	1
99140	Complication of anesthesia by emergency conditions	1

Medical Supervision - CRNA or AA

Two modifiers are used to indicate whether the service was medically directed or not medically directed in regards to anesthesia. The modifiers listed below should be used:

- QX - MEDICALLY DIRECTED
- QZ - NOT MEDICALLY DIRECTED

Medical direction should only be billed when the CRNA or AA supervision is rendered by an anesthesiologist. If a procedure is medically supervised by the surgeon, the claim should be billed as if the service were not medically directed.

Medical Supervision - Anesthesiologists

Medically directed services are defined as anesthesia services that are medically directed by an anesthesiologist for 1, 2, 3, or 4 CRNAs or AAs.

When billing for medically directed services, anesthesiologists should utilize the modifiers listed below:

- QY for medically directed services of 1 CRNA or AA (effective for 01/01/99)
- QK for medically directed services of 2, 3, or 4 CRNAs or AAs

The payment amount for the physician's service and the CRNA or AA is 50% of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

Medical Supervision – Resident

Residents may bill anesthesia services under the supervision of the teaching physician. They are allowed to bill anesthesia procedure codes using the teaching physician's provider number along with an AA and GC modifier.

Please refer to the medical supervision requirements indicated in the previous section for billing requirements when concurrent cases (limited to 4) are being supervised by the same physician.

Other Anesthesia Modifiers

Other appropriate anesthesia modifiers for anesthesiologists include the following:

Modifier	***Description***
AA	Anesthesia services performed personally by an Anesthesiologist
AB	Medical direction of own employee performed by an Anesthesiologist
AC	Medical direction of other than own employee performed by an Anesthesiologist

NOTE:

All procedures for anesthesiology services must include appropriate modifiers. CRNAs and AAs are limited to QX and QZ. Anesthesiologists are limited to QY, QK, AA, AB, and AC. Medical directing five or more concurrent cases is not allowed.

38.5.4 Referring Provider Information

Effective February 23, 2008, anesthesia providers must submit the NPI number of the referring surgeon/physician on the claim. If you file hard copy, the NPI number should be populated in block 17a of the CMS 1500 claim form. For those who file electronically, you should submit the referring surgeon/physician's NPI number in REF02 of the 837P. This is necessary for proper claims processing.

Anesthesiologists should use "OTH000" as the referring or attending NPI number for providers who are not assigned a NPI number by Medicare. For example, when providing anesthesia services for recipients who are being treated by dental providers, please use "OTH000" as the NPI number in block 17a of the CMS 1500 form. Use "OTH000" in REF02 and the ID qualifier 1G in REF 01 when filing claims electronically on the 837P. If you use PES software or a vendor, please make sure your software has been updated to accommodate this change. As a reminder, claims for anesthesia providers not containing this information will deny.

38.5.5 Place of Service Codes

The following place of service codes apply when filing claims for CRNP services:

POS Code	***Description***
11	Office
12	Home
22	Outpatient Hospital
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic

38.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

38.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Section 5.2
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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39 Patient 1st

The **Patient 1st** Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the Patient 1st program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning program requirements and billing procedures. The policies outlined in this manual are binding upon the provider. Providers should also refer to the HP Provider Insider as well as any letters, transmittals or ALERTS regarding any updates or changes within this program.

If you have any questions about this program please contact the Provider Assistance Center at 1 (800) 688-7989.

39.1 Overview

The goal of Patient 1st is to create patient centered, quality focused care through a medical home by linking Medicaid recipients with a primary medical provider (PMP). The PMP coordinates care for recipients by providing and arranging for each recipients health care needs. Enrolling recipients into a medical home reduces the need for recipients to seek basic sick care services from a hospital emergency department, reduces duplicative care and optimizes appropriate care delivery.

Patient 1st operates pursuant to an approved 1915(b) primary care case management waiver granted in accordance with Title XIX of the Social Security Act. PMPs receive a monthly case management fee per member, per month for coordinating the care of Medicaid recipients enrolled with their practice. Direct services are reimbursed fee-for-service.

Patient 1st can be successful only with the commitment of the provider community. To ensure an adequate provider base, the Alabama Medicaid Agency (Medicaid) executes provider agreements with physicians who wish to participate in the **Patient 1st** Program on a continuous basis. The physician acting as a PMP agrees to abide by all existing laws, regulations and procedures pursuant to the **Patient 1st** Program and Medicaid participation.

39.2 Eligible Primary Medical Providers (PMPs)

39.2.1 Enrollment

Alabama Medicaid providers who are interested in participating as a Patient 1st provider must complete and submit a **Patient 1st Application Package** (application and agreement) to the HP Provider Enrollment Unit.

A copy of the application package is available on Medicaid's website at www.medicaid.alabama.gov or by calling the Provider Assistance Center at 1 (800) 688-7989.

The following provider types are eligible to participate as a PMP for the Patient 1st Program:

Family Practitioners

General Practitioners

Pediatricians

Internists

OB/GYN

Federally Qualified Health Centers

Rural Health Clinics

NOTE:

When in the best interest of a patient, a nontraditional PMP may be chosen (e.g., children with special health care needs). Other physicians may be considered for PMP participation if willing to meet all contractual requirements.

A participating physician in a clinic or health center cannot work at more than three sites and must provide Medicaid with information regarding percentages of time spent at each site and the number of Patient 1st enrollees per site.

The Patient 1st enrollee must be given information regarding the usual days and hours the physician is available for scheduled appointments. If a certified nurse practitioner or physician assistant cares for an enrollee, the enrollee must know the Patient 1st physician responsible for supervision. These obligations can be fulfilled through office signs, verbal instructions or written information.

The PMP has the option of being placed on the published or non-published PMP list. The PMP must indicate their preference when completing the Patient 1st Enrollment Form and will be indicated on the provider's monthly PMP Enrollment Roster, under Special Conditions. Regardless of publication, the PMP is included in the assignment process if caseload is available and criteria can be met.

The PMP list is sent to all Medicaid recipients to assist them in selecting physicians/clinics serving their area. The PMP list, based on distance, may also be accessed via the Medicaid web site at www.medicaid.alabama.gov. The list includes the PMP's distance criteria of participation, the PMP's name, specialty, physician extenders, physical address, and phone numbers (regular and 24 hour).

39.2.2 Caseload

The following standards apply to PMP caseloads:

PMPs may serve multiple sites; however, the maximum panel a PMP can serve collectively is 1200, with the minimum of 25. PMPs may specify the number of **Patient 1st** enrollees they will accept per site.

Full time Physician Extenders (Nurse Practitioners and Physician Assistants) will allow the caseload to be extended by 400 additional patients per extender. Only two Physician Extenders per physician will be allowed and may only be counted once in a caseload extension.

The PMPs practice must be opened a minimum of 32 hours per week and the PMP must practice at that location a minimum of 32 hours per week to be considered a Full Time Equivalent (FTE).

If less than an FTE, a percentage of a total patient caseload will be allowed, based on availability.

Examples:

Maximum Hours Worked in Office/Clinic	Maximum Recipients Assigned
32 to 40 Hours	1.0 FTE = 1200 recipients
16 Hours	.5 FTE = 600 recipients
12.8 to 15.9 Hours	.4 FTE = 500 recipients
9.6 to 12 Hours	.3 FTE = 375 recipients
6.4 to 8 Hours	.2 FTE = 250 recipients
3.2 to 4 Hours	.1 FTE = 125 recipients

All caseloads will be coordinated with Medicaid through HP.

Physician extenders (Nurse Practitioners and Physician Assistants) may allow the caseload to be extended based on hours worked.

Maximum Hours Worked in Office/Clinic	Maximum Recipients Assigned
32 to 40 Hours	400 recipients
24 Hours	240 recipients
16 Hours	160 recipients
12.8 to 15.9 Hours	140 recipients
9.6 to 12 Hours	120 recipients
6.4 to 8 Hours	80 recipients
3.2 to 4 Hours	40 recipients

Only two physician extenders per physician will be allowed and may only be counted once. Patient 1st assignments will only be made to the physician or clinic panel.

Caseloads for group/clinic enrolled providers will be determined by the number of FTEs and physician extenders associated with the group.

NOTE:

If a nontraditional PMP has been assigned based on a case need, the minimum enrollee or full time requirement will not apply.

If the PMP wishes to extend the caseload above 1200 or 2000 (with extenders), a written request from the PMP for an extension of the PMP enrollee cap should be submitted in writing and must address the following:

The PMP's name and NPI;

The total number of enrollees over the cap that the PMP is requesting;

The reason for the request to extend the PMP enrollee cap;

The total number of patients the PMP is seeing who are not Medicaid (PMP may provide the actual total of patients broken down by payer source, and/or PMP's percentage of Medicaid enrollees to total patients and/or the percentage of Medicaid income to total income);

The length of time the PMP has been in practice in the area;

Description of PMP's practice, such as, is the PMP in private or group practice;

Other extenuating documentation and explanations that would justify the request for an extension of the cap.

- The request can be submitted at the time the Provider Agreement is signed or at a later date by contacting HP Provider Enrollment at (334) 215-4254.

** A PMP's caseload may be exceeded to accommodate sibling assignment, newborn assignment, or assignments for previously established patients (last PMP on file).

If the PMP wishes to decrease the number of enrollees, he/she must notify HP Provider Enrollment in writing, at least thirty (30) days in advance of the planned decrease in enrollees to allow for enrollee reassignment. If the PMP wishes to increase the maximum number of enrollees within the caseload specifications, he/she must notify HP Provider Enrollment in writing. Such changes should be faxed to (334) 215-4298.

Individual or specific recipient additions must be submitted in writing on the requesting provider's letterhead and include the following information; the provider's name and NPI as enrolled in the Patient 1st Program, the recipient's name, Medicaid number and the city in which the recipient lives. These changes can be faxed to HP at (334) 215-4140.

Any changes made to the PMP's panel should be with the understanding that no individuals eligible to enroll in Patient 1st will be discriminated against on the basis of health status or the need for health care services. Further, the PMP must accept individuals in the order in which they apply without restriction up to the limits set by the PMP and the Agency.

39.2.3 PMP Disenrollment

The PMP's agreement to participate in the Patient 1st program may be terminated by either the PMP or Agency, with cause or by mutual consent; upon at least 30 days written notice and will be effective on the first day of the month, pursuant to processing deadlines.

NOTE:

Failure to provide a 30-day notice may preclude future participation opportunities and/or recoupment of case management fees.

A written request must be submitted by the PMP to Provider Enrollment at HP with the effective date given. Patients will automatically be reassigned based on the following:

If a PMP is leaving a group practice, then patients will be reassigned to a practitioner within the group; or

If the remaining group practitioner does not want to assume the caseload, then patients will be assigned through the automated assignment process. For a short period of time, these patients will not be enrolled in the **Patient 1st** Program; or

If the PMP has made arrangements with another practitioner to assume his/her caseload, then these specifics will be taken into consideration. The disenrollment notification must specify such arrangements.

39.3 PMP Responsibilities

In order to participate as a PMP, the following requirements must be met. Detailed information is provided on specific requirements in subsequent sections.

39.3.1 Functions and Duties

The PMP and its group practice/clinic shall comply with all applicable federal and state statutes and regulations, and all amendments thereto, that are in effect when the provider agreement is signed, or that come into effect during the term of the agreement. This includes, but is not limited to the approved waiver document and Title 42 of the Code of Federal Regulations.

The Patient 1st PMP agrees to do the following:

Be a licensed physician, enrolled in the Alabama Medicaid Program, who has not been sanctioned.

Accept enrollees and be listed as a PMP in the Patient 1st Directory for the purpose of providing care to enrollees and managing their health care needs through the Medical Home concept.

Provide hospital admissions.

Provide primary care and patient care coordination services to each enrollee in accordance with the policies set forth in Medicaid provider manuals and Medicaid bulletins and as defined by Patient 1st policy.

Provide or arrange for primary care coordination and coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week as defined by Patient 1st policy. Automatic referral to the hospital emergency department for services does not satisfy this requirement. PMPs must have at least one telephone line that is answered by the office staff during regular office hours.

Provide EPSDT preventive care screenings to Medicaid eligible children age birth through 20. PMPs serving this population who do not provide EPSDT services are required to sign an agreement with another provider to provide EPSDT services. PMPs must retain a copy of this agreement in their files and must ensure that their records include information regarding the extent of these services.

Maintain a unified patient medical record for each enrollee following the medical record documentation guideline as defined by Patient 1st policy.

Promptly arrange referrals for medically necessary health care services that are not provided directly and document referral for specialty care in the medical record. Provide the authorization number (NPI) to the referred provider.

Transfer the Patient 1st enrollee's medical record to the receiving provider upon the change of primary medical provider at the request of the new primary care provider and as authorized by the enrollee within 30 days of the date of the request. Note: Patients must request their records be transferred to the new PMP and must not be charged a fee for this service.

Authorize care for the enrollee or see the enrollee based on the standards of appointment availability as defined by Patient 1st policy.

Refer for a second opinion as defined by Patient 1st policy.

Review and use all enrollee utilization and cost reports provided by the Patient 1st program for the purpose of practice level utilization management and advise the Agency of errors, omissions, or discrepancies. Review and use the monthly enrollment report as required by Patient 1st policy.

Participate with Agency utilization management, quality assessment, and administrative programs.

Provide the Agency or its duly authorized representatives and appropriate Federal Agency representatives unlimited access (including onsite inspections and review) to all records relating to the provision of services under the provider agreement as required by Medicaid policy and 42 C.F.R. 431.107.

Maintain reasonable standards of professional conduct and provide care in conformity with generally accepted medical practice following national and regional clinical practice guidelines or guidelines approved by the Patient 1st Advisory Group.

Notify the Agency of any and all changes to information provided on the initial application for participation. If such changes are not reported within 30 days of change, then future participation may be limited.

Give written notice of termination of the contract, within 15 days after receipt of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis.

- Retain records in accordance with requirements of 45 C.F.R. 74 (3 years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends).

Comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964, Title IX of the Education of Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

Receive prior approval from the Agency of any Patient 1st specific, or education materials prior to distribution.

Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages.

NOTE:

Recipients can obtain assistance with language interpretation by calling the Recipient Call Center at 1(800) 362-1504.

PMPS are prohibited from the following:

Discriminating against individuals eligible to enroll on the basis of health status or the need for health care services.

Discriminating against individuals eligible to enroll on the basis of race, color, or national origin and will not use any policy or practice that has the effect of discrimination on the basis of race, color, or national origin.

- Providing materials that make any assertion or statement (whether written or oral) that the recipient must enroll with the PMP in order to obtain benefits or in order not to lose benefits. Materials shall not make any assertion or statement that the PMP is endorsed by CMS, the Federal or State government or similar entity.
- Door-to-door, telephonic or any form of marketing.
- Knowingly engaging in a relationship with the following:
  1. An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or
  2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation. Note: The relationship is described as follows:
     a. As a doctor, officer, partner of the PMP,
     b. A person with beneficial ownership of more than five percent (5%) or more of the PMP's equity; or,
     c. A person with an employment, consulting or other arrangement with the PMP for the provision of items and services which are significant and material to the PMP's contractual obligation with the Agency.

39.3.2 Hospital Admitting Privileges Requirement

Patient 1st Primary Medical Provider (PMPs) are required to establish and maintain hospital admitting privileges or have a formal arrangement with another physician or group for the management of inpatient hospital admissions that addressed the needs of all enrollees or potential enrollees. If a PMP does not admit patients, then the *Patient 1st Hospital Admitting Agreement* form must be submitted to the Agency to address this requirement for participation.

A formal arrangement is defined as a voluntary agreement between the Patient 1st PMP and the agreeable physician/group. The agreeable party is committing in writing to admit and coordinate medical care for the Patient 1st enrollee throughout the inpatient stay. Admitting privileges or the formal arrangement for inpatient hospital care must be maintained at a hospital that is within a distance of thirty (30) miles or forty-five minutes drive time from the Patient 1st PMP's practice. If there is no hospital that meets the above geographical criteria, the hospital geographically closest to the Patient 1st PMP's practice will be accepted.

Admissions through unassigned hospital-based call groups do not meet this requirement.

Exception may be granted in cases where it is determined the benefits of a provider's participation outweigh the provider's inability to comply with this requirement.

39.3.3 24/7 Coverage Requirement

PMPs must provide enrollees with after-hours coverage. It is important that patients be able to contact their PMP to receive instruction or care at all times so that care will be provided in the most appropriate manner to the patient's condition. PMP's can meet this requirement through a variety of methods. To qualify as a Patient 1st provider , one of the following must be met:

- The afterhour's telephone number must connect the patient to the PMP or an authorized medical practitioner.

- The afterhours telephone number must connect the patient to a live voice call center system or answering service who will either direct the patient to the appropriate care site, or contact the PMP or PMP authorized medical practitioner. If the PMP is contacted, then the patient should receive instructions within 1 hour.

- The afterhours telephone number can connect to a hospital if the PMP has standing orders with the hospital to direct patients to the appropriate care site. (For example, if the patient's symptoms are such that the patient can be seen the next morning, the hospital should direct the patient to contact the PMP in the morning to make an appointment).

An office telephone line that is not answered after hours or answered after hours by a recorded message instructing enrollees to call back during office hours or to go to the emergency department for care is not acceptable. It is not acceptable to refer enrollees to the PMP's home telephone if there is not a system in place as outlined above to respond to calls. PMPs are encouraged to refer patients with urgent medical problems to an urgent care center.

39.3.4 Standards of Appointment Availability and Office Wait Times

The PMP must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 24 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 90 days of presentation or notification (15 days if pregnant)

The PMP must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability
- Scheduled appointment – within one hour
- Life-threatening emergency – must be managed immediately

If these standards cannot be met due to extenuating circumstances, then the patient should be informed within a reasonable amount of time and given an opportunity to reschedule the appointment.

39.3.5 Patient 1st Medical Records Guidelines

Medical records should reflect the quality of care received by the client. However, many times medical records documentation for the level of care provided varies from provider to provider. Therefore, in order to promote quality and continuity of care, a guideline for medical record keeping has been established by the Patient 1st program. All Patient 1st PMPs must implement the following guidelines as the standards for medical record keeping.

1. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history relates to prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (age 12 and under) there is a complete record with dates of immunization administration.

9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for hospital admissions.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic test, therapies, and other prescribed regimen, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services.

39.3.6 Recipient Education

Recipient education will be an integral part of the program to help the recipients understand the Patient 1st Program system and their responsibilities under such a system. The Agency has recently outlined in the Patient Handbook the recipient's rights and duties as being part of the Patient 1st Program. All educational materials have stressed the importance of contacting the PMP before receiving services, which services do not require a PMP referral, and most importantly, the 1-800 number to call anytime there is a question.

In addition, as the coordinator of care, it is important for PMPs to be actively involved in patient education. Patient 1st PMPs are strongly encouraged to contact all new enrollees by telephone or in writing. New enrollees are identified in the monthly PMP Enrollment Roster.

Providers should address the following subjects with each new enrollee:

The PMPs requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PMP.

- The requirement that the enrollee contact the PMP for a referral before going to any other doctor.
- The requirement that the enrollee must contact the PMP before going to the emergency department unless the enrollee feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits such as Well Child Check-ups (EPSDT) screenings for children, immunizations, check-ups, mammography, cholesterol screenings, adult health assessments, and diabetic screenings.
- The availability of additional information for enrollees from the Agency.

39.3.7 Agreement Violation Provisions

Failure to meet the terms outlined in the Patient 1st provider agreement may result in the imposition of one or more of the following sanctions:

- A limit may be imposed on member enrollment.
- All or part of the monthly case management fee may be withheld
- The PMP may be referred to Program Integrity (PI) or Quality Assurance (QA) Unit for investigation of potential fraud or for quality of care issues.
- The PMP may be referred to the Board of Medical Examiners.
- The PMP may be terminated from the Patient 1st program.

Medicaid makes the determination to initiate sanctions against the PMP and may impose one or more sanctions simultaneously based on the severity of the contract violation. The Medicaid Legal Division may initiate a sanction immediately if it is determined that the health or welfare of an enrollee is endangered or Medicaid may initiate a sanction to begin within a specific period of time. Failure to impose a sanction for a contract violation does not prohibit Medicaid from exercising its right to do so for subsequent contract violations.

39.3.8 Agreement Violation Appeals

The PMP is notified by certified mail of the sanction(s) and the right to appeal the sanction. Medicaid must receive the PMP's request for a formal evidentiary hearing by the Medicaid Legal Division no later than 15 calendar days from the receipt of the sanction notice. The hearing provides an opportunity for all side to be heard in an effort to resolve the issue. The sanctioned party may represent himself/herself or may enlist the services of an attorney or designate a representative. The findings are documented by the Legal Division and presented to the Commissioner who makes the final determination to uphold or rescind the sanction. The PMP is notified by certified mail of the Commissioner's decision.

PMPs that are terminated from the Patient 1st program – or voluntarily withdraw to avoid a sanction – are not eligible to reapply for a minimum of one year with a maximum time period to be determined by the Agency. The decision is predicated on the extent or severity of the contract violation, necessitating the termination.

39.4 Monthly Case Management Fee

The PMP is paid a medical case management fee per month for each recipient the PMP has enrolled, as of the first day of each month. However, Federally Qualified Health Centers, Independent Rural Health Clinics and Provider Based Rural Health Clinics do not qualify for the case management fee.

There is no limit on the accumulation of case management fees; however, the fees paid are contingent upon the fee components referenced in 39.4.1. The PMP agrees to the number of enrollees on a PMP's panel with a cap set at 2,000 (with extenders) enrollees. The case management fee will generally be paid on the first checkwrite of the month. The medical case management fee will be automatically generated based on Medicaid enrollment reports. Therefore, the PMP is not required to file a claim for the medical case

management fee. All other services provided are reimbursed by the current fee-for-service method.

The case management fee will appear on the 1st checkwrite of the month as a capitation payment on the provider Remittance Advice.

39.4.1 Case Management Fee Components

PMP's will receive a case management fee that reflects the contractual requirements to which the PMP has agreed. The components of the fee are delineated below. Details on the components are provided so that the PMP can determine whether the component can be met. This information will be entered based on the providers Medicaid enrollment and the Patient 1st application submitted.

- **24/7 Coverage (Required)**

  If the PMP meets the guidelines specified in Section 39.3, then **$1.00** will be built into the monthly case management fee.

Components of Monthly Case Management Fee for Pilot Counties

Applicable to PMPs located in Bibb, Chambers, Fayette, Greene, Hale, Tuscaloosa, Lee, Pickens, Limestone, Macon, Madison, and Tallapoosa counties. The components of the fee are delineated below.

24/7 Coverage (REQUIRED)	The PMP must provide voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day 7 days a week. For this service, **$1.00 PMPM** is added to the case management fee. The PMP's 24/7 contact information will be obtained from Attachment A.
Participation in the Patient Care Networks of Alabama (PCNA) Program (**OPTIONAL)** *The PMP must sign an agreement with the PCNA Administrative Entity.* *You will be notified of the PCNA Administrative Entity when it is formed. The case management fee for the patient acuity level (B in the right column) will be applied to all Patient First providers effective 4/1/2011; however, after the Entity is functional, you will only receive A and B if you sign a contract to participate with the Entity.*	**$0.50 PMPM** will be added to the case management fee. **AND** **Patient Acuity Level (Case Mix):** The illness burden of each physician/practice's panel of patients as reflected on the Patient 1st Profiler Report produced in January 2011. The Profiler Report uses Adjusted Clinical Groupings (ACG) weights designed by John Hopkins University to determine the illness burden of recipients assigned to the provider peer group. For PMPs with a value of 0.9 or greater**, $1.60 PMPM** is added to the case management fee. For PMPs with a value, less than 0.9, **$1.00 PMPM** is added to the case management fee.

Components of Monthly Case Management Fee for Non-Pilot Counties

24/7 Coverage (REQUIRED)	The PMP must provide voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day 7 days a week. For this service, **$1.00 PMPM** is added to the case management fee. The PMP's 24/7 contact information will be obtained from Attachment A. **Patient case mix based on risk stratification of patients in PMP's panel -**Based on the illness burden of each physician/practice's panel of patients as reflected on the Patient 1st Profiler Report produced in January 2011. The Profiler Report uses Adjusted Clinical Groupings (ACG) weights designed by John Hopkins University to determine the illness burden of recipients assigned to the provider peer group. For PMPs with a value of 0.9 or greater**, $1.60 PMPM** is added to the case management fee. For PMPs with a value, less than 0.9, **$1.00 PMPM** is added to the case management fee.

- **Performance**

  Additional monies may be paid to the PMPs meeting performance measurements as defined by the Agency. The additional monies will be based on the total amount of savings and the percentage of measures met by the PMP.

39.5 Monthly PMP Enrollment Roster

The following report is available to PMPs to help identify and manage patients on their panel. Effective March 1, 2010, Medicaid will discontinue printing and mailing this report. The report can be accessed through Medicaid's Interactive Website.

The first of each month, the PMP can obtain a listing of pending enrollees (new patients) that the Agency has assigned for a future date (approximately 45 days), all continuing enrollees that are the responsibility of the PMP for the month and those enrollees that have been terminated from the provider's panel. The listing will include the recipient's demographic information, Medicaid number, assignment effective/end date, aid category, reason assigned to the PMP, county code and review date. The enrollee status will be noted at the top of each page as pending, continuing or terminated.

-Pending Enrollees (New) – enrollees that are new to your panel. A reason code will be listed on the report indicating the start reason or why the enrollee was assigned to the panel

- Continuing Enrollees – enrollees that have been previously assigned and continue to be assigned to the PMP
- Terminated Enrollees (Deleted) – enrollees that have been deleted from the PMP's panel. A reason code will be listed on the report indicating the stop reason or why the enrollee was deleted from the panel

Below is the code legend that will be listed on the last sheet of the enrollment roster explaining the enrollees' start/stop reason and their aid category.

Code Legends

Aid Category codes:

21 Blind-SSI-Full Medicaid coverage
30 MLIF-Child-Full Medicaid coverage
32 MLIF-Child with No Money-Full Medicaid coverage
34 MLIF- Adult-full Medicaid coverage
36 MLIF-Adult-No Money-Full Medicaid coverage
38 MLIF-Adult-No Money-Full Medicaid coverage
39 MLIF-Child-No Money-Full Medicaid coverage
3J Transitional Medicaid-Child-Full Medicaid coverage
41 Disabled-SSI-Full Medicaid coverage
46 Disabled-D.O. No Money-Full Medicaid coverage
51 SOBRA Child-No Money (<100%FPL)-Full Medicaid coverage
52 SOBRA Child-No Money (<133%FPL)-Full Medicaid coverage
54 SOBRA Child (Newborn)-No Money-Full Medicaid coverage
55 SOBRA Child-Pregnant-No Money-Full Medicaid coverage
81 Foster Care Kids (State Opt)-DHR-Full Medicaid coverage

Start/Stop Reason codes:

01 Not happy about the PMP assignment
06 PMP location not convenient
07 Change form submitted/no reason given
08 PMP requested recipient via letter
FN Special Handling
HI Historical
NE Newborn
PP Past PMP
PR Proximity
SI Sibling (Case)

In addition, a cover sheet will be included that provides information about the PMPs panel and will list the following:

- Region – indicates the provider is enrolled in the Statewide Patient 1st program
- Distance – distance (radius) the provider will accept recipients. Default is set at 75 miles
- Current Panel Size – the number of patients currently assigned to the PMP
- Future Panel Size – the number of patients assigned once pending enrollees become effective
- Maximum Panel Size – the maximum caseload that can be assigned
- Minimum/Maximum Age – the age range of enrollees the PMP specified he/she wanted on their panel
- Effective/End Date – provider's effective and end dates as enrolled in the Patient 1st program
- Special Conditions – lists case management fee components the provider is participating in and is being paid a case management fee

- Case Management Fee – the case management fee amount paid to the provider based on the case management components he/she agreed to participate in.

It is the PMP's responsibility to review this roster every month and report any errors to Medicaid. PMP's must continue to coordinate care for any enrollees who are linked to the practice, even if a change has been requested or an error has been reported until the change or error has been resolved and reported correctly.

The PMP should use this list to gauge caseloads, ensure service can be provided to all enrollees, and to determine if any patients have previously been dismissed. Pending recipients on the list are not final, as the patient will have until the 15th of the month preceding the enrollment date to change.

If the roster is not received by the first of the month, a replacement list can be requested by calling the Provider Assistance Center at 1(800) 688-7989. An electronic version of the list can also be requested from the Provider Assistance Center.

NOTE:

This list is not a substitute for eligibility verification. All providers should always verify Medicaid eligibility prior to rendering services.

39.6 Eligible Recipients

The Agency is responsible for recipient enrollment in Managed Care programs. Patient 1st is mandatory for most Medicaid recipients. Medicaid eligibles that must participate in **Patient 1st** are those for whom eligibility has been determined as listed below. Eligibility categories include:

SOBRA eligible children

MLIF and MLIF related

Refugees

Blind

Disabled

Aged

Infants of SSI mothers

Medicaid recipients in the above categories of Medicaid eligibility are **excluded from participation in Patient 1st in the following circumstances.**

NOTE:

Those categories with an asterisk are not automatically removed from the Program. These individuals must be reported to Patient 1st for removal from the program. Removal from Patient 1st does not affect their normal Medicaid benefits.

Medicaid eligibility is retroactive only;

Recipient is enrolled in another managed care program in which access to primary care physician is limited (i.e., HMO);*

Recipient is a lock-in;

Recipient resides in a residential or institutional facility such as a nursing home or ICF/MR or a group or foster home or DYS (Department of Youth Services);*

Recipients with dual eligibility (Medicare and Medicaid); and

Recipients who have been determined to be Medically Exempt for the Patient 1st Program, including:*

Terminal illness – the enrollee has a life expectancy of six months or less or is currently a hospice patient,

Developmental delay or Impaired Mental Condition – the enrollee does not possess the ability to understand and participate in Patient 1st (*Note:* This statement is not a determination of the patient's legal mental competence),

Chemotherapy or Radiation treatment – the enrollee is currently undergoing treatment (*Note:* This is a temporary exemption that ends when the course of treatment is completed. If the therapy will last for more than six months, the exemption must be requested after the initial six-month time period during reapplication for Medicaid coverage,

Continuity of Care issues (*Note:* A temporary exemption may be granted to allow a Patient 1st enrollee to continue to see a non-participating physician while the physician is in the process of applying for participation in Patient 1st), and Diagnosis/Other – an enrollee may be granted an exemption if there is a specific diagnosis or other reason why the enrollee would not benefit from coordinated care through a PMP.

The **Patient 1st Medical Exemption Request form** must be completed by the enrollee's physician and mailed to the Patient 1st Program, Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36103 or faxed to (334) 353-3856. A copy of the form is included in Appendix E and on the Agency's website at www.medicaid.alabama.gov.

Recipients are removed from **Patient 1st** participation if they are changed to an excluded aid category, or if they lose eligibility or change place of residence. Dependent upon when a person becomes Medicaid eligible, they may not yet be enrolled in **Patient 1st.**

If you have a patient who is enrolled in **Patient 1st** who should not be enrolled, please contact the Recipient Call Center at 1(800) 362-1504.

Eligibility verification indicates enrollment status and assigned PMP name and telephone number.

39.7 Recipient Enrollment/Assignment

39.7.1 Enrollment

To facilitate enrollment into the Patient 1st Program, recipients required to participate are assigned a PMP. Recipients have the ability to change PMP providers on a monthly basis. Dependent upon when a person became Medicaid eligible, they may not yet be enrolled in Patient 1st. **Always verify eligibility**.

Recipients who are added to the eligibility file (refer to 39.7.2 below for information regarding newborns) are notified of their Patient 1st assignment approximately 45 days prior to the effective date of the assignment. The purpose of the 45-day lead time is to allow recipients to change providers prior to actual PMP assignment. Providers will be notified at the same time as recipients of assignments. The assignment process takes into account group practices and/or clinic affiliation.

The computer assignment algorithm is as follows:

Newborn Will check for the person to be on the newborn list sent from the state.

Past PMP on file and Sibling cases- will be checked. If caseload and age criteria can be met, then assignment will be made to that PMP. Additionally, sibling cases will be checked to see if a sibling is in the program based on payee number. If there is no payee number, then this step cannot be considered. Siblings already enrolled or those in the same batch will be considered. If two siblings are enrolled and assigned to different PMPs, then the new siblings will be assigned to the PMP of the youngest sibling.

Historical Claims history will be considered for 18 months.

Proximity assignment based on PMPs distance from the recipient's zip code as long as caseload is available and age criteria can be met.

Random assignment is predicated on lowest available caseload on a rotating basis.

39.7.2 Newborns

Mothers of infants who will be required to participate in the program have the opportunity to select the provider they want for their child's PMP prior to assignment by the Agency. This is accomplished through the completion and submission of a Newborn Assignment Form. These forms are available through a variety of sources including, but not limited to, the physician's office, the Maternity Care Program Care Coordinator, and the hospital. The form must be completed and submitted prior to the Agency's assignment of the infant. Newborn assignments may be faxed to HP at (334) 215-4140. In order for the request to be granted, the PMP must have available caseload for the recipient's area.

39.7.3 Eligibility Verification

It is the provider's responsibility to verify that a person is eligible for Medicaid at the time of service. There are three sources available for obtaining recipient information:

The Provider Electronic Solution (PES) is a point of service device or PC based software system, which accesses recipient information.

The Automated Voice Response System may be accessed by dialing 1 (800) 727-7848 using a true touch-tone telephone. This is an automated telephone system available approximately 24 hours a day, 7 days a week unless down for maintenance.

The Provider Assistance Center at HP can be reached at 1 (800) 688-7989 from 8:00 am – 5:00 pm, Monday through Friday.

The verification will give contact information for the recipient's assigned PMP.

39.7.4 Recipient Changes of Primary Medical Providers

Enrollees may request to change their PMP at any time. HP is responsible for processing an enrollee's change request. Enrollees can change PMPs by calling the 1-800 line, or by mailing or faxing a written request to the Agency. The Agency monitors the reasons for change as part of the program compliance protocol.

Recipients must initiate changes to their PMP assignment

Enrollments and disenrollments to effect a change in PMP are effective the first of the month, following the date of the change if the request for change is received by the Agency by the 15th of the month. If requests for changes are received after the 15th, the change is effective the 1st of the following full calendar month.

NOTE:

If changes are not received by the 15th of the month, assurances for an effective date for the first of the following month cannot be given. This will allow a 5 day processing timeframe.

Please see Appendix E of the Medicaid Provider Manual for a copy of the PMP change form that can be utilized by the recipient. Patient requested changes are confirmed by a mailing prior to the 1st of the month in which the change is effective.

39.7.5 PMP Request Change/Dismissal of Recipient

A PMP may request removal of a recipient from his panel due to good cause*. All requests for patients to be removed from a PMP's panel should be submitted in writing and provide the enrollee 30 days notice. The request should contain documentation as to why the PMP does not wish to serve as the patient's PMP.

*According to the guidelines listed in the 1915(b)(i) waiver of the Social Security Act which allows the operation of the Patient 1st program, good cause is defined as:

- Behavior on the part of the recipient which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the recipient or other affected recipients is seriously impaired,
- Persistent refusal of a recipient to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

Additionally, a Patient 1st enrollee may be disenrolled for nonpayment of co-payments or an outstanding balance if this is a standard operating procedure for the practice, is applicable to all patients regardless of payer source, and prior written notice has been provided to the enrollee.

However, a recipient may not be charged or billed a cancelled or missed appointment ("no-show") fee. Refer to Chapter 6 of the Administrative Code for further information.

The PMP is responsible for completing Form 450, "Patient 1st Recipient Dismissal Form " and sending a letter of dismissal to the enrollee. A copy of the dismissal letter must be sent as an attachment to the documentation provided to Medicaid. The dismissal letter should be addressed to the patient and signed by the PMP. Another PMP, not one in the same group as the original PMP, will be selected for the recipient.

Recipients will be given the opportunity to change the selected PMP before the active assignment date. **The original PMP must continue to provide services or make referrals for services to the recipient until such time the reassignment is complete**. All reassignments will be made effective the 1st of a month.

Dismissal requests should be faxed to Medicaid at (334) 353-3856. Form 450 "Patient 1st Recipient Dismissal Form" can be obtained on the Medicaid website at: http://www.medicaid.alabama.gov/.

PMP Disenrollment

Patient 1st enrollees will be assigned to a different PMP if a PMP dies, moves out of the service area, or loses Medicaid and/or **Patient 1st** provider status. Such reassignment is usually accomplished by automated means. Medicaid sends a notice to the affected recipients, telling them of the reassignment, and the reason for the reassignment. They may then select another PMP if the reassignment is not satisfactory.

PMP Leaves Group Practice

If it is a situation of a PMP leaving the area, then patients will be reassigned to the remaining practitioner or group.

PMP Site Change

If it is a situation of a PMP leaving one site to open another site, the patients will be reassigned to the remaining practitioner.

PMP Closing a Site

If it is a situation of a PMP maintaining two locations within the same geographical area, then the patients from the closed site will be reassigned to the site remaining open. This will apply if the PMP is maintaining a group or clinic site or private practice site.

Referral Process

Coordination of care is an important component of Patient 1st. PMPs are contractually required to either provide services or authorize another provider to treat the enrollee while adhering to the referral process. This applies even when an enrollee has failed to establish a medical record with the PMP. The patient does not have to be seen by the PMP prior to a referral being given.

PMPs may make referrals to any practitioner that can best meet the patient's needs. However, every effort should be made to refer patients to Medicaid enrolled physicians that are geographically accessible to help facilitate the reimbursement process.

In some cases, the PMP may choose to authorize a service retroactively. All referrals, including services authorized retroactively, are at the discretion of the PMP. Some services do not require referral; refer to Section 39.10 of this Chapter for more information.

In addition to Patient 1st PMP referral, prior approval (PA) - may be required to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure recipient eligibility on the date of service. Refer to Chapter 4, **Prior Approval** of the Medicaid Provider Manual for additional information about services requiring PA.

39.7.6 Referral Form

All referrals must be documented on the *Alabama Medicaid Agency Referral Form (Form 362)* or the referral form on www.Efileshare.com. Medicaid requires that the one of these two referral forms be used **for each referral authorization given**.

NOTE:

For information on the Efileshare system, please contact Laura Gilmour, Regional Sales Director at (205) 427-2262 or lgilmour@scisolutions.com. A crosswalk for the Efileshare referral form is available at www.medicaid.alabama.gov under Programs/Patient 1st/Billing Resources for Providers.

Referral authorization from the PMP must be given prior to patient treatment. If given verbally, ** a written referral form, from the PMP to the consultant, must follow within 72-hours of the verbal authorization.

The form can be obtained by accessing Medicaid's website.

39.7.7 Comprehensiveness / Duration of Referral

The comprehensiveness and duration of the referral is determined by the PMP and the other provider. The referral may cover one visit or it may cover multiple visits as long as those visits are part of a plan of care and are medically necessary. A new approval must be provided if the diagnosis, plan of care or treatment changes.

If the consulting physician decides that the recipient must be treated by another consulting physician (or another provider who is not the PMP), the first consulting physician must contact the PMP for approval and authorization to further refer the patient, unless such approval has already been **indicated on the referral form.** The second provider should then use the PMP's approval code when billing. This same procedure should be followed for **any** successive referrals.

Referrals can be for duration of up to 12 months for EPSDT referred services. Referrals from a previous PMP may be honored for a 6 month time frame. The referral number is the PMP's NPI. If the PMP is with a Clinic/ Group, the referral number is the Clinic's/Group's NPI.

39.7.8 EPSDT Screening Referrals

It is not necessary to redo EPSDT screening referrals on the Patient 1st/EPSDT Referral form. If the original screener is not the PMP, then the PMP must either sign on the original Patient 1st EPSDT referral form (anywhere is acceptable) or issue a written **Patient 1st** referral. Please refer to the Appendix A of the Medicaid Provider Manual. In addition, screenings performed prior to enrollment as Patient 1st are acceptable as long the PMP concurs with the findings and treatment plan.

39.7.9 Group/Clinic Practices

Physicians within the same group/clinic and enrolled at Medicaid with a group/clinic number are not required to have referrals among the group/clinic physicians. If a group/clinic physician is covering for another PMP, and a patient requires a referral to a provider outside the group/clinic, then the authorization number of the assigned PMP must be provided to the referred provider and noted in the chart.

39.7.10 Referral for Coverage of Non-Group/Clinic Physicians

When a physician is providing coverage for a PMP (outside of a formal group practice) and services are rendered to an enrollee, the covering physician must provide the PMP with documentation as to the nature of the services rendered and any follow-up required for placement in the patient's medical record. The PMP must provide the covering physician with a referral authorizing such coverage in order to facilitate reimbursement.

39.7.11 Referral for a Second Opinion

Patient 1st PMPs are required to refer an enrollee for a second opinion at the request of the enrollee.

39.7.12 Referrals for Non-Established Patients

The Agency understands that it may be the policy of a PMP not to issue a referral unless the patient is established. We can appreciate the need to know a patient in order to appropriately manage his or her care. However through **Patient 1st,** new patients are continually added—patients which the PMP may not have an established relationship. If a patient who is a new patient or one who has not consulted with the PMP requests a legitimate urgent referral, we suggest that you issue the referral and use this opportunity to schedule a follow-up visit. If the patient refuses to follow-up with a visit to your office at that time, it would be appropriate to refuse further referrals or pursue the option of dismissing the patient if behavior is deemed to be of a non-compliant nature. See “PMP Request Change/Dismissal of Recipient”.

Keep in mind that many of these patients have changed their PMP assignment to the physician to whom they are currently seeing or have been seeing in the past. For one month, the patient may be assigned to you as a PMP. If a referral is necessary during this one month, then it can be documented as a billing referral only.

NOTE:

PMP referral grants access only to service, it does not supersede benefit limits and/or other authorization processes. Please refer to the Appendix E for Patient 1st services that require a referral and services that **do not** require a referral.

39.7.13 Special Authorizations

There are situations in which a PMP may be requested to authorize Medicaid services for a recipient who no longer lives in the service area, who changes eligibility categories and is no longer in a category covered by **Patient 1st** , or who has changed PMPs. Examples for the most common of these situations are given below:

Example 1

The recipient moves outside the PMP's distance criteria and selects another PMP. If the recipient needs medical care and his/her address has not been changed (perhaps in the middle of the month), the provider must contact the PMP for authorization of services.

Example 2

A child is removed from an MLIF case because he/she is now in foster care and eligible for Medicaid under the foster care program. If the child needs medical care during the period that his/her **Patient 1st** still is in effect (usually in the middle of the month), the provider must contact the PMP for authorization of services in the same manner as described above.

39.7.14 Referral for Billing Purposes Only

A PMP may approve a referral for billing purposes only. Such a referral should be documented "for billing purposes only" on the standard billing referral form in the space provided under REFERRAL VALID FOR. The billing procedure for this type of referral is the same as all other referral types.

39.7.15 Billing for Referred Services

If a Patient 1st enrollee goes to any other Medicaid provider for non-emergency services without the referral of the PMP for Patient 1st services, the provider should refer the enrollee back to the PMP or contact the PMP. If the PMP authorizes the services at that time he/she will give the provider his/her NPI for entry on the claim form and Medicaid will pay the claim if the enrollee is eligible and has benefits available. If the Medicaid recipient insists upon receiving the unauthorized service, he/she should be informed that Medicaid will not pay the claim and that the recipient will be responsible for payment of services rendered.

A pharmacist does not have to contact the PMP prior to filling a prescription written by another Medicaid provider, but must enter on the claim form the license number of the prescribing physician.

For complete billing instructions, refer to Chapter 5 of the Medicaid Provider Billing Manual.

39.7.16 Authorization Number

Access to services is authorized through use of the PMP's 10-digit NPI. To facilitate the process, and lessen the administrative burden for the physician, the following procedures are used when processing claims:

Step One (Billing Provider)

The **PMP** NPI on the claim is compared against the **PMP** NPI to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.

The group number of the provider on the claim is compared against the group number on the PMP file. Groups are assigned a group number. If they match, the claim continues through Medicaid edits. 'Informal' groups are not considered to be a group as they cannot be identified systematically.

Step Two (Referring Provider)

The referring **PMP** NPI indicated on the claim is compared against the NPI to whom the recipient is assigned. If they match, the claim continues through Medicaid edits.

The referring **PMP** group number on the claim is matched against the group number on the PMP file. If they match, the claim continues through Medicaid edits.

If the claim is for **Patient 1st** coordinated services and steps one and two do not apply, the claim will be denied with an **EOB** Code of **1820**. An **1820** denial code means 'Recipient enrolled in the **Patient 1st** Program, services require referral from PMP'.

When making referrals, the PMP must provide the 10-digit NPI to be used by the consulting provider. All PMP referrals must be in writing. The PMP may make the referral verbally, but must follow with a written referral to the requesting physician within a 72-hour period of the verbal authorization.

39.7.17 Override Requests

In extenuating circumstances, on a case-by-case basis, and after thorough review, Medicaid may determine that a referral override may be prudent in some situations. Providers must request an override using the **Patient 1st Override Request form** to obtain payment. A copy of the **Patient 1st Override Request form** is in Appendix E of the Medicaid Provider Manual. Override requests must be submitted to the Patient 1st Program by mail within 90 days of the date of service. Requests will be evaluated within 60 days of receipt. Overrides will not be approved for well visits.

NOTE:
All efforts to obtain a referral from the PMP should be exhausted before an Override Request is submitted.

39.8 Complaint / Grievance Process

39.8.1 Filing a Complaint or Grievance

Enrollees can file complaints or grievances through the 1(800) 362-1504 Recipient Call Center or in writing by submitting a Patient 1st Complaint form to the address indicated on the form (a copy of the form is available in Appendix E or from the Agency). Providers can file complaints or grievances through the Recipient Call Center at 1(800) 362-1504 or in writing. Enrollees or Providers may file complaints or grievances about their assigned provider or other aspects of the **Patient 1st** Program system. Medicaid's Managed Care QA Program will thoroughly investigate each complaint or grievance and report the results of its findings back to the enrollee or provider. When appropriate, the enrollee's assigned provider will be notified to document the complaint and obtain necessary correction of problems noted. In especially acute situations, Medicaid may use the special authorization system or various procedure exception systems to resolve the grievance. The enrollee may appeal the action or may request a formal Medicaid hearing. Complaints by other providers or reports by informants are investigated similarly to grievances.

Grievance Log

Medicaid will maintain a log of the grievances received and their disposition. Complaints/Grievances will be "categorized" as a tool by which to assess program impact. Complaints/Grievances usually fall into one of the following five categories:

1. Contract violations/program policy
2. Professional conduct – general
3. Professional conduct – physical, sexual or substance abuse
4. Quality of care
5. Program fraud/abuse

39.9 Detail on Select Services

39.9.1 Benefits

Patient 1st enrollees have the same range scope, amount of services and co-payments as other Medicaid recipients. There are some services that are excluded from the **Patient 1st** program and do not require authorization by the PMP. These are obtained through the same procedure as used by other Medicaid recipients outside the Patient 1st program. It is anticipated; however, that the enrollee will look to the PMP for advice and/or coordination of these services. **Patient 1st** enrollees should be offered the same level of service coordination for non-authorized services as would other patient populations.

The **Patient 1st** Program does not extend or supersede any existing program benefit or program requirement. A matrix of what services **do** and **do not** require referral follows.

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Allergen/Immunotherapy	M	Procedure Codes 95115-95199 (Administration of allergy injections)
Ambulance	M	Ambulance-Ground and Air
CRNA	M	Certified Registered Nurse Anesthetist
Certified Emergency	M O	Any service rendered by a provider resulting from a documented certified emergency (utilize claim block 24- C with an "E" indicator on the CMS -1500 Claim Form; utilize claim block 73 with an "E" indicator on the UB-04 Claim Form.)
Dental	M D O	Dentists & Federally Qualified Health Centers (Claim Type D only), Clinics- Children's Dental/Orthodontia and Orthodontists, Oral, Maxillofacial Surgeons Procedure Codes: D8080 (Comprehensive orthodontia treatment of adolescent dentition), D8680 (Orthodontic retention-removal of appliances, construction/ placement of retainers), D9430 (Office visit for obs services during regular hours) Outpatient facility procedure codes D9420. Note: OP facilities do not require a referral for **DENTAL** procedures.
Dialysis	O	Dialysis Centers
EEG/EKG Related Services	M O	Procedure Codes: 93000-93278 (Routine ECG w/at least 12 leads w/interpretation & report), 95805-95827 (EEG related services)
Early Intervention Services	M	Provider type 63
End Stage Renal Disease	M	Nephrologists Diagnosis Code: 585.6 (End Stage Renal Disease)
EPSDT Developmental Diagnostic Assessment	M	Procedure Codes: 96110 & 96111 (EPSDT Developmental Assessment) **NOTE: Other EPSDT requires referral**
Eye Exams, non-medical	M	Optometrists **Routine Eye Care/Vision exam** Procedure Codes: 92002-92015, 92313 (Corneoscleral lens) **NOTE: Ophthalmological services require referral**
Eyeglass & Other Lens Fittings	M	Procedure Codes: 92340-92355 (Fitting of spectacles), 92310-92312 (Prescription/fitting for contact lens-medical supervision of adaptation)
Eyeglasses/Lens	M	Procedure Codes: V0100-V2799 (CMS Assignment of Vision Services), V2020 (Standard Eyeglasses, Frames), V2025 (Eyeglasses, Special Order Frames, 92315-92317 (Corneal Lens/Corneosclera Lens) 92326 (Replacement of Lens), 92370 (Repair of spectacles)
Factor 8	ANY	Procedure Codes: J7197, J7198, J7199(Anti-Inhibitor Coagulant Complex), J7193, J7194, J7195(Factor IX Complex-Per IU)

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
• FMedical • Outpatient	M 0	**Medical Outpatient:** Family Planning Indicator (Y) – Procedure Codes: 58300-58301 (Insert intrauterine device), 58600 (Ligat/Trans of fallopian tubes), 58605 (Ligat/Trans of fallopian tubes), 58611 (Ligat/Trans of fallopian tubes), 58615 (Ligat/Trans of fallopian tubes), 50610 (Initial visit), Birth control pills, Adolescent pregnancy prevention education, Hormonal IUD, 11976-11981 (Removal, implantable contraceptive capsules/Insertion, non-biodegradable drug delivery implant, 55250 (Vasectomy), 55450 (Ligation: vas deferens), 58670-58671 (Laproscopy), 57170 (Diaphragm fitting), Depo Provera; Diagnosis Codes: V25-V2590 (Contraceptive Management)
Glucose Test Strips/Lancet	M	Procedure Codes: A4253 (Blood Glucose Test/Reagent Strips for Home Blood Glucose per box of 50 - limited to 3 boxes per month), A4259 (Lancets, per box of 100 - limited to 2 boxes per month), A4233, A4234, A4235 and A4236 (Replacement batteries for use with medically necessary Home Blood Glucose Monitor owned by patient.) **NOTE: Requires prior authorization if additional strips and/or lancets are needed.**
Gynecology/Obstetrics	M	OB/GYN-Any service performed by this specialty is exempt from referral requirement. Note: **OP facility** fees for OB/GYN services require a PMP referral unless for Family Planning or Maternity Services as defined herein.
HCBS Services	M	Providers of HCBS waivered services i.e. Elderly & Disabled Waiver-ED, Homebound Waiver-EC, and MR/DD Waiver-EE)
Hearing Aids	M	Hearing Aid Dealers (EPSDT only)
Hospice	O	Hospice
Immunizations	M O	Administrative Fees for Procedure Codes: 90700-90748 (Immunization, Active DTAP for intramuscular use), 90633 (Hepatitis A Vaccine), 90636 (Hepatitis A&B, 3 Dose, Adult), 90645 (HIB Vaccine), 90647-90648 (HIB Vaccine), 90649 (Human Papilloma Virus Vaccine for both male and females ages 9-18), 90655 (Influenza, Preservative-Free), 90656 (Hemophilus Influenza Split Virus), 90657-90658 (HIB Vaccine), 90660 (Influenza Virus Vaccine, Live, Intranasal), 90669 (Pneumococcal Conjugate Vaccine 7 Valent), 90680 (Rotavirus Vaccine), Factor IX Complex, per IU, Rhogham Serum, Pneumovax 23, Pnu-Imune 23, Fluzone, DT Toxoid, Fluzone-Subviron, Recombivax-Hep B, Haemoph B Prohibit, Hepatitis B-Energix B, Antihemophilic Factor
Infant Birth Diagnosis	ANY	Diagnosis Codes: V30-V3911 (Single Liveborn)
Inpatient Consults	M	Procedure Codes: 99251-99263 (Initial inpatient consult), 99360 (Physician Standby), 99436 (Attendance at delivery)
Inpatient Hospital • General • Psychiatric • Physician Hospital Visit	I	Hospital

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Laboratory	M	Independent Labs & Hospitals-(Claim Type OP) - Outpatient Hospital Lab Services-Procedure codes: 36415 (Routine Venipuncture), 36416 (capillary blood specimen), 80048-89399 (Pathology & Lab Organ or Disease Panels); Outpatient Hospital Chemotherapy-procedure codes: 96400-96549 (Chemotherapy Administration)
Long Term Care (LTC) • Intermediate Care Facility-Mentally Retarded (ICF-MR) • Nursing Home	I	Nursing Homes & ICF-MR Facilities
Maternity Care Program	M	Maternity Care Program-Primary Caregiver
Maternity Services	M O	Diagnosis Codes: 640-67699 (Pregnancy-related)
Mental Health Services	M	Mental Health Services **NOTE:** Includes Community Mental Health Centers and other providers with same provider type. PMP notification is required for services rendered.
Newborn Care	M	Procedure Codes: 54150 (Circumcision/clamp), 54160 (Circumcision/surgical), 99440 (Newborn resuscitation), 99431-99436 (History/exam of newborn), 99360 (Physician Standby)
Optometrist/Optician	M	Optometrist/Optician **Routine Eye Care/Vision exam (Glasses/Lens do not require PMP referral)**
Physicians	M	Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians ****All other physicians require referral in any office or outpatient setting.**
Pregnancy-Related Services	M O I	Diagnosis Codes: 640-67699 (Pregnancy-related), V22-V242 (Normal pregnancy-routine postpartum f/u), V27-V289 (Outcome of delivery)
Preventive Education	M	County Health Department, Preventive Ed
Professional Component	M	Modifier 26; Procedure Codes: 93010 (Interpretation/Report of Cardiography), 93237 (Physician review/report), 93300-93399 (Echo)
Radiology	M	Independent Radiologists & Hospitals (Claim Type OP) Outpatient Hospital Radiology-procedure codes: 70010-79999 (Diagnostic Radiology)

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

PATIENT 1ST SERVICES REQUIRING PMP REFERRAL

Service	Claim Type	System Identification
Ambulatory Surgical Center	O	Lithotripsy other than physicians and centers **NOTE:** Includes Ambulatory Surgical Centers and Lithotripsy
Anesthesia	M	Physicians **EXCEPTION:** Anesthesiologists
Audiologists' Services	M	Audiologists (EPSDT ONLY)
Chiropractor Services	M	Chiropractors. (EPSDT or QMB recipients only)
Clinics	M D	Clinics **EXCEPTION:** Children's Dental & Children's Orthodontia (Orthodontist) Procedure Codes: 08080 (Comprehensive orthodontia treatment of adolescent dentition), 08680 (Orthontic retention-removal of appliances, construction/placement of retainers), 09430 (Office visit for obs services during regular hours)
County Health Department	M	**EXCEPTION:** County Health Department/Preventive Education
Durable Medical Equipment	M	Durable Medical Equipment-DME **EXCEPTION:** L8000, L8010, L8020 and L8030.
EPSDT Screenings	M	Procedure Codes: 99381-EP – 99395-EP Initial and Periodic EPSDT Screenings require a PMP referral. Please refer to Appendix A of the Provider Billing Manual.
FQHC Services (Federally Qualified Health Center)	M	FQHCs **EXCEPTION:** Family Planning Indicator (Y)
Home Health	O	Home Health Providers **NOTE:** Inpatient services do not require a referral, however, discharge planning of outpatient services (i.e. home health, DME, specialist visits) **do require** a PMP referral.
Independent Nurse	M	Independent Nurses
Nephrology	M	**EXCEPTION:** Nephrologists-Diagnosis Code: 585 (End Stage Renal Disease (ESRD))
Optometrist/Optician Svcs /Ophthalmologists	M	Optometrists/Opticians/Ophthalmologists), for medical diagnosis.
Outpatient Hospital Services	M O	Hospitals-Procedure Codes: 99281-99285, outpatient surgical procedures and therapies (PT, ST and OT), observation beds and non-certified emergencies. **EXCEPTION:** Outpatient Hospital Radiology (procedure codes: 70010-79999); Outpatient Hospital Lab Services (procedure codes: 36415, 80048-89399); Outpatient Hospital Chemotherapy (procedure codes: 96400-96549) Outpatient facility procedure code D9420. Outpatient facilities do not require a referral for DENTAL procedures.
Physicians	M	Physicians-any billing by physicians unless the particular provider type or service is excluded **EXCEPTION:** Anesthesiologists, Oral & Maxillofacial Surgeons, Pathologists, Radiologists/Diagnostic, Nuclear Medicine Physicians
Podiatrists' Services	M	Podiatrists (EPSDT and QMB only)
Private Duty Nurse	O	Private Duty Nurses (EPSDT only)
Psychologists' Services	M	Psychologists (EPSDT only)
Rural Health Clinics	M	Rural Health Clinics
Therapists' Services	M	Physical Therapists, Occupational Therapists and Speech Therapists. Outpatient therapy services must be a result of an EPSDT or for QMB recipients.

M=Medical (CMS 1500) I=Inpatient O=Outpatient D=Dental

39.9.2 Emergency Services

Access to certified emergency services will not be restricted by the **Patient 1st** Program. Certified emergencies in outpatient emergency room settings do not require referral or prior authorization by the PMP. However, documentation should be maintained by the provider of service to support emergency certification.

39.9.3 Certified Emergency Services

A certified emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

The attending physician is the only one who can certify an emergency visit. In determining whether a claim should be submitted and documented as a certified emergency, consider the following guidelines:

The case should be handled on a situational basis. Take into consideration the person presenting, their medical background, extenuating circumstances, presenting symptoms, time of day, and availability of primary care (e.g., weekend, night or holiday.)

Determine whether the presenting symptoms as reported would be reasonably expected to cause the patient to expect a lack of medical attention could result in an unfavorable outcome.

Document why this case is a certified emergency. Documentation does not need to be extensive but should justify the certification.

If not an emergency, **do not certify** the visit. Note that follow-up care should not be certified as an emergency (i.e. physical therapy, suture removal, rechecks, etc.)

Ancillary or billing staff is not permitted to certify. Certification must be done by the attending physician.

Children or adults brought to the ER for exam due to suspected abuse or neglect may be certified by virtue of the extenuating circumstances.

Hospitals and physicians who provide "certified emergency" services in the Emergency Room (ER) are not required to have a referral from the PMP. Please note that follow-up care should not be certified as an emergency and in some cases may require PMP referral (i.e. physical therapy, suture removal, rechecks, etc.).

In order for the claim not to require a Patient 1st referral, there must be an "E" indicator in the appropriate claim block. Refer to the Chapter Five of the Billing Manual for further instructions.

Providers should bill certified emergency services separately from those of non-certified emergency services, which require PMP referral.

The Agency stresses the importance of coordinating with the PMPs regarding the care of Medicaid recipients in order to preserve the continuity of care and the "medical home" concept of the Patient 1st program.

39.9.4 EPSDT Services

For recipients of Medicaid, birth to age 21, the EPSDT Screening is a comprehensive preventive service at an age appropriate recommended schedule. It is the only reimbursable preventive medical service for this age group. There are numerous components of the EPSDT, all of which are required in the Federal Early Periodic Screening Diagnosis Treatment (EPSDT) program. All age appropriate components must be performed at the time of a screening exam. These components are listed and described in Appendix A of the Alabama Medicaid Provider Manual.

PMP's are requested to either perform or make arrangements for EPSDT screenings. The PMP is responsible for ensuring that age appropriate EPSDT screenings are provided. If a PMP cannot or chooses not to perform the comprehensive EPSDT screenings, the PMP may authorize another provider to perform the screenings for enrollees in the birth to 21 year age group.

If the PMP enters into an agreement with a screener in order to meet this Patient 1st requirement for participation, the agreement containing the original signatures of the PMP or the authorized representative and the screener or an authorized representative must be submitted within the enrollment application. The PMP must keep a copy of this agreement on file. If this agreement is executed after enrollment a copy must be submitted within ten (10) days of execution.

The agreement can be entered into or terminated at any time by the PMP or the screener. The Agency and HP must be notified immediately of any change in the status of the agreement.

If there is an agreement between the PMP and a Screener to provide EPSDT services, the PMP agrees to:

- Refer Patient 1st patients for EPSDT screenings. If the patient is in the office, the physician/office staff will assist the patient in making a screening appointment with the Screener within ten (10) days.
- Maintain, in the office, a copy of the physical examination and immunization records as part of the patient's permanent record.
- Monitor the information provided by the Screener to assure that children in the Patient 1st program are receiving immunizations as scheduled and counsel patients appropriately if found in noncompliance with well child visits or immunizations.
- Review information provided by the Screener to coordinate any necessary treatment and/or follow-up care with patients as determined by the screening.
- Notify the Agency and HP immediately of any changes to this agreement.

The Screener must agree to:

- Provide age appropriate EPSDT examinations and immunizations within sixty (60) days of the request for patients who are referred by the PMP or are self-referred.
- Send EPSDT physical examination and immunization records within 30 days to the PMP.

- Notify the PMP of significant findings on the EPSDT examination or the need for immediate follow-up care within 24 hours. Allow the PMP to direct further referrals for specialized testing or treatment.
- Notify the Agency and HP immediately of any changes to this agreement.

Immunizations

Immunizations do not require PMP referral; however, the PMP must maintain documentation of immunizations received. Documentation must include: the date the immunization was given, the type of immunization, and who provided the immunization. PMPs are required to ensure that immunizations are up-to-date for children in their panel.

Providers should be aware that through **Patient 1st** new patients will be assigned, many of which, will be children. These children will be looking to the PMP for immunizations and/or documentation of immunizations, especially in the months prior to school starting. PMPs should be prepared to immunize these children or make arrangements to get appropriate information from the immunizing provider to meet the school rush**. ALL PMPs SHOULD MAKE EVERY EFFORT TO WORK WITH OTHER PROVIDERS IN THE COMMUNITY TO ENSURE THAT ALL CHILDREN ARE FULLY AND APPROPRIATELY IMMUNIZED**.

EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal of these services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

Care coordination services are available for eligible children from birth through 20 years of age at no cost to any provider who wishes to utilize them. The Agency, along with the Department of Public Health, identifies children at greatest risk who have potential for effective intervention. These Medicaid eligible recipients are targeted for outreach.

The scope of services is designed to support the physician's office personnel in identifying, contacting, coordinating services and providing office visit follow-up for children. Areas targeted include:

- Under utilization of EPSDT and immunization services,
- Vision/Hearing Screenings, including Newborn hearing screening follow-up,
- Dental Screenings,
- High utilization of Emergency Room visits,
- Elevated Blood Lead levels,
- Abnormal Sickle Cell and Metabolic Screening results,
- Referral follow-up,
- Missed appointment follow-up
- Outreach for At Risk children, and
- Teen Pregnancy Prevention Services coordination.

In addition, care coordinators are available to assist with transportation services. Care coordinators may receive referrals from physicians and dentists regarding Medically-at-Risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, care coordinators will encourage and assist in recruiting private physicians to improve services to this population.

EPSDT care coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select “Programs”, then select “EPSDT”. A list of EPSDT care coordinators by county and telephone numbers is available to support your office personnel.

39.10 Program Enhancements

Deleted: ~~**Disease Management** section~~

The following enhancements are designed to help the PMP achieve the overall program goal of establishing a medical home for our recipients that is accountable and cost-effective.

Added: **In Home Monitoring Program** section

39.10.1 In Home Monitoring Program

The In Home Monitoring Program is a collaborative program between the Alabama Medicaid Agency; Alabama Department of Public Health (ADPH); and the University of South Alabama, Center for Strategic Health Innovation (USACSHI). Patients with a diagnosis of Congestive Heart Failure, Diabetes, or Hypertension are eligible for enrollment in this in-home monitoring program. The goal of the program is to decrease exacerbation episodes, emergent care visits, hospital admissions and medical costs.

Referrals for In Home Monitoring may be accepted from any source, including physicians, Patient 1st Care Coordinators, Patient Care Networks, patient or caregiver, the Health Department, hospitals, home health agencies, or community based organizations. Orders for In Home Monitoring along with the specific parameters for daily monitoring must be obtained from the patient’s PMP prior to evaluation and admission.

An ADPH Nurse Care Manager evaluates the patient, provides any needed equipment including a scale, glucometer, blood pressure cuff, and phone with a speaker. The patient data is transmitted through an automated phone system, which may be accessed through a landline or cell phone. The data is sent to a secure, web-based data collection and documentation system developed by USACSHI named the Real-Time Medical Electronic Date Exchange (RMEDE), which is monitored by the ADPH Nurse Care Managers on a daily basis.

Alerts are generated to the ADPH Nurse Care Manager when a patient’s data reports are outside their specific parameters. The Primary Medical Provider or ADPH Nurse Care Manager will follow-up with the patient and determine what services are needed.

In addition to the alert feature, the RMEDE system will generate valuable patient data reports monthly for each PMP participating in the In Home Monitoring Program. Summary data will also be provided to Medicaid for monitoring the program.

To refer a patient to the In Home Monitoring Program, contact the local Alabama Department of Public Health Home Health Agency, or call the ADPH Home Health State Office at 1-800-225-9770.

Added: To refer a…equals one unit

Enrollment: ADPH is enrolled with provider type 05 (home health) and provider specialty 970 (disease management).

ADPH Billing Instructions: ADPH bills on a UB-04 claim form using the following codes:

- Revenue Code: 789
- Procedure Code: G9008-U4 (ADPH Nurse Case Management)

Billing Units: 5 minutes equals one unit

39.10.2 Patient Intervention (Case Management)

In addition to the technology that will be available through the biomonitoring box, the Agency will be partnering with the Alabama Department of Public Health to provide patient intervention services. These services will be provided through social workers and will target patients who are identified as non-discriminate users of the emergency room, identified by PMPs as needing educational reinforcement and/or may have a disease state that requires extra monitoring. It is the intention that referrals will be made by the Agency as well as the PMP. These type services will be available statewide and reimbursed fee for service.

39.11 Quality Assurance Activities

Quality assurance activities and program monitoring will be the responsibility of the Medicaid Managed Care Quality Assurance Program and the Patient 1st Program. Monitoring efforts will look at all facets of the program including measuring the PMP against established program goals, determining contract compliance and focusing in on program outcomes all of which involve both administrative and performance measures.

The Profile Report (Profiler) will be the central source of data for program reporting and measurement. This report is based on claims information and one is produced for each PMP. The data in the report is collected from paid claims and is processed to produce characterizations of providers, their enrollee panel and provides comparisons of providers within a peer group.

The Profiler will have three primary components:

- Individual report cards sent to each PMP to provide activity information and program measurements

- A summary report on all providers for use by the Agency. The summary information will be used to monitor the program and identify program outliers.

- Detail reports will identify program areas that need follow-up.

Program over-site activities involve monitoring both administrative measures and performance measures.

Administrative measures are collected using focused reviews and are not primarily dependent on paid claims data. These measurements focus on:

- **24/7 Medical Coverage**

  Ensures PMPs are meeting the requirement for providing after hours coverage to enrollees.

- **Referral Report**

  Monitors PMP's referral numbers to ensure appropriate usage by other providers.

- **PMP Patient Disenrollments**

  Ensures PMPs are not selectively dismissing patients so that performance measures can be met.

- **HP Enrollment Process**

  Ensures patients are linked to the most appropriate caregiver based on patient choice, family linkage and/or historical patterns of care. This will be aimed at internal processes.

- **Complaints and Grievances**

  Ensures patients and providers have a consistent mechanism to express concerns and dissatisfaction with the Patient 1st Program or services provided through the program.

- **Recipient Targeted Survey (REOMBS)**

  Monitors the enrollee's health care experience in order to improve the Patient 1st Program and identify potential problems.

- **Cost Monitoring**

  Costs will be reviewed quarterly to ensure budget neutrality requirements are being met, to track overall costs per recipient and to track costs/savings.

Performance measures are primarily claims driven and focus on:

- **Generic Dispensing Rate**

  The percentage of generic prescriptions ordered for the Primary Medical Provider's (PMP) panel. This percentage will be compared to the performance of their peer group and risk adjusted.

- **Visits Per Unique Enrollee**

  Average number of visits per recipient seen by the PMP. The PMP's expected visit rate will be computed by weighting the performance of the PMP's peer group. The measure will compare the PMP's actual visit rate with their expected visit rate.

- **Number of Emergency Room Visits**

Will identify PMP's that are not providing care to recipients for which they are receiving a case management fee but who's members are instead seeking care in the emergency room. This information may be used by the Agency to reassess the PMP's continued participation in the Patient 1st Program.

- **Number of Hospital days per 1000 patients**

  Will identify effective management of recipients by the PMP outside the hospital setting, especially those with chronic conditions. This is expected to result in improved patient outcomes and Agency savings.

- **Percent of Asthma patients with one or more ER visits with the primary diagnosis of Asthma**

  This is a quality measure aligning Patient 1st with established "Together for Quality" (TFQ) measures. It will identify providers who are effectively managing recipients with Asthma.

- **Percent of Diabetic patients who have had at least one HbA1c test during review period**

  This is a quality measure aligning Patient 1st with established "Together for Quality" (TFQ) measures. It will identify providers who are effectively managing recipients with Diabetes.

- **Age appropriate EPSDT screenings for 0-5 year old population**

  This will identify providers who are performing age appropriate EPSDT screenings. This reinforces early treatment and prevention while reinforcing the medical home concept.

The Agency must ensure all requirements of the Centers for Medicare and Medicaid Services (CMS) are met; therefore the above list of measures is not inclusive and may be modified.

39.12 Obtaining Forms / Educational Materials

Patient 1st forms may be obtained by accessing the Medicaid website.

NOTE:
Educational materials are also available for use by providers and may be obtained using the online ordering form on the Agency's website at www.medicaid.alabama.gov. A catalog listing these materials is also on the website.

Some materials available for download from the website include:

"Your Guide to Alabama Medicaid". This 36 page booklet describes the services covered, co-payments, the different types of eligibility, patient responsibilities, as well as other useful information.

"Alabama Medicaid Covered Services and Co-Payments" (English or Spanish). Describes services covered by Medicaid and associated co-payments.

"EPSDT Brochure". This is a colorful pamphlet that encourages Well-Child checkups and outlines the periodicity schedule.

"Are you expecting a baby?" This full colored brochure lets pregnant women enrolled in Medicaid know who to contact for prenatal care in their county of residence.

39.12.1 Medicaid Forms

The following forms can be found in Appendix E and/or on the Medicaid website www.medicaid.alabama.gov under Programs/Patient 1st:

Immunization Record
Alabama Medicaid Agency Referral Forms
EPSDT Documentation
Complaint/Grievance Form
PMP Change Form
Newborn PMP Request Form
Request For Educational Material
Patient 1st Override Form
Patient 1st Medical Exemption Form
Patient 1st Recipient Dismissal Form

39.13 Patient 1st Billing Instructions

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing.

39.14 Contact Information Summary

For general Patient 1st billing questions or to request an application package call the Provider Assistance Center: 1 (800) 688-7989

To increase the maximum number of enrollees within a caseload the request may be faxed to HP Provider Enrollment: (334) 215-4298 or mailed to HP Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To change distance criteria or disenroll from the program the request may be faxed to HP Provider Enrollment: (334) 215-4298 or mailed to HP Provider Enrollment, PO Box 241685, Montgomery, AL 36124

To obtain recipient information on eligibility, benefit limits, or coverage call the Provider Assistance Center: 1 (800) 688-7989

Automated Voice Response System: 1 (800) 727-7848

To address program and policy questions, for individual or specific recipient additions or deletions, for recipient language interpretation services or to report patients enrolled in Patient 1st who should not be enrolled call the Recipient Call Center: 1(800) 362-1504

Patient 1st forms may be requested on Medicaid's website at www.medicaid.alabama.gov.

Newborn assignment forms may be faxed to HP at (334) 215-4140.

Patient dismissal requests may be faxed to Medicaid at (334) 353-3856.

For written correspondence to the Agency: Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624

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100 Children's Specialty Clinics

Children's Specialty Clinic Services are specialty-oriented services provided by an interdisciplinary team to children who are eligible for EPSDT services and who experience developmental problems. Children's Specialty Clinic Services include preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided in a clinic setting that is not part of a hospital, but is operated to provide medical care on an outpatient basis to children with special health care needs.

Clinic services include the following outpatient services:

- Services furnished at the clinic by or under the direction of a physician or dentist
- Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address

Clinics include:

Arthritis
Augmentative Communication
Behavior Assessment
Biochemical Genetics
Cerebral Palsy
Child Development
Cleft Palate
Cystic Fibrosis
Dentistry
Eye
Feeding (OT)
Genetics
Hearing
Hearing Aid
Hearing Assessment
Hemophilia
Limb Deficiency
Multiple Disabilities
Neurology
Neuromotor
Neurosurgery
Orthopedic
Pediatric Communication
Pediatric Evaluation
Pediatric Orthopedic
Pediatric Surgery
Psycho-education
Scoliosis
Seating, Positioning & Mobility
Seizure
Speech Pathology
Spina Bifida
Teen Transition
Urology

Eligible persons may receive Children's Specialty Clinic Services through providers who contract with Medicaid to provide services to children eligible for EPSDT services.

The policy provisions for clinic providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 61.

100.1 Enrollment

HP enrolls children's specialty clinics and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code,* and the *Alabama Medicaid Provider Manual.*

In order to meet federal enrollment criteria, all Children's Rehabilitation Services providers must have a NPI with ADRS/CRS identified as payee. Sparks Rehab Center shall submit claims for clinic services to Medicaid under the physician's clinic NPI or (if no physician is present) under the clinic NPI.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a clinic is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for clinic-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Clinics are assigned a provider type of 57(Clinics). Valid specialties for clinics include the following:

- Children's Rehabilitation Service (015)
- EPSDT (560)
- Hemophilia (990)
- Orthodontia (273)
- Radiology Clinics (995)
- Sparks Rehab Center (850)
- Optometry (180)
- United Cerebral Palsy (UCP) (840)

NOTE:

Physicians affiliated with children's specialty clinics are enrolled with their own NPI, which links them to the clinic. The provider type for the physician is 57 (Clinics). The valid specialties are any of those specialties valid for physicians. Please refer to Chapter 28, Physician, for a listing of valid specialties.

All other personnel affiliated with the children's specialty clinic, such as physician assistants or nurse practitioners, bill using the clinic's NPI, and are not assigned individual NPIs.

Enrollment Policy for Children's Specialty Clinics

Providers are clinics organized apart from any hospital that operate to provide specialty care through an interdisciplinary team approach.

Clinics must meet recognized standards of care for children with special health care needs and provide services in their clinics for the following disciplines, at a minimum:

- Specialty physicians
- Nurses
- Social workers/service coordinators
- Physical therapists/Occupational therapists
- Audiologists
- Nutritionists
- Speech/language pathologists

All providers serving children must meet state and federal criteria for participation in the Medicaid program.

100.2 Benefits and Limitations

All Children's Specialty Clinic Services must be furnished by or under the direction of a physician directly affiliated with the clinic. "Under the direction of" means the physician must see the patient at least once, prescribe the type of care, and periodically (at least annually, unless the scope of services requires more frequent review) review the need for continued care.

Providers must develop a patient care plan that provides medical and rehabilitative services as well as coordination and support services to children with special health care needs.

Case management/service coordination is an integral part of ADRS/CRS clinic activities. Case managers/service coordinators provide services such as assessment, care plan development, linking/coordination of services, and parent counseling, parent and child education, and follow-up. Types of services provided include assisting the family with surgery/hospital arrangements, scheduling and coordinating appointments for evaluation and treatment, referral to appropriate resources as needed, home visits, school visits, patient and parent counseling/anticipatory guidance, and patient support. Individual case managers must meet the following criteria at a minimum: a four-year college degree or a registered nurse, and all case managers/service coordinators must receive training appropriate to the need of the target population.

Children’s Specialty Clinic Teams

The clinic teams are usually comprised of physicians, registered nurses, social workers, therapists, audiologists, and rehabilitation assistants, clerical and/or support personnel. Clinic composition may vary depending on the type of clinic; however, clinic team protocol must be furnished to and approved by Medicaid. Clinic team protocol will be updated on an as-needed basis, but annually at a minimum. The team will establish a written patient care plan. The case management team then implements this plan.

100.2.1 Covered Services

Children's Specialty Clinic Services do not include services rendered under other Medicaid programs.

Children's Specialty Clinic Services are covered when provided by a Medicaid-enrolled children's specialty clinic provider.

Types of covered services provided in clinics include:

- Diagnosis of medical condition
- Completion of durable medical equipment assessments
- Development of a patient care plan
- Therapy (physical, speech/language, occupational)
- Patient/parent education
- Audiology services
- Physician services
- Psychological services
- Multidisciplinary evaluations
- Orthotic services
- Prosthetic services
- Optometrical services
- Dental services
- Nutrition services
- Prescriptions for services or medications
- Nursing and social work services
- Case management
- Hearing aid services
- Vision services

For details of dental services covered in children’s specialty clinics see Rule No. 560-X-15.06 (3) of the *Alabama Medicaid Administrative Code.*

A patient care plan is required for each child and a service coordinator is responsible for arranging specialty and needed social services for the family.

100.2.2 Reimbursement

Children's Specialty Clinics will be reimbursed by an encounter rate. For more information regarding reimbursement for governmental providers, please refer to the “Children’s Specialty Clinic Services Reimbursement Manual.”

Governmental providers of Children's Specialty Clinic Services will be reimbursed by an encounter rate based on reasonable allowable cost, as defined by OMB Circular A-87, established by the Medicaid Agency based on completion of the required cost report documentation.

Non-governmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.

Claims may be submitted for reimbursement for only one clinic visit per date of service per recipient, except in the case of dental visits. A dental encounter may be billed in conjunction with only one other clinic visit for the same date of service for the same recipient.

NOTE:

Procedure code D8080 is limited to once per year with prior authorization.

Procedure code D8680 is limited to once every two years with prior authorization.

Procedure code D9310 is limited to once per recipient per lifetime with prior authorization.

100.2.3 Encounters

Covered encounters are face-to-face clinic contacts during which a health professional team provides medical services to a patient. They are identified based on the data from clinic sign-in sheets and the individual medical records.

The definition of a health professional depends upon the type of clinic. To be counted as a physician encounter, the highest level health professional must be a physician.

Examples of physician encounters include the following types of visits, all of which are attended by a physician:

- Arthritis
- Cerebral palsy
- Cleft palate
- Clubfoot
- Craniofacial
- Cystic fibrosis
- Eye
- Genetics
- Hearing
- Hemophilia
- Limb Deficiency
- Multi-specialty
- Neurology
- Neuromotor
- Neurosurgical
- Orthopedic
- Pediatric Evaluation
- Pediatric surgery
- Scoliosis
- Seizure
- Spina bifida
- Teen Transition
- Urology clinics

To be counted as a non-physician encounter, the health professional(s) must be qualified to perform the service, and although a physician is not present, the service must be provided under the direction of a physician. Examples of non-physician clinics include augmentative communication, feeding (OT), hearing aid orientation/maintenance, infant/toddler functional evaluation, and seating.

Multiple contacts with the same health professional(s) that take place on the same day at a single location constitute a single encounter. Services incident to an encounter, or subsequent to the clinic encounter, such as social

services, case management, nursing, writing of prescriptions, clerical, therapy, and pre-certification evaluations are inclusive in the encounter and should not be billed separately.

For example, if a client comes to the limb deficiency clinic, the minimum staffing standards must be met in order for the contact to be counted as an encounter. In this case, the orthopedist, physical therapist, and social worker must be present. Their face-to-face contact with the client constitutes an encounter. Subsequent visits for purposes of physical therapy only by the therapist do not constitute an encounter since these costs are included in the encounter rate that is billed only when the minimum staffing standards for a clinic are met.

100.2.4 Maintenance of Records

The provider must make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider will permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. The provider maintains complete and accurate fiscal records that fully disclose the extent and cost of services.

The provider maintains documentation of Medicaid clients' signatures. These signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the clients' signatures and dates of service.

The provider maintains all records for a period of at least three years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three-year period, the provider retains the records until the legal action is resolved. The provider must keep records in a format that facilitates the establishment of a complete audit trail in the event the items are audited.

100.3 Prior Authorization and Referral Requirements

Clinic procedure codes generally do not require prior authorization; however, **orthodontia services always require prior authorization**. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

100.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Children's Specialty Clinics.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

100.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Children's specialty clinics that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Online adjustment functions

- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

100.5.1 Time Limit for Filing Claims

Medicaid requires all claims for clinics to be filed within one year from the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

100.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

100.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes have been approved for billing by children's specialty clinics.

Clinic Services

Procedure Code	***Who Can Bill***	***Description***
99203-HT	CRS	Neurology, Neuromotor, Cerebral Palsy, Cleft Palate, Hemophilia, Limb Deficiency, Pediatric Assessment,Pediatric Orthopedic Specialty, Seizure, and Spina Bifida.
99204-HT	CRS	(New Patients) Arthritis, Genetics, and Limb Deficiency.
99213-HT	CRS	Regular Clinic, which includes Neurology, Limb Deficiency, Pediatric Assessment, Pediatric Orthopedic Specialty Clinic, Cleft Palate Clinic, Cerebral Palsy, Hemophilia, Seizure, Spina Bifida, and Neuromotor Clinic
99214-HT	CRS, Sparks	Specialty Clinic, which includes Pediatric Communication Clinic,-Cystic Fibrosis Clinic, and Genetics Clinic
99205-HT	CRS, Sparks	Interdisciplinary Team Clinic (new patient) – limited to only once per physician per recipient lifetime Cystic Fibrosis Clinic, and Pediatric Evaluation.
99215-HT	CRS, Sparks	Interdisciplinary Team Clinic (established patient) – repeat clinic visits Interdisciplinary Team Clinics include Augmentative Communication Technology Evaluation, Behavior Assessment Clinic, Biochemical Genetics Clinic, Cystic Fibrosis Clinic, Feeding Clinic, Seating Clinic, Pediatric Evaluation, and Teen Transition Clinic.

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
ARTHRITIS CLINIC 99212-HT	*RHEUMATOLOGIST or IMMUNOLOGIST Ophthalmologist Orthopedist	*NURSE (BSN) *PHYSICAL THERAPIST Occupational Therapist Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
AUGMENTATIVE COMMUNICATION/ TECHNOLOGY CLINIC Evaluation 99215-HT	Under the direction of a physician	*SPEECH/LANGUAGE PATHOLOGIST (CCC/SLP) *PHYSICAL THERAPIST *OCCUPATIONAL THERAPIST *REHABILIATION TECHNOLOGY SPECIALIST	*LICENSED SOCIAL WORKER Vocational Rehabilitation Counselor Secretary

*Denotes minimum staffing standards

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
CEREBRAL PALSY CLINIC 99212-HT Also known as NEURO-ORTHO CLINIC	*ORTHOPEDIST or PEDIATRIC NEUROLOGIST or NEUROLOGIST or PEDIATRICIAN or PHYSICAL MEDICINE	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist Speech/Language Pathologist (CCC/SLP)	*LICENSED SOCIAL WORKER Secretary
CLEFT PALATE CLINIC 99212-HT	*PLASTIC SURGEON *ORTHODONTIST or DENTIST Pediatrician Geneticist Prosthodontist Otolaryngologist Oral Surgeon	*NURSE (BSN) *AUDIOLOGIST *SPEECH/ LANGUAGE PATHOLOGIST (CCC/SLP) *REGISTERED DIETITIAN Genetics Counselor/RN	*LICENSED SOCIAL WORKER Mental Health Counselor Secretary
CYSTIC FIBROSIS CLINIC 99214-HT 99205-HT or 99215-HT	*PULMONOLOGIST Allergist/Immunologist Gastroenterologist	*NURSE (BSN) *REGISTERED DIETITIAN Respiratory Therapist Pharmacist Audiologist	*LICENSED SOCIAL WORKER Secretary
EYE CLINIC 99212-HT	*OPHTHALOMOLOGIST or OPTOMETRIST	*NURSE (BSN) Optician Ophthalmic Technician	*LICENSED SOCIAL WORKER Secretary
FEEDING CLINIC 99215-HT	Under the direction of a physician	*REGISTERED DIETITIAN *OCCUPATIONAL THERAPIST *SPEECH/ LANGUAGE PATHOLOGIST (CCC/SLP) *NURSE (BSN)	*LICENSED SOCIAL WORKER Secretary
GENETICS CLINIC 99204-HT or 99214-HT	*GENETICIST	*NURSE (BSN) *GENETICS NURSE/ COUNSELOR Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
HEARING CLINIC 99212-HT	*OTOLARYNGOLOGIST	*AUDIOLOGIST *NURSE (BSN) Speech/language Pathologist (CCC/SLP) Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
HEARING AID CLINIC and Maintenance Evaluation 99215-HT	Under the direction of a physician	*AUDIOLOGIST Nurse (BSN)	Licensed Social Worker Secretary

*Denotes minimum staffing standards

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
HEARING ASSESSMENT CLINIC 99215-HT	Under the direction of a physician	*AUDIOLOGIST Nurse (BSN)	Licensed Social Worker Secretary
HEMOPHILIA CLINIC 99203-HT or 99213-HT	*HEMATOLOGIST Orthopedist Dentist	*NURSE (BSN) *PHYSICAL THERAPIST Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
LIMB DEFICIENCY CLINIC 99213-HT or 99203-HT or 99204-HT	*PEDIATRIC ORTHOPEDIC SURGEON and/or PHYSICIAL MEDICINE & REHABILITATION PHYSICIAN	*PHYSICAL THERAPIST *PROSTHETIST Occupational Therapist Nurse (BSN)	*LICENSED SOCIAL WORKER Secretary
NEUROLOGY CLINIC Also known as PEDIATRIC ASSESSMENT PEDIATRIC NEUROLOGY 99203-HT or 99213-HT	*NEUROLOGIST	*NURSE (BSN) *REGISTERED DIETITIAN Physical Therapist Occupational Therapist Speech/language Pathologist (CCC/SLP)	*LICENSED SOCIAL WORKER Secretary
NEUROMOTOR CLINIC 99212-HT or 99203 or 99213	*PHYSICAL MEDICINE Neurosurgeon Orthopedist Urologist	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist Neuro-psychologist Speech/language Pathologist (CCC/SLP)	*LICENSED SOCIAL WORKER Recreational Therapist Secretary
NEUROSURGERY CLINIC 99212-HT	*NEUROSURGEON	*NURSE (BSN) Physical Therapist (on call) Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
ORTHOPEDIC CLINIC 99212-HT	*ORTHOPEDIST	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist Speech/language Pathologist DME Vendor Orthotist	*LICENSED SOCIAL WORKER Secretary
PEDIATRIC EVALUATION CLINIC	*DEVELOPMENTAL PEDIATRICIAN	*NURSE (BSN) *PHYSICAL THERAPIST	*LICENSED SOCIAL WORKER Secretary

CRS CLINIC TEAMS

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
99205-HT or 99215-HT		Registered Dietician Occupational Therapist Speech/Language Pathologist	
PEDIATRIC ORTHOPEDIC SPECIALTY CLINIC 99203-HT or 99213-HT	*PEDIATRIC ORTHOPEDIST	*NURSE (BSN) *PHYSICAL THERAPIST Registered Dietitian Occupational Therapist Speech/Language Pathologist DME Vendor Orthotist	*LICENSED SOCIAL WORKER Secretary
PEDIATRIC SURGERY CLINIC 99212-HT	*SURGEON	*NURSE (BSN) *REGISTERED DIETITIAN	*LICENSED SOCIAL WORKER Secretary
SCOLIOSIS CLINIC 99212-HT	*ORTHOPEDIST	*NURSE (BSN) *PHYSICAL THERAPIST Registered Dietitian	*LICENSED SOCIAL WORKER Secretary
SEATING, POSITIONING & MOBILITY CLINIC 99215-HT	Under the direction of a physician	*PHYSICAL OR OCCUPATIONAL THERAPIST	*DME SPECIALIST Licensed Social Worker Secretary
SEIZURE CLINIC 99203-HT or 99213-HT	*NEUROLOGIST	*NURSE (BSN) *REGISTERED DIETITIAN Pharmacist	*LICENSED SOCIAL WORKER Secretary
SPEECH PATHOLOGY CLINIC 99203-HT or 99213-HT	Under the direction of a physician	*SPEECH/LANGUAGE PATHOLOGIST Audiologist	Licensed Social Worker Administrative Support Assistant
SPINA BIFIDA CLINIC 99212-HT Also known as: MULTI-SPECIALTY CLINIC	*ORTHOPEDIST or NEUROSURGEON or UROLOGIST	*NURSE (BSN) *PHYSICAL THERAPIST *REGISTERED DIETITIAN Occupational Therapist	*LICENSED SOCIAL WORKER Secretary

*Denotes minimum staffing standards

CRS CLINIC TEAMS

Added: ONE OR MORE…on diagnosis/need)

SPECIALTY CLINIC	MEDICAL STAFF	PARA-MEDICAL STAFF	SOCIAL and ADMINISTRATIVE STAFF
TEEN TRANSITION CLINIC 99215-HT	*PHYSICAL MEDICINE or ADOLESCENT MEDICINE SPECIALIST or PEDIATRICIAN	ONE OR MORE OF THE FOLLOWING (optional): NURSE, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, AUDIOLOGIST, NUTRITIONIST, SPEECH-LANGUAGE PATHOLOGIST or YOUTH CONSULTANT/ADVOCATE (based on diagnosis/need)	*TWO OF THE FOLLOWING: REHABILITATION TECHNOLOGY SPECIALIST or VOCATIONAL ASSESSMENT SPECIALIST or INDEPENDENT LIVING SPECIALIST *LICENSED SOCIAL WORKER Vocational Rehabilitation Counselor Recreational Therapist Secretary
UROLOGY CLINIC 99212-HT	*UROLOGIST	*NURSE (BSN) Registered Dietitian	*LICENSED SOCIAL WORKER Secretary

*Denotes minimum staffing standards

NOTE:
Claims for Radiology codes 70010 – 79999 must be filed separately from claims for all other services.

Non-Clinic Services

Children's Specialty Clinics also provide, or arrange provision of, non-clinic services. The following procedure codes shall be utilized and will be reimbursed on a fee-for-service basis.

Procedure Code	*Who Can Bill*	*Description*
70010-79999	CRS	Radiology
J7188 J7189 J7190 J7191 J7192	CRS	Injection, Von Willebrand factor complex, per i.u. Factor ViiA, per 1mcg. Factor viii (antihemophilic factor, human), per i.u. Factor viii (antihemophilic factor, porcine), per i.u. Factor viii (antihemophilic factor, recombinant), per i.u.
J7197 J7198 J7199	CRS	Antithrombin iii (human), per i.u. Anti-inhibitor, per i.u. Hemophilia clotting factor, not otherwise classified
J7193 J7194 J7195	CRS	Factor ix (antihemophilic factor, purified, non-recombinant) Factor ix, complex, per i.u. Factor ix (antihemophilic factor, recombinant), per i.u.
D8080	CRS	Comprehensive Orthodontic Treatment of the Adolescent Dentition (requires prior authorization)
D8680	CRS	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s)) (requires prior authorization)
D9310	CRS	Consultation
L3650	CRS	Shoulder orthosis (SO), figure of "8" design abduction restrainer
L3660	CRS	SO, figure of "8" design abduction restrainer, canvas and webbing
L3670	CRS	SO, acromio/clavicular (canvas and webbing type)
L3700	CRS	Elbow orthoses (EO), elastic with stays
L3710	CRS	EO, elastic with metal joints
L3720	CRS	EO, double upright with forearm/arm cuffs, free motion
L3730	CRS	EO, double upright with forearm/arm/cuffs, extension/flexion assist
L3740	CRS	EO, double upright with forearm/arm cuffs, adjustable position lock with active control
L3800	CRS	Wrist-hand-finger-orthoses (WHFO), short opponens, no attachments
L3805	CRS	WHFO, long opponens, no attachment
L3810	CRS	WHFO, addition to short and long opponens, thumb abduction ("C") bar
L3815	CRS	WHFO, addition to short and long opponens, second M.P. abduction assist
L3820	CRS	WHFO, addition to short and long opponens, IP extension assist, with M.P. extension stop
L3825	CRS	WHFO, addition to short and long opponens, M.P. extension stop
L3830	CRS	WHFO, addition to short and long opponens, M.P. extension assist
L3835	CRS	WHFO, addition to short and long opponens, M.P. spring extension assist
L3840	CRS	WHFO, addition to short and long opponens, spring swivel thumb
L3845	CRS	WHFO, addition to short and long opponens,

Procedure Code	*Who Can Bill*	*Description*
		thumb IP extension assist with M.P. stop
L3850	CRS	WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855	CRS	WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860	CRS	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.
L3900	CRS	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven
L3901	CRS	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven
L3906	CRS	WHO, wrist gauntlet, molded to patient model
L3907	CRS	WHFO, wrist gauntlet with thumb spica, molded to patient model
L3908	CRS	WHO, wrist extension control cock-up, non-molded
L3910	CRS	WHFO, Swanson design
L3912	CRS	HFO, flexion glove with elastic finger control
L3914	CRS	WHO, wrist extension cock-up
L3916	CRS	WHFO, wrist extension cock-up with outrigger
L3918	CRS	HFO, knuckle bender
L3920	CRS	HFO, knuckle bender, with outrigger
L3922	CRS	HFO, knuckle bender, two segments to flex joints
L3924	CRS	WHFO, Oppenheimer
L3926	CRS	WHFO, Thomas suspension
L3928	CRS	HFO, finger extension, with clock spring
L3930	CRS	WHFO, finger extension, with wrist support
L3932	CRS	FO, safety pin, spring wire
L3934	CRS	FO, safety pin, modified
L3936	CRS	WHFO, Palmer
L3938	CRS	WHFO, dorsal wrist
L3940	CRS	WHFO, dorsal wrist, with outrigger attachment
L3942	CRS	HFO, reverse knuckle bender
L3944	CRS	HFO, reverse knuckle bender, with outrigger
L3946	CRS	HFO, composite elastic
L3948	CRS	HFO, finger knuckle bender
L3950	CRS	WHFO, combination Oppenheimer, with knuckle bender and two attachments
L3952	CRS	WHFO, combination Oppenheimer, with reverse knuckler and two attachments
L3954	CRS	HFO, spreading hand
L3960	CRS	Shoulder-elbow-wrist-hand orthosis (SEWHO), abduction positioning, airplane design
L3962	CRS	SEWHO, abduction positioning, erbs palsy design
L3964*****	CRS	SEO, mobile arm support attached to wheelchair, balanced, adjustable – **Requires Prior Authorization**
L3965*****	CRS	SEO-mobile arm support. Attached to wheelchair, balanced, adjustable rancho type – **Requires Prior Authorization**
L3966*****	CRS	SEO, mobile arm support attached to wheel chair, balanced, reclining – **Requires Prior Authorization**
L3968*****	CRS	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) – **Requires Prior Authorization**
L3969*****	CRS	SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support –

Procedure Code	*Who Can Bill*	*Description*
		Requires Prior Authorization
L3970*	CRS	SEO, addition to mobile arm support, elevating proximal arm – **Requires Prior Authorization**
L3972*	CRS	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control – **Requires Prior Authorization**
L3974*	CRS	SEO, addition to mobile arm support, supinator – **Requires Prior Authorization**
L3980	CRS	Upper extremity fracture orthosis, humeral
L3982	CRS	Upper extremity fracture orthosis, radius/ulnar
L3984	CRS	Upper extremity fracture orthosis, wrist
L3985	CRS	Upper extremity fracture orthosis, forearm, hand with wrist hinge
L3986	CRS	Upper extremity fracture orthosis, combination of humeral, radius/ulnar, wrist, (example-colles fracture)
L3995	CRS	Addition to upper extremity orthosis, sock, fracture or equal, each
L3999*	CRS	Upper limb orthosis, not otherwise specified – **Requires Prior Authorization**
L4000	CRS	Replace girdle for Milwaukee orthosis
L4010	CRS	Replace trilateral socket brim
L4020	CRS	Replace quadrilateral socket brim, molded to patient model
L4030	CRS	Replace quadrilateral socket brim, custom fitted
L4040	CRS	Replace molded thigh lacer
L4045	CRS	Replace non-molded thigh lacer
L4050	CRS	Replace molded calf lacer
L4055	CRS	Replace non-molded calf lacer
L4060	CRS	Replace high roll cuff
L4070	CRS	Replace proximal and distal upright for KAFO
L4080	CRS	Replace metal bands KAFO proximal thigh
L4090	CRS	Replace metal band KAFO-AFO, calf or distal thigh
L4110	CRS	Replace leather cuff, KAFO, calf or distal thigh
L4130	CRS	Replace pretibial shell
L4205	CRS	Repair pretibial shell
L4210	CRS	Repair of orthotic device, repair or replace minor parts

*Requires PA

NOTE:

Refer to Chapter 37, Therapy (Occupational, Physical, and Speech) for the therapy codes.

100.5.4 Place of Service Codes

The place of service code 99 (Other Unlisted Facility) applies when filing claims for clinic services, except for dental and orthodontia services. For dental and orthodontia services, use place of service 11.

100.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

100.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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101 County Health Departments

Medicaid contracts with the State of Alabama Department of Public Health to reimburse services provided by County Health Departments.

101.1 Enrollment

HP enrolls county health departments and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Administrative Code*, and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a county health department is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for health department-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

County health departments are assigned a provider type of 13 (County Health). Valid specialties for county health departments that employ physicians include the following:

- Family Planning (083)
- Environmental Lead Assessment (980)
- EPSDT (560)
- Immunizations (900)
- Primary Care Clinic (720)
- Prenatal Clinic (181)
- Preventive Education (183)

County health departments that are enrolled to provide hospice services are assigned a provider type of 06 (Hospice). The valid specialty is Hospice (060).

County health departments that are enrolled to provide home health services are assigned a provider type of 05 (Home Health). The valid specialty is Home Health (050).

NOTE:

Physicians affiliated with county health departments are assigned their own NPI, which links them to the health department. The provider type for the physician is 13 (County Health Department). The valid specialties are any of those specialties valid for physicians. Refer to Section 28.1, Enrollment, for a listing of valid physician specialties.

All other personnel affiliated with the county health department, such as physician assistants or nurse practitioners, bill using the health department's NPI, and are not assigned individual NPI.

101.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Consent of a Minor

Any minor who is 14 years of age or older; has graduated from high school; or is married, divorced, or pregnant may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself. The consent of another person is not necessary.

101.2.1 EPSDT

County health departments providing EPSDT services should refer to Appendix A, EPSDT, for specifics regarding benefits and limitations.

EPSDT off-site screening providers must follow the protocols and procedures for EPSDT off-site services listed in the EPSDT appendix. Failure to comply may result in recoupment of the funds paid to the provider.

101.2.2 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

Scope of Services

The scope of services include and are designed to support physician's office personnel with identifying, contacting, coordinating, and providing follow up for visits with your office for children who are behind on their EPSDT screenings, immunizations, vision/hearing screenings, dental screenings, identify recipients who have high utilization of emergency room visits; follow up services for newborn hearing screenings, elevated blood lead levels, abnormal sickle cell and metabolic results; follow up on referrals, missed appointments, identify children at greatest risk for targeted outreach, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, EPSDT Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Reports

The following reports provided by the Alabama Medicaid Agency will be utilized by the Alabama Department of Public Health (ADPH) to assist with the following items.

- Monthly Eligibles Report – enables Care Coordinators the ability to track eligible recipients
- Monthly Selected Services Report – enables Care Coordinators to ascertain utilization of EPSDT services, immunizations, elevated blood lead levels, dental services, and high utilization of emergency room visits.

In addition, the Agency and ADPH has developed strategies to identify the children at greatest risk and with the potential for effective intervention utilizing diagnosis codes. Care Coordinators can track referrals, missed appointments, and follow up appointments utilizing the reports listed above.

The following information obtained from ADPH will be utilized as follows:

- Metabolic and Sickle Cell Screening – enables Care Coordinators the ability to track eligible recipients with abnormal results
- Newborn Hearing Screening - enables Care Coordinators the ability to track eligible recipients with abnormal results
- Immunizations - enables Care Coordinators the ability to track eligible recipients with inadequate or delayed immunizations

Measurement Criteria

- ADPH will provide a monthly Summary Report by county.
- EPSDT screenings, immunizations, dental screenings, follow up on elevated blood lead levels, referred visits, kept appointments will increase after the first two years of implementation.

Participation

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Procedure code G9008, type of service 1 with modifier "EP" (e.g., G9008-EP) will be utilized for billing purposes. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "General", then select "About". A list of EPSDT Care Coordinators by county and telephone numbers is available to support physician office personnel.

101.2.3 Family Planning

County health departments providing family planning services should refer to Appendix C, Family Planning, for specific benefits, limitations, covered services and family planning diagnosis codes.

101.2.4 Prenatal

Prenatal services listed below are the services provided to a pregnant woman not participating in a maternity care program during the period of gestation, including obstetrical, psycho-social, nutrition, health education, and related coordination directed toward protecting and ensuring the health of the woman and the fetus. For recipients enrolled in the maternity care program, refer to Chapter 24, Maternity Care Program.

Medicaid provides prenatal services to persons who are eligible for Medicaid benefits and are deemed pregnant through laboratory tests or physical examination, without regard to marital status.

Prenatal services provided by county health departments must conform to the Program Guidelines for prenatal services under the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act), Migrant Health Centers, or Community Health Centers.

Procedure	***Description***
99212-HD	Prenatal Clinic Visit – Includes diagnosis of pregnancy, comprehensive history, complete physical examination, preparation of medical record, risk assessment, diabetic and genetic screening, referral services, counseling services, collection of specimens for lab tests, hemoglobin or hematocrit and chemical urinalysis. Also includes reevaluation of the pregnancy during the prenatal period.
59430	Postpartum Clinic Visit – An in-depth evaluation of a patient in a stage of recovery from childbirth, requiring the development of or complete reevaluation of medical data, including history of labor and delivery, complications and/or pregnancy outcome, a complete physical examination, and the ordering of appropriate diagnostic tests and procedures. Patient education to include formal conference with the patient to review findings and contraceptive services.

101.2.5 Preventive Health

Refer to Chapter 30, Preventive Health Education, for specifics regarding benefits and limitations. Services are **limited** to the billing of the following two procedure codes:

Procedure Code	***Description***
S9445	Prenatal Education – Limited to pregnant female recipients. Limited to diagnosis codes V220 - V222.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509.

101.2.6 Environmental Lead Investigators

A qualified investigator must have graduated from a four-year college or university with a minimum of 30 semester hours or 45 quarter hours of continued coursework in biology, chemistry, environmental science, mathematics, physical science, or a minimum of at least five years of permanent employment in an environmental health field. Any person employed must have successfully completed the training program for environmentalists conducted by the Alabama Department of Public Health before being certified by the Alabama Department of Public Health.

Environmental Lead Investigations are billable as a unit of service. A unit of service is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Testing of substances that must be sent off-site for analysis, or any non-medical activities such as removal or abatement of lead sources, or relocation efforts, are not billable as part of an Environmental Lead Investigation.

Please refer to Appendix A, EPSDT, for further information regarding lead levels and children.

101.2.7 Adult Immunizations

County health departments that provide immunizations to Medicaid-eligible recipients who are 19 years old and older must submit a claim for the appropriate HCPCS code. Vaccines are reimbursable on a fee-for-service basis. The administration fee is included in the price of the vaccine. Do not bill a separate procedure code for administration of the vaccine.

Refer to Appendix H, Alabama Medicaid Injectable Drug List, for procedure codes.

101.2.8 Home Health

County health departments providing home health care services should refer to Section 17.2, Benefits and Limitations, for specifics regarding home health benefits and limitations.

101.2.9 Hospice

County health departments providing hospice care services should refer to Section 18.2, Benefits and Limitations, for specifics regarding hospice benefits and limitations.

Refer to Section 18.5.3, Procedure Codes, Revenue Codes and Modifiers, for hospice procedure codes.

101.2.10 Physicians/Practitioners

Physicians and practitioners practicing within a county health department should refer to Section 28.2, Benefits and Limitations, for specifics regarding physician benefits and limitations.

Physicians have a NPI for each health department clinic/clinic type for which they provide services. Billable charges depend on the clinic, for example, Prenatal, EPSDT screening clinic, Family Planning, etc.

101.2.11 *Vaccines for Children (VFC)*

The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under-insured. The Alabama Department of Public Health (1(800) 469-4599) administers this program.

Refer to Appendix A, EPSDT, for information about the VFC program.

101.3 Prior Authorization and Referral Requirements

County health department procedure codes generally do not require prior authorization. Any service provided outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Claims for recipients enrolled in the Patient 1st Program **require a referral** from the recipient's assigned Primary Medical Provider (PMP). Refer to Chapter 39, Patient 1st for more information on obtaining a referral through the Patient 1st Program.

101.4 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

Deleted: ~~The copayment amount…and family planning.~~

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

Added: The copayment amount… for each procedure

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

Added: 90847, 90849, 90853… then copay applies

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

If one of these CPT codes is applicable for your practice, then copay applies.

Added: Copayment does not…Medicaid required copayment.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

101.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

101.5.1 Time Limit for Filing Claims

Medicaid requires all claims for county health departments to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

101.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

101.5.3 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare
- Locally assigned codes issued by Medicaid. Effective for dates of service on or after 01/01/2004, use national codes.

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional, and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

101.5.4 Place of Service Codes

The following place of service codes apply when filing claims for health department services:

POS Code	***Description***
11	Office
12	Home
34	Hospice
71	State or Local Public Health Clinic
81	Independent Laboratory

101.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

101.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Family Planning	Appendix C
Medicaid Standard Injectable Drug List	Appendix H
Outpatient Hospital/ASC Procedure List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Patient 1st	Chapter 39

102

102 Intermediate Care Facility for the Mentally Retarded (ICF-MR)

An Intermediate Care Facility for the Mentally Retarded (ICF-MR) is an institution that primarily provides the diagnosis, treatment or rehabilitation of the mentally retarded or persons with related conditions. ICF-MRs provides a protected residential setting, ongoing evaluations, planning, 24-hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.

The policy provisions for ICF-MR facilities can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10.

102.1 Enrollment

HP enrolls ICF-MR facilities and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid and an ICF-MR provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for ICF-MR related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

ICF-MR facilities are assigned a provider type of 3 (Intermediate Care Facility for Mentally Retarded). The valid specialty for ICF-MR facilities is Intermediate Care Facility (030).

Enrollment Policy for ICF-MR Facilities

To participate in the Alabama Medicaid Program, ICF-MR facilities must meet the following requirements:

- Possess certification for Medicare Title XVIII
- Submit a letter to the Long Term Care Division requesting enrollment
- Submit a budget to the Provider Audit Division for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Patient Agreement with Medicaid

The Provider Agreement presents in detail the requirements imposed on each party to the agreement.

102.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

ICF-MRs must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

102.2.1 Therapeutic Visits

Payments to ICF-MR facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid will track the use of therapeutic leave through the claims processing system.

An ICF-MR must provide written notice to the resident and a family member or legal representative of the resident specifying the Medicaid policy upon a resident taking therapeutic leave and at the time of transfer of a resident to a hospital.

An ICF-MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility.

102.2.2 Review of Medicaid Residents

The Alabama Medicaid Agency or its designated agent will perform the following types of review of services provided to Medicaid residents in nursing facilities and in ICF-MR facilities:

- Pre-admission review on all Medicaid residents to assure the necessity and appropriateness of their admission and that a physician has certified the need
- The effectiveness of discharge planning
- Quality assessment and assurance

Annual physical examinations are required for ICF-MR residents.

102.2.3 Utilization Review

The Utilization Review function in the ICF-MR facilities is the responsibility of Medicaid or its designee.

The Utilization Review function in the ICF-MR facility is a facility-based review conducted by the Department of Mental Health.

DMH provides Medicaid with a written Utilization Review Plan. The Utilization Review Plan must include written description of who will perform the Utilization Review. At least one team member must be knowledgeable about the treatment of this type resident (Qualified Mental Retardation Professional).

The Utilization Review team **must not** include an individual who meets any of the following criteria:

- Is directly responsible for the care of the recipient whose case is being reviewed
- Is employed by the ICF-MR

The facility staff provides necessary administrative support to the review team.

The review team reviews each resident for the necessity of continued stay. Re-certifications are conducted 60 days from the date of the initial certification; 180 days from the date of the initial certification; 12 months from the date of the initial certification; 18 months from the date of the initial certification; 24 months from the date of the initial certification; and every 12 months thereafter.

DMH provides Medicaid with a semi-annual report of utilization reviews carried out in the ICF-MR facilities.

102.2.4 Resident Medical Evaluation

The admitting and attending physician must certify the necessity for admission of a resident to an intermediate care facility and make a comprehensive medical evaluation. The facility maintains this evaluation as part of the resident's permanent record.

Each Medicaid resident in an intermediate care facility must have a written medical plan of care established by his physician. The plan of care must be periodically reviewed and evaluated by the physician and other personnel involved in the individual's care.

102.2.5 Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

102.2.6 Resident Records

Medicaid or its designated agent will perform a 10% random retrospective review of Medicaid nursing facility/ICF/MR facility residents’ records to determine appropriateness of admission on a monthly basis.

102.3 Prior Authorization and Referral Requirements

ICF-MR residents are exempt from the Patient 1st program. No referrals are required for billing.

102.3.1 ICF-MR Applications

The medical determination for admission or continued care in an ICF-MR is made by the facility designated Qualified Mental Retardation Professional (QMRP).

The facility must maintain the following documents for the retrospective review:

- A fully completed written application form 361 (Formerly XIX-LTC-18)
- The resident's physical history
- The resident's psychological history
- The resident's interim rehabilitation plan
- A social evaluation of the resident

Before the ICF-MR may admit an individual, it must determine that his or her needs can be met. The interdisciplinary professional team must do the following:

- Conduct a comprehensive evaluation of the individual, covering physical, emotional, social and cognitive factors.
- Define the individual's need for service without regard to the availability of these services.
- Review all available and applicable programs of care, treatment, and training and record its findings.

If the ICF-MR determines that admission is not the best plan but that the individual must be admitted, it must clearly acknowledge that admission is inappropriate and actively explore alternatives for the individual. An otherwise eligible recipient or the recipient’s sponsor cannot be billed when the ICF-MR fails to submit all forms in a timely manner.

102.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by ICF-MR facilities.

102.5 Completing the Claim Form

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims for general claims filing information and instructions.

102.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ICF-MR facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

102.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

102.5.3 Covered Revenue Codes

Claims for ICF-MR facilities are limited to the following revenue codes:

Code	*Description*
101	All inclusive room & board
184	Intermediate Care Facility charge

102.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

102.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

102.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Outpatient Hospital/ASC Procedure List	Appendix I
Patient 1st	Chapter 39
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

103

103 Local Education Agencies (LEAs)

Changes in federal law have made it possible for state education agencies to finance health-related education services through Medicaid and private insurance companies. Medicaid works with the State Department of Education, Special Education Services (SES), and the Local Education Agencies (LEAs) throughout the state to reimburse for these services.

Background Information

In 1975, the Individuals with Disabilities Education Act, formerly the Education for All Handicapped Children Act (P.L. 94-142) was signed into law, guaranteeing every child the right to a free, appropriate public education (FAPE) and related services in the least restrictive environment possible. Section 300.301 (a) (b) of the 34 Code of Federal Regulations states the following:

- Each State may use whatever state; local, federal, and private sources of support are available in the State to meet the requirements of this part. For example, when it is necessary to place a handicapped child in a residential facility, a State could use joint agreements between agencies involved for sharing the cost of that placement.
- Nothing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a handicapped child.

In 1986, a General Accounting Office report recommended that Medicaid law be amended to allow Medicaid to pay for related services they typically would have covered if P.L. 94-142 were not in effect (GAO HRD 86-62BR). Congress acted on this recommendation through the Medicare Catastrophic Coverage Act (P.L. 100-360), which was signed into law on July 1, 1988.

A provision of P.L. 100-360 amended Section 1903 of the Social Security Act specifying that Medicaid was not restricted from covering services furnished to a child with disability simply because the services are included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Congress further clarified that federal Medicaid matching funds are available for the cost of health services that are furnished to a child with disabilities, even though the services are included in the child's IEP or IFSP.

Regulations implementing the Individuals with Disabilities Education Act of 2004 require that school districts secure parental permission prior to billing Medicaid for services provided by the school districts. The regulation can be found at 34CFR 300.154(d).

In summary, Congress has established that while State education agencies are financially responsible for educational services, in the case of a Medicaid-eligible child, State Medicaid agencies remain responsible for the "related services" identified in a child's IEP if the services are covered under the State's Medicaid plan.

In November 1989, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) was passed requiring Medicaid to cover all medically necessary services allowed under Section 1905(a) to "correct and ameliorate defects and physical and mental illnesses and conditions discovered by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening, regardless of whether these services are included in the Medicaid State Plan." This act provides a mechanism for the local education agencies, through their professional staff, to bill Medicaid for health-related services that meet Medicaid's criteria for reimbursement.

Participation

Effective 10/1/03, the scope of services that can be billed through the LEA will be expanded. Refer to Section 103.6 for details on covered services. The LEA will need to have qualified subcontractors or employees in place to perform direct services. The LEA will bill the appropriate code identifying the procedure performed. Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

The LEA must verify that no practitioner providing service has been terminated, suspended, or barred from the Medicaid or Medicare Program. The lists of terminated, suspended and barred practitioners are available on Medicaid's website at www.medicaid.alabama.gov.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

LEA National Provider Identifier

A provider who contracts with Alabama Medicaid as an LEA is added to the Medicaid system with the National Provider Identifiers (NPI) provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for LEA-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

The qualifications for direct service providers are delineated in the scope of services. It is the responsibility of the LEA to ensure that direct service providers meet these qualifications. RNs, LPNs and School nurses must practice within the scope of the Standards of Nursing Practice as defined in Rule 610-X-6. Other practitioners must meet their own licensing requirements and practice within the scope of those licenses or credentials.

103.1 Records and Samples

Providers of service are required to keep the following records and, upon request, furnish these records to authorized State representatives of the Alabama Medicaid Agency, the Department of Health and Human Services, the State Examiners of Public Accounts, the State Attorney General, the

Comptroller General, the General Accounting Office, and the State Department of Education:

- A copy of the original and all updates of the Individualized Education Program (IEP), including parental signature. The IEP should be updated yearly.
- Description of specific professional services and activities provided with the date, the duration of services and activities rendered, and the name and title of the professional providing services and activities
- Dated updates/progress notes describing the student's progress, or lack thereof, signed or initialed by the professional providing services and activities
- The School's Official Attendance Record
- Discharge notes from services completed/treatment summary

All records shall be completed promptly, filed, and retained for a minimum of five years from the date of services or until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever is longer.

NOTE:

Failure to furnish records upon request may result in recoupment of funds paid.

103.1.1 Progress Notes

Medicaid highly recommends that therapists follow the SOAP method for recording appropriate documentation. The letters SOAP outline the four parts of documentation:

Subjective comment
Objective or goal
Assessment
Plan: Continue, Add, or Delete

An example of a progress note developed using the SOAP method would be:

Date	*Student progressing in all areas. Auditory discrimination tasks are improving (50 to 70%). Single word level production for new goals continues to be difficult. Continue present plan.* *Signature of Therapist*

After the initial date of treatment, it is recommended that the therapist also SOAP all additional visits.

Date	*Showed marked improvement aud-dis (l) and blends; otherwise about the same. Encouraged to continue notebook. Continue present plan.* *Signature of Therapist*

NOTE:

Progress notes must be written after each service. Each progress note must be dated and signed or initialed. Electronic signatures on electronic medical records are acceptable.

103.1.2 Recipient Signature Requirement

Medicaid recognizes that the parents do not take their children to school each day; therefore, it would be impossible to obtain a parental signature for each date of service. To meet Medicaid's recipient signature requirement, the LEA must have the following:

- An IEP signed by the parent or responsible guardian that indicates the services the student will receive (for example, speech therapy three times a week for nine months)
- An attendance record that reflects the student was in attendance for the date of service

103.2 Prior Authorization and Referral Requirements

Services provided through an LEA do not require EPSDT, prior authorization or Patient 1st referral.

103.3 Cost Sharing (Copayment)

Copayment does not apply to services provided through LEA providers.

103.4 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
NOTE: When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

103.4.1 Performing and Billing National Provider Identifiers

BILLING: In block 33 of the CMS-1500 claim form, enter the billing provider NPI and the billing provider's name.

PERFORMING: In block 24J of the CMS-1500 claim form, enter the School District's individual NPI.

The 10-digit NPI reflects services provided, per school district. A separate NPI will not be needed for each specialty that is providing services at each school district.

103.4.2 Place of Service

Claims should be filed with Place of Service (POS) Code 11 – office.

103.4.3 Time Limit for Filing Claims

Medicaid requires all claims for local education agencies to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

103.4.4 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610. The diagnosis code must come from the direct provider of service unless a diagnosis code is listed.

NOTE:
ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

103.4.5 Required Claim Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

103.5 Covered Services

Covered services are face-to-face health related services provided to a student, group of students, or parent/guardian on behalf of the student. Covered services are listed in the Alabama State Plan of Medical Assistance and are medically necessary for the development of the IEP or fully documented in the IEP. An IEP must be completed in order for services to be billed. Covered services are:

- Intake/Evaluation
- Audiology Services
- Developmental Diagnostic Assessments
- Vision Screening
- Hearing Screening
- Occupational Therapy
- Physical Therapy
- Behavioral Health Services
- Health Aide Services
- Speech/Language Services

The CPT manual lists most required procedure codes. Certain CPT codes must be billed with the SE modifier as indicated. The services in this section may be covered by Medicaid when provided by an authorized provider according to an IEP. **Annual limitations are based on calendar year.**

The following paragraphs provide a detailed list of covered services, grouped by service.

103.5.1 Intake/Evaluation

Service Description: The intake evaluation presents psychological, social functioning and medical needs for development of an initial treatment plan for subsequent treatment and/or evaluation. The intake evaluation considers: family history, educational history, medical background, and a description of the significant problems of the child. Services must be specified in the treatment plan (IEP).

Professional Qualifications: Multidisciplinary team as identified by the needs of the child that may include the following professionals as licensed under Alabama law: psychologist, professional counselor, certified social worker, marriage and family therapist, or registered nurse.

Procedure Code:

Procedure Code/ Modifier	***Description***	***Daily Limits***	***Annual Limits***
90801 SE	Intake/evaluation, utilize dx code V62.9	1	1

103.5.2 Audiology Services

Service Description: Audiology services necessary for the development or the student's IEP or documented in the IEP included, but are not limited to evaluations, tests, tasks and interviews to identify hearing loss in a student whose auditory sensitivity and acuity are so deficient as to interfere with normal functioning.

Professional Qualifications: Must meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
92551 SE	Screening test, pure tone, air only	1	12
92552 SE	Pure tone audiometry (threshold); air only	1	12
92553 SE	Pure tone audiometry (threshold); air and bone	1	12
92555 SE	Speech audiometry threshold	1	12
92556 SE	Speech audiometry threshold with speech recognition	1	12
92567 SE	Tympanometry (impedance testing)	1	12
92592 SE	Hearing aid check; monaural	1	12
92593 SE	Hearing aid check; binaural	1	12

103.5.3 Developmental Diagnostic Assessments

Service Description: Administration of a standardized objective and/or projective tests of an intellectual, personality or related nature in a face-to-face interaction between the client and the professional and interpretation of the test results to determine medical/mental needs.

Professional Qualifications: Testing may be performed by the following professionals who are licensed under Alabama law: psychologist, professional counselor, certified social worker, or registered nurse with a master's degree in psychiatric nursing.

AND

Have documentation of training at the pre-service or in-service level on administering developmental assessments and meet any additional requirements of the specific test publishers.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
96101 SE	Developmental Diagnostic – administered by a physician or psychologist, first hour; face-to-face	1	12
96102 SE	Developmental Diagnostic – administered by a technician, first hour; face-to-face	1	12
96103 SE	Developmental Diagnostic – administered by a computer	1	12

103.5.4 Vision Assessments

Service Description: Vision assessments may be performed on students 3 through 20 years of age once a year unless additional screenings are medically necessary.

Professional Qualifications: A person who has been trained on the device by observing a trained employee on a minimum of three patients, verbalization of understanding the procedure and successful completion of the procedure on at least three patients.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
99173 SE	Vision Screen, utilize diagnosis code V72.0	1	1

103.5.5 Hearing Assessment

Service Description: Hearing assessments may be performed beginning at 3 years of age. After the initial screening, all children may be assessed once a year unless additional screenings are medically necessary.

Professional Qualifications: A person that has been trained on the device by observing a trained employee on a minimum of three patients, verbalization of understanding the procedure and successful completion of the procedure on at least three patients.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
92551 SE	Hearing Screen, utilize diagnosis codes V72.11, V72.12 or V72.19	1	1
92567 SE	Tympanometry (impedance testing) *, utilize diagnosis codes V72.11, V72.12 or V72.19 *must be provided under the direction of an audiologist	1	12

103.5.6 Occupational Therapy

Service Description: Occupational Therapy services, necessary for the development of the students IEP or documented in the IEP include, but are not limited to:

1. Evaluation of problems which interfere with the student's functional performance

2. Implementation of a therapy program or purposeful activities which are rehabilitative, active or restorative as prescribed by a licensed physician,

These activities are designed to:

A. improve, develop or restore functions impaired or lost through illness, injury or deprivation,

B. improve ability to perform tasks for independent functioning when functioning is impaired or lost,

C. prevent, through early intervention, initial or further impairment or loss of function,

D. correct or compensate for a medical problem interfering with age appropriate functional performance.

Professional Qualifications: Must be licensed by the Alabama State Board of Occupational Therapy. Occupational therapy assistants may assist in the practice of occupational therapy only under the supervision of an OT. Occupational therapy assistants must have an Associate of Arts degree and must be licensed by the Alabama State Board of Occupational Therapy. Supervision of certified OT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the OT making the visit.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Medicaid **does not** cover group occupational therapy. Covered occupational therapy services do not include recreational and leisure activities such as movies, bowling, or skating. Use the following procedure codes for services prescribed by a physician and provided by a qualified occupational therapist:

Procedure Code/ Modifier	***Description***	***Daily Limits***	***Annual Limit***
97003 SE	Occupational therapy evaluation	1	1
97004 SE	Occupational therapy re-evaluation	1	1
97110 SE	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*	4	96

*If additional services are needed, provider of service must use modifier 22. Medicaid monitors the use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which therapy is ordered.

103.5.7 Physical Therapy

Service Description: Physical Therapy services, necessary for the development of the student's IEP or documented in the IEP include, but are not limited to:

1. Evaluations and diagnostic services
2. Therapy services which are rehabilitative, active, restorative. These services are designed to correct or compensate for a medical problem and are directed toward the prevention or minimization of a disability, and may include:
   a. developing, improving or restoring motor function
   b. controlling postural deviations
   c. providing gait training and using assistive devices for physical mobility and dexterity
   d. maintaining maximal performance within a student's capabilities through the use of therapeutic exercises and procedures.

Professional Qualifications: Must be licensed by the Alabama Board of Physical Therapy. Physical therapy assistants may provide services only under the supervision of a qualified physical therapist. PT assistants must be licensed by the Alabama Board of Physical Therapy. Supervision of licensed PT assistants must include one-to-one on-site supervision at least every sixth (6th) visit. Each supervisory visit must be documented and signed by the PT.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Use the following procedure codes for services prescribed by a physician and provided by a qualified physical therapist. Physical therapy is not covered for groups. Physical therapy services may not be span billed.

Procedure Code/Modifier	***Description***	***Daily Limits***	***Annual Limit***
97001 SE	Physical therapy evaluation	1	1
97002 SE	Physical therapy re-evaluation	1	1
97110 SE	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility*	4	96

*If additional services are needed, provider of service must use modifier 22. Medicaid monitors the use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which therapy is ordered.

103.5.8 Behavioral Health Counseling

Service Description: Behavioral health services based on a treatment plan with focused intervention and specific goals designed to maximize strengths and reduce behavioral problems or functional deficits.

These services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications:

A psychologist licensed under Alabama law OR a professional counselor licensed under Alabama law OR a certified social worker licensed under Alabama law OR a registered nurse who has completed a master's degree in psychiatric nursing OR school psychologist certified by the Alabama State Department of Education.

Procedure Codes:

CPT Code/ Modifier	*Description*	*Daily Max*	*Annual Max*
H0025 SE	Behavioral health counseling, billed in 15 minute increments, utilize dx code V62.9	4	1200

103.5.9 Health Aide Services

Service Description: Services provided to an individual to enable a student to independently function within the school setting with emphasis on training and assistance. Examples of these services include: transferring and ambulating, and assistance with food, nutrition and diet activities.

Professional Qualifications: School Health Aide services are provided by staff that have been trained and remain under the direction of skilled professional medical personnel. Aides shall possess a high school diploma or equivalent, completed a course and obtained certification as a nursing assistant and shall posses a current card in first aid and CPR.

Procedure Codes:

Procedure Code/ Modifier	*Description*	*Daily Limits*	*Annual Limits*
T1004 SE	School Health Aide, Billed in 15 minute increments, utilize diagnosis code V65.49	32	9600

103.5.10 Speech/Language Services

Service Description: Speech/language therapy services necessary for the development of the student's IEP or documented in the student's IEP include, but are not limited to:

1. Diagnostic services
2. Screening and assessment
3. Preventive services
4. Corrective services

Speech therapy services may be provided in an individual, group or family setting. The number of participants in the group should be limited to assure effective delivery of service.

Professional Qualifications: Must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology. Speech Therapy Assistants must have a bachelor’s degree in Speech Pathology, and be registered by the Alabama Board of Speech, Language Pathology, and Audiology. The licensed speech pathologist must document direct observation of at least 10% of all clinical services provided by the assistant. Speech therapists may supervise no more than the equivalent of two full-time assistants concurrently.

All services must be performed within the scope of services as defined by the licensing board.

Procedure Codes:

Use the following procedure codes for services provided by a qualified speech pathologist for individuals with speech disorders. Speech therapy services may not be span-billed.

Procedure Code/ Modifier	***Description***	***Daily Limits***	***Annual Limits***
92506 SE	Evaluation of speech, language, voice, communication, and/or auditory processing	1	4
92507 SE	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	1	300
92508 SE	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group 2 or more individuals	1	300

103.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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104 Psychiatric Hospital (Recipients 65 & Over)

For purposes of this chapter, an inpatient is a person, age 65 or over, who has been admitted to a free-standing psychiatric facility specializing in the diagnosis, treatment, and care of geriatric patients, for the purpose of maintaining or restoring them to the greatest possible degree of health and independent functioning.

The policy provisions for psychiatric hospitals can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 5.

104.1 Enrollment

HP enrolls psychiatric hospital providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychiatric hospital is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for psychiatric-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Psychiatric hospitals are assigned a provider type of 01 (Hospital). The valid specialty for psychiatric hospitals is Inpatient Psychiatric Hospital Over 65 (011).

Enrollment Policy for Psychiatric Hospital Providers

To participate in the Alabama Medicaid Program, psychiatric hospital providers must meet the following requirements:

- Receive certification for participation in the Medicaid/Medicare program
- Possess a license as a free-standing acute geriatric psychiatric hospital by the state of Alabama in accordance with current rules contained in the *Rules of Alabama State Board of Health Division of Licensure and Certification,* Chapter 420-5-7. State hospitals that do not require licensing as per state law are exempt from this provision.
- Be accredited by the Joint Commission on Accreditation of Healthcare Organizations
- Specialize in the care and treatment of geriatric patients with serious mental illness
- Have on staff at least one full-time board certified geriatric psychiatrist/geriatrician
- Employ only staff who meet training certification standards in the area of geriatric psychiatry as defined by the State's mental health authority
- Be recognized as a teaching hospital affiliated with at least one four-year institution of higher education that employs a multi-disciplinary approach to the care and treatment of geriatric patients with serious mental illness
- Provide outpatient and community liaison services throughout the state of Alabama directly or through contract with qualified providers
- Submit a written description of an acceptable utilization review plan currently in effect
- Submit a budget of cost for its inpatient services for its initial cost reporting period, if a new provider
- Exist under the jurisdiction of the State's mental health authority

After enrollment, psychiatric hospitals are required to submit a monthly inpatient census report using the PSY-4 form. The census report must be received on or before the tenth of each month for the preceding month.

It is the facility's responsibility to ensure compliance with all federal and state regulations and to ensure that all required documentation is included in the recipient's record. Failure to comply will result in denial of payment and possible recoupment of reimbursements made previously.

104.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

The number of days of care charged to a recipient of inpatient psychiatric service is always a unit of a full day. A day begins at midnight and ends 24 hours later. The midnight to midnight method is used in reporting days of care for the recipient, even if the facility uses a different definition of day for statistical or other purposes.

Medicaid reimbursement is available for the day of admission, but not the day of discharge.

Inpatient psychiatric services for recipients age 65 or over, are covered services when provided under the following circumstances:

- Psychiatric services are provided in a free-standing psychiatric hospital exclusively for the treatment of persons age 65 or over with serious mental illness.
- Psychiatric services are provided under the direction of a geriatric psychiatrist.
- The psychiatric facility providing services is enrolled as a Medicaid provider.
- The recipient is admitted to the psychiatric facility during the entire hospitalization.
- The recipient is age 65 years or older.

Inpatient psychiatric services for recipients age 65 and over are unlimited if medically necessary and the admission and/or the continued stay reviews meet the approved psychiatric criteria. These days do not count against the recipient's inpatient day limitation for care in an acute care hospital.

Therapeutic visits away from the psychiatric facility to home, relatives, or friends are authorized if certified by the attending physician as medically necessary in the treatment of the recipient. An admission to a general hospital does not count as a therapeutic visit.

- Therapeutic visits may be authorized up to 14 days per admission if certified by the attending physician as medically necessary in the treatment of the recipient. No part of the time spent on any therapeutic leave may be billed to Medicaid.
- Return to inpatient status from therapeutic visits exceeding 14 days per admission will be considered a readmission with the required certification of need for treatment documented in the patient's record.
- Therapeutic visit records will be reviewed retrospectively by the Quality Assurance Division at Medicaid. Providers who have received payments for therapeutic visits will have funds recouped.

Certification of Need for Service

Certification of need for services is a determination that is made by a physician regarding the Medicaid recipient's treatment needs for admission to the facility.

The physician must certify for each applicant or recipient that inpatient services in a mental hospital are needed.

The certification must be made at the time of admission. No retroactive certifications will be accepted.

For individuals applying for Medicaid while in the hospital, the certification must be made before Medicaid can authorize payment.

The physician must complete the PSY-5 form, which is the certification of need for care. This form must be kept in the patient's record.

The PSY-6 form, which is the recertification of need for continued inpatient services, or acceptable equivalent approved by Medicaid, must be completed by a physician, a physician assistant, or a nurse practitioner acting under the supervision of a physician. The PSY-6 form or equivalent must be completed at least every 60 days after initial certification. This form must be kept in the patient's record.

The physician must complete an assessment note in the patient's record within 24 hours of a patient's return from any leave status.

Medical, Psychiatric, and Social Evaluation

Before admission to a psychiatric facility or before authorization for payment, the attending physician, psychiatrist, or staff physician must make a medical evaluation of each individual's need for care in the facility. Appropriate professional personnel must make a psychiatric and social evaluation.

Each medical evaluation must include:

- Diagnosis
- Summary of present medical findings
- Medical history
- Mental and physical functional capacity
- Prognosis
- A recommendation by the physician concerning admission to the psychiatric facility or continued care in the psychiatric facility, for individuals who apply for Medicaid while in the facility

Plan of Care

The attending physician or staff physician must establish a written plan of care for each individual before admission to a mental hospital and before authorization of payment.

The plan of care must include the following:

- Diagnosis, symptoms or complaints indicating a need for admission to inpatient care
- Description of the functional level of the patient
- Treatment objectives
- Orders for medications, treatments, therapies, activities, restorative/rehabilitative services, diet, social services, and special procedures needed for health and safety of the patient
- Continuing care plans that include post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family and community service providers upon discharge

The attending or staff physician and other appropriate staff involved in the care of the recipient must review the plan of care at least every 90 days or when significant changes occur in patient functioning or acuity.

The plan of care is evaluated to ensure that the recipient receives treatment that maintains or will restore the patient to the greatest possible level of health and independent functioning.

A written report of the evaluations and the plan of care must be in the individual's record at the time of admission or immediately upon completion of the report if the individual is already in the facility.

Utilization Review (UR) Plan

As a condition of participation in the Alabama Medicaid program, each psychiatric facility must do the following:

- Have in effect a written UR Plan that provides for review of each recipient's need for services that the facility furnishes to the recipient.
- Maintain recipient information required for UR, which includes the certification of need for service and the plan of care.

- Provide a copy of the UR Plan and any subsequent revisions to Medicaid for review and approval.

Provider Preventable Conditions (PPCs)

Provider Preventable Conditions (PPCs) are clearly defined into two separate categories: Healthcare Acquired Conditions and Other Provider Preventable Conditions (OPPCs)

Healthcare Acquired Conditions include Hospital Acquired Conditions (HACs).

OPPCs include but are not limited to the following; surgery on a wrong body part, wrong surgery on a patient, surgery on a wrong patient.

Non- payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPCs must meet the following criteria:

- The PPC must be reasonably preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC 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 PPC must result in significant harm. The OPPCs 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 30 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 OPPCs 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 a PPC.

Reporting Other Provider-Preventable Conditions (OPPCs).

The following OPPCs must be reported to Medicaid by encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Each hospital will receive a password specifically for e-mail reporting. Reportable "OPPCs" include but are not limited to:

- 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.medicaid.alabama.gov under Programs/Medical Services/Hospital Services although hospitals may submit their own form as long as it contains all required information.

NOTE:

***Reporting is required only when not filing a UB-04 claim.**

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

Psychiatric hospitals and RTF's should use the POA indicator on claims for these HACs as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. 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. 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:

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	999.60 (CC) 999.61 (CC) 999.62 (CC) 999.63 (CC) 999.69 (CC)
Pressure Ulcer Stages III & IV	707.23 (MCC) and 707.24 (MCC)
Falls and Trauma: -Fracture -Dislocation	Codes within these ranges on the CC/MCC list: 800-829.1

Selected HAC	CC/MCC (ICD-9-CM Codes)
-Intracranial Injury -Crushing Injury -Burn -Electric Shock	830-839.9 850-854.1 925-929.9 940-949.5 991-994.9
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 psychiatric hospital or RTF 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.

Non-payment of provider preventable conditions shall not prevent access to services for Medicaid beneficiaries.

No reduction in payment for a PPC will be imposed on a hospital provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in Provider payment may be limited to the extent that the following apply:

- The Identified PPC would otherwise result in an increase in payment.
- Psychiatric hospitals and RTF's are paid based on a daily per diem rate. It is the responsibility of the hospital to identify any Health Care-Acquired Condition and not seek payment for any additional days that have lengthened a recipient's stay due to a PPC.

In reducing the amount of days: Hospitals are to report a value code of '81' on the UB-04 claim form along with any non-covered days and the amount field must be greater than '0'.

It is the responsibility of the psychiatric hospital or RTF 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.

It is the psychiatric hospital or RTF'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.

Payment

Payment for inpatient services provided by psychiatric facilitates for individuals age 65 and older shall be the per diem rate established by Medicaid for the hospital. The per diem rate is based on the Medicaid cost report and all the requirements expressed in the *Alabama Medicaid Administrative Code,* Chapter 23. Ancillary charges (lab, x-ray, etc.) may not be billed in addition to the facility per diem rate.

Patient liabilities, if applicable, are deducted from the per diem. The hospital is responsible for collecting the liability amount from the patient and/or the patient's sponsor.

Providers are required to file a complete uniform Medicaid cost report for each fiscal year. Medicaid must receive two copies of this report within three months after the Medicaid year-end cost report.

Hospitals that terminate participation in the Medicaid program must provide a final cost report within 120 days of the date of termination of participation.

NOTE:
If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of $100 per day for each calendar day after the due date.

104.3 Prior Authorization and Referral Requirements

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Claims for recipients enrolled in the Patient 1st Program **do not require a referral** from the recipient's assigned Primary Medical Provider (PMP).

Authorization for Admission

All admissions to psychiatric hospitals for recipients age 65 or older must be approved by Medicaid prior to payment authorization using the Alabama Prior Review and Authorization Request Form.

Medical records or other documentation may be requested when the medical necessity of the admission cannot be determined from the application form. Providers will receive notification when admissions are not found to be medically necessary.

Applications must be submitted within eight working days after admission. Applications that are not received within eight working days will be approved beginning the day the application is received, provided the criteria for admission are met.

Information required for admission review includes, but is not limited to the following:

- Recipient information that includes:
  - Admitting diagnosis
  - Events leading to hospitalization
  - History of psychiatric treatment
  - Current medications
  - Physician orders
  - Presenting signs and symptoms
- Verification that Certification of Need Form (PSY-5) has been completed
- Verification that medical, social, and psychiatric evaluations have been completed
- Verification that initial treatment plan (Plan of Care) is present on recipient's chart

Medicaid uses the Psychiatric Criteria for Age 65 or Over to approve or deny the admission.

- If the admission is approved, the facility receives approval to bill for the stay and assigns date for the initial continued stay review (CSR).
- If the admission cannot be approved based on the information received, additional information will be requested.
- If Medicaid determines that the admission is not medically necessary, the facility will be notified within two working days after a determination has been made.

Re-Admission Criteria

Medicaid will use the following criteria for re-admissions:

- Continued **need** to evaluate and treat for persistence of the patient's underlying psychiatric disease that led to psychiatric commitment / admission; and /or,

- Continued **need for** psychopharmacological and therapeutic interventions for modification and stabilization of the patient's behavior as related to the psychiatric disease**.**

Continued Stay Reviews

The hospital's utilization review personnel are responsible for performing continued stay reviews on recipients who require continued inpatient hospitalization.

The initial continued stay review should be performed on the date assigned by Medicaid. Later reviews should be performed at least every 90 days from the initial CSR date assigned, provided the patient is approved for continued stay. Each continued stay review date assigned should be recorded in the patient's record.

If the facility's utilization review personnel determine that the patient does not meet the criteria for continued stay, the case should be referred to the facility's psychiatric advisor. If the advisor finds that the continued stay is not needed, the hospital's utilization review procedure for denial of a continued stay should be followed.

If a final decision of denial is made, the hospital notifies the recipient and the attending physician within two days of the adverse determination. Medicaid should be notified in writing within 10 days after the denial is made.

The facility's utilization review personnel are responsible for notifying Medicaid whenever patients are placed on leave status or return from leave. A brief summary describing the outcome of the therapeutic leave should be addressed at this time for patients returning from any leave status.

104.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, or family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

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

NOTE:
Copayment is not a third party resource. Do not record copayment on the UB-04.

104.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

Psychiatric hospital providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

104.5.1 Time Limit for Filing Claims

Medicaid requires all claims to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

104.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

104.5.3 Revenue Codes

Refer to the Alabama UB-04 Manual, published by the Alabama Hospital Association, for a complete list of revenue codes.

104.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

104.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

104.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

105

105 Rehabilitative Services - DHR, DYS, DMH, DCA

Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness, substance abuse, or co-occurring mental illness and substance abuse diagnoses. These services are provided to recipients on the basis of medical necessity.

Direct services may be provided in the client's home, a supervised living situation, or organized community settings, such as community mental health centers, public health clinics, nursing homes, etc. Direct services can be provided in any setting, except in licensed hospital beds, that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

The policy provisions for rehabilitative services providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 47.

105.1 Enrollment

HP enrolls rehabilitative services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, and the *Alabama Medicaid Agency Administrative Code*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with the Alabama Medicaid Agency as a rehabilitative services provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for rehabilitation-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Rehabilitative services providers are assigned a provider type of 11 (State Rehabilitative Services). The valid specialties for State Rehabilitative Services are:

- Rehabilitative Services - DMH (111)
- Rehabilitative Services – DHR, DYS, DCA (118)
- Psychiatry (Psychiatrist only) (339)

Enrollment Policy for Rehabilitative Services Providers

To participate in the Alabama Medicaid Program, rehabilitative services providers must meet the following requirements. Service providers must demonstrate that they meet the criteria in either (1), (2), OR (3) and both (4) AND (5) below.

1. A provider must be certified as a community mental health center by DMH and must have demonstrated the capacity to provide access to the following services through direct provision or referral arrangements:
   - Inpatient services through referral to community hospitals and through the attending physician for community hospitalizations
   - Substance abuse services including intensive outpatient services and residential services
2. For the provision of Substance Abuse Rehabilitative Services an entity:
   - Must be an organization that is currently certified by the Alabama Department of Mental Health and Mental Retardation (DMH) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and
   - Must submit an application to and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.
3. The Department of Human Resources (DHR), the Department of Youth Services (DYS), and the Department of Children's Services (DCA) are eligible to be rehabilitative services providers for children under age 21 if they have demonstrated the capacity to provide an array of medically necessary services, either directly or through contract.

   Additionally, DHR may provide these services to adults in protective service status. At a minimum, this array includes the following:
   - Individual, group, and family counseling
   - Crisis intervention services
   - Consultation and education services
   - Case management services
   - Assessment and evaluation
4. A provider must demonstrate the capacity to provide services off-site in a manner that assures the client's right to privacy and confidentiality and must demonstrate reasonable access to services as evidenced by service location(s), hours of operation, and coordination of services with other community resources.
5. A provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Medicaid does not cover all services listed above, but the

provider must have demonstrated the capacity to provide these services.

105.1.1 Minimum Qualifications for Rehabilitative Services Mental Illness Professional Staff

Rehabilitative Services Mental Illness Professional Staff qualifications are as follows:

- A physician licensed under Alabama law to practice medicine or osteopathy
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A certified social worker licensed under Alabama law
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 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 as described in DMH standards
- Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions
- A pharmacist licensed under Alabama law may provide medication monitoring

105.1.2 Minimum Qualifications for Rehabilitative Services Substance Abuse Professional Staff

Rehabilitative Services Substance Abuse Professional Staff qualifications are as follows:

- Clinical screening and assessments of a substance abuse client must be performed by a person with at least two years of substance abuse treatment experience who meets any one or more of the following qualifications:
  - Licensed as a physician, psychologist, certified social worker, or counselor
  - Possesses a master's degree in a clinical area

- Treatment planning and counseling of substance abuse clients must be performed by any one or more of the following qualified professionals:
  - A person with a master's degree in a clinical area with a clinical practicum
  - A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting
  - A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience. A bachelor's level individual with less than two (2) years of direct care substance abuse experience must receive at a minimum two hours per month of documented case-development supervision from a qualified master's level clinician. Upon the individual obtaining two years of direct care substance abuse experience the case-development supervision would no longer be required and the individual would only need to receive two hours per month of ongoing documented supervision.
  - A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary process for certification. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

— Services must be provided by practitioners consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law

— Services rendered to persons with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above, unless an exception is specifically noted and defined in the service descriptions

105.1.3 Minimum Qualifications for DHR/DYS/DCA Child & Adolescent Services, DHR Adult Protective Services Professional Staff

DHR/ DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional Staff qualifications are as follows:

— A physician licensed under Alabama law to practice medicine or osteopathy

— A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners

— A psychologist licensed under Alabama law

— A professional counselor licensed under Alabama law

— A marriage and family therapist licensed under Alabama law

— A social worker licensed under Alabama law

— A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses

— A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing

- 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 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 professional experience supervised by a master's level or above clinician with two years of post graduate professional experience
- Services rendered to persons with a primary psychiatric diagnosis must be delivered by a person meeting the criteria listed above unless an exception is specifically noted and defined in the service descriptions
- A pharmacist licensed under Alabama law may provide medication monitoring

105.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

Treatment eligibility is limited to individuals with a diagnosis within the range of 290-316, assigned by a licensed physician, a licensed psychologist, a licensed physician's assistant, a certified nurse practitioner, or a licensed professional counselor of mental illness or substance abuse as listed in the most current International Classification of Diseases - Clinical Modification (ICD-CM). Medicaid does not cover the V codes for adult treatment services; however, it does cover intake evaluation and diagnostic assessment even if the resulting diagnosis is a V code. For treatment services provided to children under 21, or those adults receiving DHR protective services, the only V code Medicaid covers for reimbursement is unspecified psychosocial circumstance.

105.2.1 Covered Services

While Medicaid recognizes that family involvement in the treatment of individuals in need of rehabilitative services is necessary and appropriate, provision of services where the family is involved clearly must be directed to meeting the client's treatment needs. Medicaid does not cover services for non-Medicaid eligible family members independent of meeting the client's treatment needs.

Only the following rehabilitative services qualify for reimbursement under this program:

- Intake Evaluation
- Physician/Medical Assessment and Treatment
- Diagnostic Testing
- Crisis Intervention
- Individual Counseling
- Family Counseling
- Group Counseling
- Medication Administration

- Medication Monitoring
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Rehabilitative Day Program
- Mental Illness Child and Adolescent Day Treatment
- Treatment Plan Review
- Mental Health Consultation
- Adult Substance Abuse Intensive Outpatient Services
- Child and Adolescent Substance Abuse Intensive Outpatient Services
- In-home Intervention
- Pre-hospitalization Screening
- Basic Living Skills
- Family Support
- Assertive Community Treatment (ACT)
- Program for Assertive Community Treatment (PACT)
- Methadone Treatment

This section contains a complete description of each covered service along with benefit limitations.

Services must be provided in a manner that meets the supervisory requirements of the respective certifying authority or as authorized by state law.

Intake Evaluation (90791-HE 90791-HF)

HE = Mental Illness HF = Substance Abuse

Definition

Initial clinical evaluation of the client's request for assistance. Substance abuse clients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, client's reported physical and medical condition, the need for additional evaluation and/or treatment, and the client's fitness for rehabilitative services.

Key service functions include the following:

- A clinical interview with the client and/or family members, legal guardian, or significant other
- Screening for needed medical, psychiatric, or neurological assessment, as well as other specialized evaluations
- A brief mental status evaluation
- Review of the client's presenting problem, symptoms, functional deficits, and history
- Initial diagnostic formulation
- Development of an initial treatment plan for subsequent treatment and/or evaluation
- Referral to other medical, professional, or community services as indicated

Eligible Staff - Mental Illness Services

Clinical evaluation and assessments of a mental illness client may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 or other areas that require equivalent clinical course work, 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 postgraduate clinical experience as described in DMH standards

Eligible Staff - Substance Abuse Services

Clinical evaluation and assessments of a substance abuse client may be performed by a person with at least two years of substance abuse treatment experience who possesses any one or more of the following qualifications:

- Licensed as a psychologist, social worker, or professional counselor
- Has a master's degree in a clinical area that included a clinical practicum

Eligible Staff - DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Clinical evaluation and assessments of a child and adolescent services/adult protective services client may be performed by a person who possesses any one or more of the following qualifications:

- A physician licensed under Alabama law to practice medicine or osteopathy
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 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 part of the requirements for the degree
  - Has six months of post master's level professional experience supervised by a master's level or above clinician with two years of postgraduate professional experience
- An individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above.

Billing Unit:	Episode
Maximum Units:	One per year
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (H0032), Child and Adolescent In-Home Intervention (H2022-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment and that protects the client's rights to privacy and confidentiality.

Additional Information

An intake evaluation must be performed for each client considered for initial entry into a treatment program. This requirement applies to any organized program or course of covered services that a client enters or attends to receive scheduled or planned rehabilitative services. Individuals who are transferred between programs within an agency do not require a new intake at the time of transfer.

The intake evaluation process determines the client's need for rehabilitative services based upon an assessment that must include relevant information from the following areas:

- Family history
- Educational history
- Relevant medical background
- Employment/Vocational history
- Psychological/psychiatric treatment history
- Military service history
- Legal history
- Alcohol/Drug use history
- Mental status examination
- A description/summary of the significant problems that the client experiences

The intake evaluation process also results in the development of a written treatment plan (service plan, individualized family service plan, plan of care, etc.) completed by the fifth client visit or within ten working days after admission into a day treatment or residential program. The treatment plan will do the following:

- Identify the clinical issues that will be the focus of treatment.
- Specify those services necessary to meet the client's needs.
- Include referrals as appropriate for needed services not provided directly by the agency.
- Identify expected processes/outcomes toward which the client and therapist will be working to impact upon the specific clinical issues.
- Be approved in writing by a licensed psychologist, certified social worker, professional counselor, a marriage and family therapist, a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses, a registered nurse licensed under Alabama law with master's degree in psychiatric nursing, a physician licensed under Alabama law, or a physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners.

— Service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, crisis intervention and resolution, mental health consultation, pre-hospitalization screening, and treatment plan review. Changes in the treatment plan must be approved by a person licensed under Alabama law to practice psychology, certified social work, professional counseling, marriage and family therapy, or medicine; or a registered nurse licensed under Alabama law with master's degree in psychiatric nursing. For child and adolescent services or adults receiving DHR protective services, the person who approves the treatment plan must meet the criteria in Requirements for Client Intake, Treatment Planning, and Service Documentation section.

Physician Medical Assessment and Treatment (H0004-HE H0004-HF)

Definition

Contact between a client, another service agency provider, or independent practitioner and a licensed physician, physician assistant, or certified nurse practitioner occurring in an individual, group, or family setting for the purpose of medical/psychiatric development of a medication regimen, the provision of therapeutic services, or the provision of case consultation.

Key service functions include the following:

- Specialized medical/psychiatric assessment of physiological phenomena
- Psychiatric diagnostic evaluation
- Medical/psychiatric therapeutic services
- Assessment of the appropriateness of initiating or continuing the use of psychotropic or detoxification medication

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Physician medical assessment and treatment may be performed by a physician licensed under Alabama law to practice medicine or osteopathy, a physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners, or a Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses.

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Substance Abuse Intensive Outpatient Services (H0015), Child and Adolescent Substance Abuse Intensive Outpatient Services (H0015-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

All services rendered by a physician, physician assistant, or nurse practitioner that meet the definition above should be billed under this code including those rendered via teleconference with a direct service or consultation recipient.

If this service is provided via video telecommunication, it **must** include the option of an interactive audio and video telecommunications system which permits two-way communication between the distant site physician and the Medicaid recipient. This service does **not** include a telephone conversation, electronic mail message, or facsimile transmission between the physician, recipient, or a consultation between two physicians.

The origination site **must** be located at one of the following:

- Physician's office,
- Hospital,
- Critical access hospital
- Rural health clinic, or
- Federally qualified health center
- Community Mental Health Center (to include co-located sites with partnering agencies)
- Public Health Department

The distant site is the location of the physician providing the telecommunications professional services. This can be within or outside of the state of Alabama as long as the physician has an Alabama license and is enrolled as an Alabama Medicaid provider.

Standards for Recipient/Provider Participation:

Medicaid covers services provided via telemedicine for eligible recipients when the service is medically necessary, the procedure is individualized, specific, consistent with symptoms or confirmed diagnosis of an illness or injury under treatment, and not in excess of the recipient's needs.

All confidentiality laws and other requirements that apply to written medical records shall apply to electronic medical records, including the actual transmission of the service and any recordings made during the time of the transmission.

All transmissions must utilize an acceptable method of encryption adequate to protect the confidentiality and integrity of the transmission information. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver.

Providers of telemedicine services shall implement confidentiality protocols that include, but are not limited to:

- specifying the individuals who have access to electronic records;
- usage of unique passwords or identifiers for each employee or other person with access to the client records;
- ensuring a system to prevent unauthorized access, particularly via the internet
- ensuring a system to routinely track and permanently record access to such electronic medical information.

In order for providers to qualify for Medicaid reimbursement for telemedicine services, the origination site must be located in the state of Alabama. The distant site can be located within or outside the state of Alabama as long as the physician has an Alabama license and is enrolled as an Alabama Medicaid provider. Each telemedicine site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telemedicine services meet the requirements of state and federal laws and professional care standards for recipients.

The physician shall make the protocols and guidelines available for inspection at the telemedicine site, and to the Medicaid Agency upon request.

The physician shall keep a complete medical record on all telemedicine services provided to recipients with documentation of the use of telemedicine technology documented in the record. This will include the treatment plan, progress notes, and treatment plan reviews.

An appropriately trained staff or employee familiar with the recipient's treatment plan or familiar to the recipient must be immediately available in-person to the recipient receiving a telemedicine service to attend to any urgencies or emergencies that may occur during the service. "Immediately available" means the staff or employee must be either in the room or in the area outside the telemedicine room in easy access for the recipient.
If the recipient chooses to waive this requirement, the health care provider administering the telemedicine service shall document this fact in the medical record.

Additionally, in providing telemedicine services, health care providers shall ensure that the telecommunication technology and equipment used at the recipient site, and at the physician site, is sufficient to allow the health care practitioner to appropriately evaluate, diagnose, or treat the recipient for services billed to Medicaid.

Health care physicians and health care facilities shall follow all applicable state and federal laws and regulations governing their practice, including, but not limited to, the requirements for maintaining confidentiality and obtaining informed consent. They shall also verify recipient eligibility prior to administering medical treatments.

Informed Consent:

Prior to an initial telemedicine service, the physician who delivers the service to a recipient shall ensure that the following written information is provided to the recipient in a form and manner which the recipient can understand, using reasonable accommodations when necessary, that:

- S/he retains the option to refuse the telemedicine service at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the recipient would otherwise be entitled;
- Alternative options are available, including in-person services, and these options are specifically listed on the client's informed consent statement;
- All existing confidentiality protections apply to the telemedicine consultation;

- S/he has access to all medical information resulting from the telemedicine consultation as provided by law for patient access to his/her medical records;
- The dissemination of any client identifiable images or information from the telemedicine consultation to anyone, including researchers, will not occur without the written consent of the recipient;
- S/he has a right to be informed of the parties who will be present at each end of the telemedicine consultation and s/he has the right to exclude anyone from either site; and
- S/he has a right to see an appropriately trained staff or employee in-person immediately after the telemedicine consultation if an urgent need arises, or to be informed ahead of time that this is not available.

The physician shall ensure that the recipient's informed consent has been obtained before providing the initial service. The recipient's signature indicates that s/he understands the information, has discussed this information with the physician or his/her designee, and understands the informed consent may apply to follow-up health services with the same physician. The physician providing the telemedicine service, or staff at the recipient site, shall retain the signed statement and the statement must become a part of the recipient's medical record. A copy of the signed informed consent must also be given to the recipient.

If the recipient is a minor or is incapacitated or is mentally incompetent such that s/he is unable to sign the statement, the recipient's legally authorized representative shall sign the informed consent statement to give consent, and retention and distribution of the consent form shall follow previously noted protocol.

Modifiers:

In addition to modifier HE or HF, all procedure codes billed for telemedicine services must be billed with modifiers **GT** (via interactive audio and video telecommunications system) or **GQ** via asynchronous (store & forward) telecommunications system).

Diagnostic Testing done by physician or psychologist (96101-HE 96101-HF)

Definition

Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the psychologist or psychiatrist and interpretation of the test results.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure code 96101 -Diagnostic testing may only be performed by:

- A psychiatrist licensed under Alabama law

OR

— A psychologist licensed under Alabama law

Billing Unit:	One hour
Maximum Units:	5 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

The time started and time ended of service delivery will not include time spent for scoring, interpretation and report writing (at this time). 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.

Diagnostic Testing done by technician (96102-HE 96102-HF)

Definition

Administration of standardized objective and/or projective tests of an intellectual, personality, or related nature in a face-to-face interaction between the client and the technician and interpreted by a qualified health care professional.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Procedure code 96102 -Diagnostic testing may be performed by: a person who possesses any one or more of the following qualifications:

- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 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 postgraduate clinical experience.

Billing Unit:	One hour
Maximum Units:	5 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Diagnostic Testing administered by a computer (96103-HE 96103-HF)

Definition

Administration of standardized objective and/or projective tests (eg, MMPI) of an intellectual, personality, or related nature by a computer and interpreted by a qualified health care professional.

Eligible Staff - Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Diagnostic testing-procedure code 96103 must be administered by a computer and interpreted by a qualified health care professional.

Billing Unit:	One
Maximum Units:	1 per year
Billing Restrictions:	None

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Automated interpretation of diagnostic testing is not billable. Diagnostic testing may be billed at any time during treatment so long as the annual cap is not exceeded.

Crisis Intervention (H2011)

Definition

Immediate emergency intervention by a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse with the client, family, legal guardian, and/or significant others to ameliorate a client's maladaptive emotional/behavioral reaction. Service is designed to resolve the crisis and develop symptomatic relief, increase knowledge of where to turn for help at a time of further difficulty, and facilitate return to pre-crisis routine functioning.

Key service functions include the following:

- Specifying factors that led to the client's crisis state, when known
- Identifying the maladaptive reactions exhibited by the client
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the client for treatment at an alternative setting, when indicated

Eligible Staff - Mental Illness Services

Crisis intervention and resolution may be performed by a person who possesses any one or more of the following qualifications:

- A physician licensed under Alabama law to practice medicine or osteopathy or a certified registered nurse practitioner (CRNP) practicing within the scope approved by the Alabama Board of Nursing
- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law
- 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 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 postgraduate clinical experience
- An individual who has completed an approved case management training course

Eligible Staff - DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager, or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above.

Billing Unit:	15 minutes
Maximum Units:	12 per day, 4380 per calendar year
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT(H0040), PACT (H0040-HQ)

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Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

If the client is unable to sign a receipt for service or if the service is rendered by phone, the documentation in the client's record should so indicate. The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Individual Counseling - (90832, 90834, 90837-HE 90832, 90834, 90837-HF)

Definition

A treatment plan focused intervention between a client and a rehabilitative services or child and adolescent services/adult protective services professional. Treatment is designed to maximize strengths and to reduce behavioral problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational and/or community adjustment.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the client's treatment plan
- On-going assessment of the client's presenting condition and progress made in treatment

Eligible Staff - Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Individual counseling may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 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 postgraduate clinical experience

Eligible Staff - Substance Abuse Services

- Clinical screening and assessment of a substance abuse client must be performed by a person with at least two years of substance abuse treatment experience who meets any one or more of the following qualifications:

Licensed as a physician, psychologist, certified social worker, or counselor;

Possesses a master's degree in a clinical area.

- Treatment planning and counseling of substance abuse clients must be performed by any one or more of the following qualified professionals:

A person with a master's degree in a clinical area with a clinical practicum;

A person with a master's degree in a clinical area that did not require a clinical practicum and one year of supervised clinical experience in a substance abuse treatment/rehabilitation setting;

A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience: A bachelor's level individual with less than two (2) years of direct care substance abuse experience must receive at a minimum two hours per month of documented case-development supervision from a qualified master's level clinician. Upon the individual obtaining two years of direct care substance abuse experience the case-development supervision would no longer be required and the individual would only need to receive two hours per month of ongoing documented supervision;

A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary process for certification. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

- Services must be provided by practitioners consistent with their training, experience, and scope of practice as established by their respective disciplines and Alabama law.
- Services rendered to clients with a primary alcoholism or drug abuse diagnosis must be delivered by a person meeting the criteria listed above, unless an exception is specifically noted and defined in the service descriptions.

Billing Unit:	1 unit
Maximum Unit:	1 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Effective for Date of Services 01-01-2013 and thereafter:
Max Unit = **1 per day**
Billing = 1 of the following codes:

- Code 90832 = therapy given for 16 to 37 minutes
- Code 90834 = therapy given for 38 to 52 minutes
- Code 90837 = therapy given for 53 minutes or greater

Family Counseling 90846-HE 90846-HF (without patient present)
90847-HE 90847-HF (with patient present)
90849-HE 90849-HF (multiple family group)

Definition

A treatment plan focused intervention involving a client, his or her family unit, and/or significant others, and a rehabilitative services, substance abuse, or child and adolescent services/adult protective services professional. Treatment is designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational, and/or community adjustment.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the client's treatment plan
- On-going assessment of the client's presenting condition and progress being made in treatment

Eligible Staff - Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Family counseling may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 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 postgraduate clinical experience

Eligible Staff - Substance Abuse Services

Services may be provided by a person with at least one year of substance abuse treatment experience who meets any one or more of the following qualifications:

- A person licensed as a psychologist, certified social worker, or professional counselor
- A person with a master's degree in a clinical area
- A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience

— A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience-based, voluntary accreditation process. Such certification must have mutual reciprocity with surrounding states and be nationally recognized.

Billing Unit:	30 minutes
Maximum Units:	3 per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session.

When a family consists of a Medicaid eligible adult and child(ren) and the therapy is *not* directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is *not* eligible and the family therapy is directed to the adult and *not* the child, the service may *not* be billed using the child's recipient id number.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's recipient id number ***must*** be used for billing purposes. When a specific child is identified as the primary patient of treatment, that child's recipient ID number ***must*** be used for billing purposes. A family may be biological, foster, adoptive or other family unit.

A family is *not* a group and providers may *not* submit a claim for each eligible person attending the same family therapy session.

All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Group Counseling (90853-HE, 90853-HF)

Definition

A treatment plan focused intervention involving a group of clients, and a rehabilitative services, substance abuse, or child and adolescent services/adult protective services professional. Treatment utilizes interactions of group members to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder or substance abuse problem that interferes with a client's personal, familial, vocational, and/or community adjustment.

Key service functions include the following:

- Face-to-face interaction where interventions are tailored toward achieving specific goals and/or objectives of the client's treatment plan
- On-going assessment of the client's presenting condition and progress being made in treatment

Eligible Staff - Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Group counseling may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- 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 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 postgraduate clinical experience

Eligible Staff - Substance Abuse Services

Group counseling for substance abuse services clients may be performed by a person with at least one year of substance abuse treatment experience who meets any one or more of the following qualifications:

- A person licensed as a psychologist, certified social worker, or professional counselor
- A person with a master's degree in a clinical area
- A person with a bachelor's degree or an RN and two years of supervised substance abuse clinical experience
- A person certified as a qualified substance abuse professional by an independent board established for the purpose of providing an experience based, voluntary accreditation process. Such certification

must have mutual reciprocity with surrounding states and be nationally recognized

Billing Unit:	30 minutes
Maximum Units:	3 per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child & Adolescent Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional information

The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR Protective Services.

Medication Administration 96372-HE 96372-HF (Injectable meds) H0033-HE H0033-HF (oral meds)

Definition

Administration of oral or injectable medications as directed by a physician.

Eligible Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Medication administration for child and adolescent services/adult protective services clients may be performed by a person who possesses any one or more of the following qualifications:

- A registered nurse licensed under Alabama law
- A licensed practical nurse licensed under Alabama law under the direction of a physician

Billing Unit	Episode
Maximum Units	1 per day, 365 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

This service does not include the intravenous administration of medications, nor does it include the preparation of medication trays in a residential setting. Medicaid covers this service under substance abuse for methadone clients only. Procedure codes 96372 HE, 96372 HF, H0033 HE, or H0033 HF may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Utilization will be monitored through retrospective reviews.

Medication Monitoring (H0034)

Definition

Face-to-face contact between the client and a rehabilitative services, or child and adolescent services/adult protective services professional, pharmacist, RN, or LPN for the purpose of reviewing the overt physiological effects of psychotropic medications; monitoring compliance with dosage instructions; instructing the client and/or caregivers of expected effects of psychotropic medications; assessing the client's need to see the physician; and recommending changes in the psychotropic medication regimen.

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Medication monitoring for mental illness and child and adolescent services/adult protective services clients may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law who has completed a master's degree in psychiatric nursing
- A pharmacist licensed under Alabama law
- 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 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 postgraduate clinical experience

- Registered nurse licensed under Alabama law
- Licensed Practical Nurse licensed under Alabama law

Billing Unit	15 minutes
Maximum Units	2 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (H0035), Adult Intensive Day Treatment (H2012), Child and Adolescent Mental Illness Day Treatment (H2012-HA), In-Home Intervention (H2021, H2022-HA), ACT (H0040), PACT (H0040-HQ).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The code V unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Partial Hospitalization Program (H0035)

Definition

A physically separate and distinct organizational unit that provides intensive, structured, active, clinical treatment with the goal of acute symptom remission, immediate hospital avoidance, reduction of inpatient length of stay, or reduction of severe persistent symptoms and impairments that have not responded to treatment in a less intensive level of care.

Key service functions include the following services, which must be available with the program as indicated by individual client need:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Individual, group, and family counseling
- Coping skills training closely related to presenting problems (e.g., stress management, symptom management, assertiveness training, and problem solving; as opposed to basic living skills, such as money management, cooking, etc.)
- Activity therapy closely related to the presenting problems that necessitated admission (e.g., aerobics, maintaining a recovery diary, creative expression (art, poetry, drama) pertaining to the recovery process)
- Medication administration
- Medication monitoring
- Family education closely related to the presenting problems, such as diagnosis, symptoms, medication, coping skills, etc.
- Patient education closely related to the presenting problems, such as diagnosis, symptoms, medication, etc., rather than academic training

Eligible Staff – Mental Illness Services

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

Billing Unit:	A minimum of 4 hours
Maximum Units:	1 per day, 130 days per year
Billing Restrictions:	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Physician Medical Assessment and Treatment (H0004), Medication Administration (96372 HE, 96372 HF, H0033), Medication Monitoring (H0034), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017). These restrictions apply while a client is attending/actively enrolled in Partial Hospitalization whether or not the restricted services occur on the same day as Partial Hospitalization.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment and that protects the client's rights to privacy and confidentiality.

Additional Information

H0035 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 130 units per year. Utilization will be monitored through retrospective reviews.

Adult Intensive Day Treatment (H2012)

Definition

An identifiable and distinct program that provides highly structured services designed to bridge acute treatment and less intensive services, such as Rehabilitative Day Program and Outpatient, with the goals of community living skills acquisition/enhancement, increased level of functioning, and enhanced community integration. Intensive Day Treatment shall constitute active, intermediate level treatment that specifically address the client's impairments, deficits, and clinical needs.

The following services must be available within the program as indicated by individual client need:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program
- Individual, group, and family counseling
- Activity/recreational therapy (e.g., sports, leisure activities, hobbies, crafts, music, socialization, field trips)
- Social skills training (e.g., conversation and interpersonal skills)
- Coping skills training (e.g., stress management, symptom management, problem solving)
- Utilization of community resources
- Family education closely related to the presenting problems such as diagnosis, symptoms, medication, coping skills, etc.)
- Basic living skills (e.g., Adult Basic Education, GED, shopping, cooking, housekeeping, grooming)
- Medication administration
- Medication monitoring
- Client education closely related to presenting problems, such as diagnosis, symptoms, medication, etc. rather than academic training

Eligible Staff – Mental Illness Services

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 hours per year
Billing Restrictions:	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Medication Administration (96372 HE, 96372 HF, H0033), Medication Monitoring (H0034), Partial Hospitalization Program (H0035), and Rehabilitative Day Program (H2017). These restrictions apply while a client is attending/actively enrolled in Intensive Day Treatment whether or not the restricted services occur on the same day as Intensive Day Treatment.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Rehabilitative Day Program (H2017)

Definition

An identifiable and distinct program that provides long-term recovery services with the goals of improving functioning , facilitating recovery, achieving personal life goals, regaining feelings of self-worth, optimizing illness management, and helping clients to become productive participants in family and community life. The Rehabilitative Day Program constitutes active structure, rehabilitative interventions that specifically address the individual's life goals, builds on personal strengths and assets, improves functioning, increases skills, promotes a positive quality of life, and develops support networks. The Rehabilitative Day Program should provide (1) and (2) below and at least one more service from the following list of services based on the needs and preferences of clients participating in the program.

Key service functions include the following:

1. Initial screening to evaluate the appropriateness of the client's participation in the program
2. Development of an individualized program plan

— Structured work oriented activities (e.g., learning and practicing good work habits and/or developing skills to help consumer prepare for specific jobs appropriate to their level of ability)

— Educational skills (e.g., Adult Basic Education, GED, computer skills, support and assistance with returning to school)

— Employment assistance (services designed to help client attain and sustain volunteer work, part-time employment, or a full-time job)

— Sheltered employment opportunities (e.g., thrift store, garden center, or sheltered workshop)

— Goal-oriented groups (e.g., groups designed to help clients identify, discuss, achieve and/or maintain personal life goals, such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family, etc.)

— One-to-one goal-oriented sessions (e.g., one-to-one services designed to help a client identify, discuss, achieve and/or maintain personal life goals, such as living in preferred housing, having a job, returning to school, having friends, being a contributing member of the community, fulfilling a productive role in a family, etc.)

— Skill building (e.g., skills training sessions focused on learning, improving, and maintaining daily living skills, such as grocery shopping, use of public transportation, social skills, budgeting, laundry, and housekeeping, to help clients develop and maintain skills they need to achieve and/or sustain personal life goals

— Utilization of community resources

Eligible Staff – Mental Illness

The program must be staffed and have a program coordinator as required in the current *Community Mental Health Program Standards Manual* or subsequent revisions.

Billing Unit:	15 minutes
Maximum Units:	16 per day, 4160 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization Program (H0035) or Intensive Day Treatment (H2012).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Child and Adolescent Mental Illness Day Treatment (H2012-HA)

Definition

A combination of goal-oriented rehabilitative services designed to improve the ability of a client to function as normally as possible in his or her regular home, school, and community setting when impaired by the effects of a mental or emotional disorder. Programs that provide an academic curriculum as defined by or registered with the State Department of Education and that students attend in lieu of a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Individual, group and family counseling
- Education for the client's parents or guardians regarding emotional and cognitive development and needs
- Services that enhance personal care skills
- Services that enhance family, social, and community living skills
- Services that enhance the use of leisure and play time

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services

The program must be staffed and have a program coordinator as required by the applicable certifying/licensing authority.

Billing Unit:	One hour
Maximum Units:	4 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Individual (90832), Family (90846, 90847, 90849), or Group Counseling (90853), Medication Administration (96372 HE, 96372 HF, H0033), Medication Monitoring (H0034). These restrictions apply while a client is actively enrolled in Day Treatment whether or not the restricted services occur on the same day as Day Treatment.

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Treatment Plan Review (H0032)

Definition

Review and/or revision of a client's individualized treatment plan by a qualified staff member who is not the primary therapist for the client. This review will evaluate the client's progress toward treatment objectives, the appropriateness of services being provided, and the need for a client's continued participation in treatment. This service does not include those activities or costs associated with direct interaction between a client and his or her primary therapist regarding the client's treatment plan. That interaction must be billed through an alternative service, such as individual counseling.

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

- Treatment plan review, for mental illness and child and adolescent services/adult protective services clients, may be performed by a person who possesses any one or more of the following qualifications:
  - A psychologist licensed under Alabama law
  - A social worker licensed under Alabama law
  - A registered nurse licensed under Alabama law who has completed a masters in psychiatric nursing
  - A professional counselor licensed under Alabama law
  - A marriage and family therapist licensed under Alabama law
  - For services billed through DHR, a supervisor employed by DHR as a Service Supervisor or a Senior Social Work Supervisor
  - For services billed through DHR or DYS, 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, or other areas, and who (a) has successfully completed a practicum as part of the requirement for the degree or (b) has six months of post-master's level or above clinical with two years of postgraduate professional experience

Billing Unit:	15 minutes
Maximum Units:	1 event with up to 2 units per quarter, 8 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791), Child and Adolescent In-Home Intervention (H2022-HA), ACT (H0040), and PACT (H0040-HQ).

Location

This service may be provided wherever the client's clinical record is stored. This service may be billed while a client is in an inpatient setting since it is not a face to face service.

Additional Information

The client's treatment plan must be reviewed at least every three months. In cases where only an intake or diagnostic assessment is provided with no further treatment, treatment plan reviews are not covered. One treatment plan review will be covered following a three-month interval of no services delivered; any subsequent reviews with no intervening treatment are disallowed.

Providers must document this review in the client's clinical record by noting on the treatment plan that it has been reviewed and updated or continued without change. Medicaid covers this service for mental illness diagnoses only. The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services. The person who completes the treatment plan review for DHR children, adolescents, or adults must meet the criteria in Section 105.2.3.

Mental Health Consultation (H0046)

Definition

Assisting other external service agency providers or independent practitioners in providing appropriate services to an identified Medicaid client by providing clinical consultation.

Key service functions include written or verbal interaction in a clinical capacity in order to assist another provider to meet the specific treatment needs of an individual client and to assure continuity of care to another setting.

Eligible Staff – Mental Illness

Mental health consultations for mental illness services clients may be performed by a person who possesses any one of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A marriage and family therapist licensed under Alabama law
- A registered nurse licensed under Alabama law
- 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 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 postgraduate clinical experience

Eligible Staff – DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Mental health consultations for child and adolescent services/adult protective services clients may be delivered by an individual employed by a public provider department who meets the state merit system qualifications for Social Service Caseworker, or Youth Services Counselor II, Youth Services Case Manager or above, or an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies who meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above.

Billing Unit:	15 minutes
Maximum Units:	24 per day, 312 per year
Billing Restrictions:	ACT (H0040), PACT (H0040-HQ), In-Home Intervention (H2021, H2022-HA)

Location

There are no excluded settings. This service may be billed while a client is in an inpatient setting since it is not a face to face service.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The V code unspecified psychosocial circumstance is covered only for children and adolescents, or adults receiving DHR protective services.

Consults may be billed for the staff time spent obtaining prior authorizations and overrides for prescription medications. In addition to the eligible staff listed above LPNs may bill for their time directly related to performing this activity. LPNs **are not** eligible to bill for consults for any other type of activity. Acceptable documentation can be a progress note entered in the client's record or the approved authorization/override form filed in the record and dated and signed by the staff member performing the work.

Adult Substance Abuse Intensive Outpatient Services (H0015)

Definition

A combination of time limited, goal oriented rehabilitative services designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle.

Key service functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program plan
- Medical services including prescription of medication and medication management
- Group and family counseling
- Substance abuse education
- Pre-discharge planning
- Family therapy focusing on client and family education regarding substance abuse and community support
- Linkage to community resources

Eligible Staff – Substance Abuse Services

This program must be staffed and have a program coordinator as required in the current *Community Substance Abuse Standards Manual*.

Billing Unit:	1 hour
Maximum Units:	6 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (H0004)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Up to three family members included in family counseling may be counted for reimbursable units.

Child and Adolescent Substance Abuse Intensive Outpatient Services (H0015-HA)

Definition

A structured treatment designed to assist clients in reaching and maintaining a drug and alcohol free lifestyle. Programs that provide an academic curriculum as defined by and registered with the State Department of Education and that students attend in lieu of services provided by a local education agency cannot bill Medicaid for the time devoted to academic instruction.

Key services functions include the following:

- Initial screening to evaluate the appropriateness of the client's participation in the program
- Development of an individualized program
- Group and family counseling
- Education for the client's parents or guardians regarding substance abuse and associated problems
- Substance abuse education for client
- Medical services including the prescription of medication and medication management

Eligible Staff – Substance Abuse Services

The program must be staffed and have a program coordinator as required in the current *Community Substance Abuse Standards Manual*.

Billing Unit:	1 hour
Maximum Units:	6 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (H0004).

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Up to three family members included in family counseling may be counted for reimbursable units.

(Adult) In-Home Intervention (H2021)

Definition

Home based services provided by a treatment team to serve individuals who refuse other outpatient services and/or who need temporary additional support due to increased symptoms or transition from a more intense level of services, to defuse an immediate crisis situation, stabilize the living arrangement, and/or prevent out of home placement of the client.

Key service functions include the following when provided by a tea composed of a Rehabilitative Services Professional (master's level clinician) and a Case Manager:

— Individual or family counseling

— Crisis intervention

— Mental Health Consultation

— Basic Living Skills

— Family Support

— Case Management

— Medication Monitoring

Key service functions include the following when provided by a team composed of a Registered Nurse and a Case Manager:

— Crisis Intervention

— Mental health Consultation

— Basic Living Skills

— Family Support

— Case Management

— Medication Monitoring

— Medication Administration

Eligible Staff – Mental Illness

In-home intervention for mental illness clients are provided by a two-person team minimally composed of the following:

— A rehabilitative services professional staff member or

— A registered nurse licensed under Alabama law and

— A person with a bachelor's degree

Each team member must successfully complete an approved case management training program.

Billing Unit:	15 minutes
Maximum Units:	24 per day, 2016 per year
Billing Restrictions:	May not be billed in combination with Individual Counseling (90832), Family Counseling (90846, 90847, 90849), Mental Health Consultation (H0046), Case Management, Family Support (H2027), Basic Living Skills (H0036) or Medication Monitoring (H0034)

Location

Please note that in-home intervention, while by definition and practice is usually provided in the client's home, infrequently may be provided in other locations. Such exceptions will not render the service ineligible for billing as In-Home Intervention.

When the Adult In-Home Intervention team members are together in the same location providing services as a team, H2021 must be billed and unbundled services cannot be billed for that time period. When the team members work independently of each other, each team member must document as to the specific service rendered and bill under the applicable code [i.e. Individual Counseling (90804), Mental Health Consultation (H0046), etc.] and the billing restrictions will not apply. Travel time to and from the service location must be excluded from the billing.

Utilization will be monitored through retrospective reviews.

Child and Adolescent In-Home Intervention (H2022-HA)

Definition

Time limited home based services provided by a treatment team in order to defuse an immediate crisis situation, stabilize the family unit, and prevent out of home placement of the child or adolescent consumer, who presents with a serious emotional disturbance and who is at risk of out of home placement.

Key service functions include the following:

— Individual Counseling

— Family Counseling

— Family Support

— Basic Living Skills

— Crisis intervention (24 hour availability)

— Medication Monitoring

— Mental Health Consultation

— Case Management Services

— Treatment Plan Review

Eligible Staff – Mental Illness

In-home intervention for mental illness clients may be provided by a two-person team minimally composed of the following:

- A master's level mental health professional with one year of post master's experience in child and adolescent or family therapy

— A person with a bachelor's degree

— Each team member must successfully complete an approved case management training program and In-home Training Program

Billing Unit:	One day (children)
Maximum Units:	One per day, 140 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791), Crisis Intervention (H2011), Individual Counseling (90804), Family Counseling (90846, 90847, 90849), Treatment Plan Review (H0032), Mental Health Consultation (H0046), Case Management, Family Support (H2027), Basic Living Skills (H0036) or Medication Monitoring (H0034) while a family is enrolled in In-Home intervention.

Location

Please note that In-Home intervention, while by definition and practice is usually provided in the child or adolescent consumer's home, infrequently may be provided in non-traditional settings including educational, child-welfare, family court, local parks, or clinic, etc. Such exceptions will not render the service ineligible for billing.

Additional Information

- Medicaid covers this service for mental illness diagnoses only.
- Only persons who meet the definition for Serious Emotional Disturbance (SED) and who are at imminent danger of removal from the home are eligible for this service.
- The team will always be together during the provision of services to children and their families. These services should be billed on a per diem basis while the family is enrolled and receiving in-home intervention services even though a service might not be provided every day.
- Span-billing may be utilized by multiplying the appropriate number of units for the month by the daily rate.
- Covered for children and adolescents only (age 5 to 18 years of age).
- Covered for transitional age young adults (age 18 to 26 years of age).
- The active caseload for a team will not exceed six (6) families.
- In-home must be available other than 8:00 A.M. to 5:00 P.M.
- All In-home clients must be referred to a Case Manager after the In-home team has completed the In-home Intervention.
- The intensive nature of this service should be reflected in the average hours of direct service per family per week.
- In-Home Intervention should follow service delivery patterns taught in the DMH approved In-Home Training Program to maintain the consistency and fidelity of the model.
- Treatment Plan must be completed within 30 days of the first face-to-face contact with the consumer. The Treatment Plan should address the treatment needs identified by the approved assessment tool.
- Signatures for services are secured on the day the service is delivered.
- In-Home Intervention Services are discontinued and enrollees are referred to other services when the team is no longer a two-person team. Examples would include the loss of one of the team members, extended illness, maternity leave, etc. exceeding a two week period.
- Utilization will be monitored through retrospective reviews.

Pre-hospitalization Screening (H0002-HE H0002-HF)

Definition

Face-to-face contact between a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse and a client to determine the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

Key service functions include the following:

- A clinical assessment of the client's need for local or state psychiatric hospitalization
- An assessment of whether the client meets involuntary commitment criteria, if applicable
- Preparation of reports for the judicial system and/or testimony presented during the course of commitment hearing
- An assessment of whether other less restrictive treatment alternatives are appropriate and available
- Referral to other appropriate and available treatment alternatives

Eligible Staff – Mental Illness, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Pre-hospitalization screening may be performed by a person who possesses any one or more of the following qualifications:

- A psychologist licensed under Alabama law
- A professional counselor licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse licensed under Alabama law
- 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 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 postgraduate clinical experience.

Billing Unit:	30 minutes
Maximum Units:	4 per day, 16 per year
Billing Restrictions:	None

Location

Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Additional Information

Providers may bill for time spent in court testimony while a client is in an inpatient unit.

Basic Living Skills (H0036 – Individual; H0036-HQ – Group)

Definition

Psychosocial services provided on an individual or group basis to enable a client to maintain community tenure and to improve his or her capacity for independent living.

Key services functions include the following:

- Training and assistance in developing or maintaining skills such as personal hygiene, housekeeping, meal preparation, shopping, laundry, money management, using public transportation, medication management, healthy lifestyle, stress management, and behavior education appropriate to the age and setting of the client
- Patient education about the nature of the illness, symptoms, and the client's role in management of the illness

Eligible Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Basic living skills may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Meets the qualifications for MI, SA, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above
- Is a registered nurse licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	2080 units per year
	20 per day (individual)
	8 per day (group)
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021,H2022-HA), ACT (H0040), PACT (H0040-HQ)

Location

The only excluded settings are hospitals. Services can be delivered in any setting that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Family Support (H2027 – Individual; H2027-HQ – Group)

Definition

Service provided to families of rehabilitative services clients to assist them in understanding the nature of the illness of their family member and how to help the client be maintained in the community.

Key service functions include, as appropriate, but are not limited to education about the following:

- The nature of the illness
- Expected symptoms
- Medication management
- Ways in which the family member can cope with the illness

Eligible Staff – Mental Illness, Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

Family support services may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Meets the qualifications for MI, SA, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager, or above, or is an employee of an agency or entity under contract to serve the target population of one of the same public provider agencies and meets an approved equivalency for Social Service Caseworker, Youth Services Counselor II, Youth Services Case Manager or above
- Is a registered nurse licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	416 units per year
	8 per day for services provided to an individual client's family
	8 per day for services provided to a group of clients' families
Billing Restrictions:	May not be billed in combination with In-Home Intervention (H2021, H2022-HA) Family Counseling (90846 HE, 90846 HF, 90847 HE, 90847 HF, 90849 HE, 90849 HF), ACT (H0040), PACT (H0040-HQ)

Location

Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality.

Assertive Community Treatment (ACT) (H0040)

Program for Assertive Community Treatment (PACT) (H0040-HQ)

Definition

Treatment services provided primarily in a non-treatment setting by a member of an ACT or PACT team, staffed in accordance with DMH certification standards to adults with serious mental illness who are in a high-risk period due to an exacerbation of the illness and/or returning from an episode of inpatient/residential psychiatric care, or who are consistently resistant to traditional clinic-based treatment interventions and are difficult to engage in an ongoing treatment program.

Key service functions include, but are not limited to, the following:

- Intake
- Physician assessment and treatment
- Medication administration
- Medication monitoring
- Individual, group, and/or family counseling
- Crisis intervention
- Mental health consultation
- Case management
- Family support
- Basic living skills

The only services that may be billed in addition to ACT or PACT are Partial Hospitalization (H0035), Intensive Day Treatment (H2012), and Rehabilitative Day Program (H2017). Billing in combination with Rehabilitative Day Program should occur only on a transitional basis (within 14 calendar days) as a client moves from a team intervention to a less acute array of individually delivered services.

Eligible Staff – Mental Illness

There must be an assigned (ACT or PACT) team that is identifiable by job title, job description, and job function. The team must be staffed in accordance with DMH certification standards. Each member of the team must be known to the client and must individually provide services to each client in the team's caseload. The team will conduct a staffing of all assigned cases at least twice weekly. The caseload cannot exceed a 1:12 staff to client ratio on an ACT team where the part-time psychiatrist is not counted as one staff member or a 1:10 staff to client ratio on a PACT team.

Billing Unit:	One day
Maximum Units:	365 days per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (90791), Physician Medical Assessment and Treatment (H0004), Medication Administration (96372-HE), Medication Monitoring (H0034), Basic Living Skills (H0036), Family Support (H2027), Individual (90804-HE), Family (90846-HE, 90847-HE, 90849-HE), Group Counseling (90853-HE), Crisis Intervention (H2011), Mental Health Consultation (H0046) , or Treatment Plan Review (H0032) .

Location

The only excluded settings are nursing homes. ACT and PACT services may be billed on a daily basis even though the client might not be seen or contacted by the team each day. ACT and PACT services may be billed while a client is hospitalized briefly for stabilization or medical treatment. Services can be delivered in any setting that is convenient for both the family and staff member, that affords an adequate service environment, and that protects the client’s rights to privacy and confidentiality.

Additional Information

Documentation of the required staffings and all client contacts by ACT and PACT team members shall be included in the client's medical record. All service documentation shall follow the guidelines in Section 105.2.3. Client signatures are not required for ACT and PACT key service functions; however, services which are provided outside the ACT and PACT benefit will require client signatures. H0040 and H0040-HQ may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per calendar year. Utilization will be monitored through retrospective reviews.

Methadone Treatment (H0020)

Definition

Methadone treatment is a periodic service designed to offer the individual an opportunity to effect constructive changes in his/her lifestyle by using Methadone in conjunction with the provision of rehabilitation and medical services. Methadone treatment is also a tool in the detoxification and rehabilitation process of narcotic-dependent individuals. For the purpose of detoxification, Methadone is used as a substitute narcotic drug. It is administered in decreasing doses for a period not to exceed 21 days. For individuals with history of psychoactive substance dependence or severe narcotic dependency prior to admission to the service, Methadone may also be used in maintenance treatment. In these cases, it may be administered or dispensed in excess of 21 days at relative stable dosage levels with the treatment goal of an eventual drug-free state.

Eligible Staff –Substance Abuse

The program must be staffed and have a Program Coordinator as required in the current *Community Substance Abuse Standards Manual* or subsequent revisions.

Billing Unit:	One day
Maximum Units:	365 per year
Billing Restrictions:	None

Location

Services can be delivered in any setting that is acceptable for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality. Location should be in compliance with all applicable federal, state, and local codes.

Additional Information

No more than 35 clients who do not meet the requirements for Phase III under the *Community Substance Abuse Standards Manual* will be assigned to a counselor, provided that the counselor may increase the ratio to 1:50 by adding 15 clients to the caseload who have been in opiate replacement treatment and qualify for Phase III requirements under the *Community Substance Abuse Standards Manual*. Clients who receive take-home doses under the hardship waivers, but do not otherwise satisfy Phase III requirements shall not be deemed Phase III clients.

H0020 may be span-billed by multiplying the appropriate number of units for the month by the daily rate. Benefits are limited to 365 units per year. Utilization will be monitored through retrospective reviews.

105.2.2 Reimbursement

The Medicaid reimbursement for each service provided by a rehabilitative services provider is based on the following criteria and does not exceed the lowest of the following amounts:

- The customary charges of the provider but not more than the prevailing charges in the locality for comparable services under comparable circumstances
- The amount billed
- The fee schedule established by Medicaid as the maximum allowable amount
- Reimbursement for services provided by state agencies is based on actual costs as follows:
- Agencies must submit an annual cost report not later than 60 days following the close of the fiscal year. This report must indicate not only the costs associated with providing the services, but also statistical data indicating the units of service provided during the fiscal year.
- Medicaid will review cost reports for reasonableness and an average cost per unit of service will be computed.
- Medicaid will use the average cost, trended for any expected inflation, as the reimbursement rate for the succeeding year.
- If the cost report indicates any underpayment or overpayment for services during the reporting year, Medicaid will make a lump sum adjustment.
- New rates are effective January 1 of each year.

Actual reimbursement is based on the rate in effect on the date of service. Only those services that qualify for reimbursement are covered under this program.

105.2.3 Requirements for Client Intake, Treatment Planning, and Service Documentation

An intake evaluation must be performed for each client considered for initial entry into organized programs or course of covered services. Individuals who are transferred between programs within an agency do not require a new intake at the time of transfer.

To determine a client's need for rehabilitative services, providers must perform an intake evaluation based on assessment of the following information:

- Family history
- Educational history
- Relevant medical background
- Employment/vocational history
- Psychological/psychiatric treatment history
- Military service history
- Legal history
- Alcohol/drug use history
- Mental status examination
- A description of the significant problems that the client is experiencing

Providers use the standardized substance abuse psychosocial assessment as the intake instrument for substance abuse clients.

Eligible Staff – Substance Abuse, DHR/DYS/DCA Child and Adolescent Services, DHR Adult Protective Services

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth client visit with the primary therapist or within ten working days after admission into a day treatment program, substance abuse intensive outpatient program, or residential program. The treatment plan must include the following:

- Identification of the clinical issues that will be the focus of treatment
- Specific services necessary to meet the client's needs
- Referrals as appropriate for needed services not provided directly by the agency
- Identification of expected outcomes toward which the client and therapist will be working to impact upon the specific clinical issues

  Unless clinically contraindicated, the client will sign/mark the treatment plan to document the consumer's/client's participation in developing and/or revising the plan. If the client is under the age of 14 or adjudicated incompetent, the parent/foster parent/legal guardian must sign the treatment plan.

The treatment plan must be approved in writing by any one of the following:

- A psychologist licensed under Alabama law
- A social worker licensed under Alabama law
- A Certified Registered Nurse Practitioner (CRNP) licensed under Alabama law practicing within the scope as defined by the Joint

Committee of the Alabama Board of Nursing and the Alabama Board of Medical Examiners for Advanced Practice Nurses

- A registered nurse licensed under Alabama law who has completed a master's in psychiatric nursing
- A professional counselor licensed under Alabama law
- A physician licensed under Alabama law
- A physician assistant licensed under Alabama law and practicing within the guidelines as outlined by the Alabama Board of Medical Examiners
- A marriage and family therapist licensed under Alabama law
- A supervisor employed by DHR as a Service Supervisor or a Senior Social Work Supervisor
- For services billed through DHR, DYS, or DCA, 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, or other areas that require equivalent course work and who meets at least one of the following qualifications: (a) has successfully completed a practicum as part of the requirement for the degree or (b) has six months of post-master's level professional experience supervised by a master's level or above clinical with two years of postgraduate professional experience

Eligible Staff – Mental Illness

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth client visit with the primary therapist or within ten working days after admission into a day treatment program, substance abuse intensive outpatient program, or residential program. The treatment plan must include the following:

- Represents a person-centered, recovery-oriented treatment planning process through which consumers are assisted to articulate their vision and hope for how their lives will be changed for the better within three to five years (long term recovery vision), to identify short-term outcomes that will assist in achieving the recovery goal (treatment goals), and to specify services and supports including referrals to outside agencies necessary to overcome barriers to achieving the outcomes (necessary services and supports)
- Identifies needed safety interventions based on history of harm to self or others
- Uses a strengths-based approach to treatment planning by identifying consumer and environmental positive attributes that can be used to support achievement of goals and objectives
- Identifies psychiatric, psychological, environmental, and skills deficits that are barriers to achieving desired outcomes
- Identifies treatment and supports that are needed to address barriers to achieving desired therapeutic goal
- Is approved in writing by a licensed physician, certified nurse practitioner, licensed physician's assistant, licensed psychologist, licensed certified social worker, a licensed marriage and family therapist, a registered nurse with a master's degree in psychiatric nursing, or a licensed professional counselor.

Service types must be specified in the treatment plan in order to be paid by Medicaid, with the exception of intake evaluation, crisis intervention and resolution, mental health consultation, pre-hospitalization screening, and treatment plan review. Changes in the treatment plan must be approved as described above.

The preferred course of treatment for persons with co-occurring disorders (MI/SA) is integrated services where both mental illness and substance abuse clinical issues are addressed in the same treatment setting, whether that setting primarily provides mental illness or substance abuse treatment. In cases where integrated services are not possible, a dually diagnosed client may receive mental illness and substance abuse services simultaneously from one or more certified providers. In cases where mental illness and substance abuse services are provided independently, the daily caps specific to each service are cumulative for the day and are not interactive.

In all cases, the diagnosis and treatment plan should reflect both disorders and the interventions needed for both.

After completion of the initial treatment plan, staff must review the client's treatment plan once every three months to determine the client's progress toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. Providers must document this review in the client's clinical record by noting on the treatment plan that it has been reviewed and updated or continued without change. Staff, as specified above, must perform this review.

Treatment plan reviews are not covered in cases where only an intake or diagnostic assessment is provided with no further treatment. One treatment plan review is covered following a three-month interval of no services delivered. Any subsequent reviews with no intervening treatment are disallowed.

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested must comply with any applicable certification or licensure standards and must include the following, at a minimum:

- The identification of the specific services rendered
- The date and the amount of time that the services were rendered (to include the time started and the time ended)
    - For Mental Health Consultation, Diagnostic Testing, Pre-Hospital Screening, Basic Living Skills, and Crisis Intervention which can be provided in multiple, non-continuous times during the same day, it is permissible to aggregate the billable hours that are delivered at different times during the day and to write one note that covers all the different times showing one beginning and ending time covering the time span from start to finish with that consumer and service for that day.
    - Partial Hospitalization, Adult Intensive Day Treatment, Rehabilitative Day Program, Child and Adolescent Day Treatment, Assertive Community Treatment, Program for Assertive Community Treatment, and In-Home Intervention which are billed either hourly up to a daily maximum or per diem will show the time the service is started for the day and ended for the day.
- The signature of the staff person who rendered the services
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials, or computer entry.

Documentation of Medicaid recipients' signatures may be entered on a sign-in log, service receipt, or any other record that can be used to indicate the client's signature and the date of service. The client's signature is only required one time per day that services are provided. Treatment plan review, mental health consultation, pre-hospitalization screening, crisis intervention, family support, ACT, PACT, and any non-face-to-face services that can be provided by telephone do not require client signatures.

ACT and PACT services are billed as a bundled service on a daily rate even though the client might not be seen or contacted by the team each day. Documentation of the required staffings and any service provided to or on behalf of a client must be included in the client's medical record.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment. Documentation failing to meet the minimum standards noted above will result in recoupment of payments.

Additional Information

Documentation

Documentation should not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes should not be ***preprinted*** or predated with the exception that a group therapy note may have a general section that identifies the participants (i.e. the number of participants, etc.), the topic, and a general description of the session which is copied for each participant. However, each participant must also have individualized documentation relative to his/her specific interaction in the group and how it relates to their treatment plan.
- The progress note should match the goals on the plan and the plan should match the needs of the recipient. The interventions should be appropriate to meet the goals. There should be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan should not be signed or dated prior to the plan meeting date.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time/date entry stamp.

- If utilizing a computer entry system, there must be a written policy for documentation method in case of computer failure/power outage.

Corrections

- White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

105.3 Prior Authorization and Referral Requirements

Rehabilitative services procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines. Rehabilitative services do not require a Patient 1st referral.

105.4 Cost Sharing (Copayment)

Copayment does not apply to rehabilitative services.

105.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Rehabilitative services providers who bill Medicaid claims electronically receive the following benefits:

— Quicker claims processing turnaround

— Ability to immediately correct claim errors

— Online adjustments capability

— Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

105.5.1 Time Limit for Filing Claims

Medicaid requires all claims for rehabilitative services to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions for more information regarding timely filing limits and exceptions.

105.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes, within the range of 290-316, must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. The V code unspecified psychosocial circumstance is covered only for children and adolescents or adults receiving DHR protective services. Claims filed for pregnant women (SOBRA) must include V222 (pregnant state, incidental) as well as the appropriate MI/SA diagnosis code.

105.5.3 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers. Use the modifiers to distinguish mental illness/substance abuse, adult/child and adolescent, individual/group services.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible DMH MI-SA/DHR/DYS staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.-This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible DMH MI-SA/DHR/DYS staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (*http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html*) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly.

105.5.4 Place of Service Codes

The following place of service codes apply when filing claims for rehabilitative services:

POS Code	***Description***
11	Office
12	Home
31	Skilled Nursing Facility or Nursing Home
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
52	Psychiatric Facility Partial Hospitalization
53	Community Rehabilitative Services Center
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
99	Other Unlisted Facility

105.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

105.5.6 Billing Instructions for Medical-related Services

Instructions for Claims with Dates of Service August 1, 2000 and Thereafter

1. Bill Medicare on a UB-04.
2. Services covered by Medicare should be automatically crossed over to Medicaid as a UB-04 outpatient crossover. If for some reason the claim never crosses over or the claim is denied after crossing over, send an Institutional Medicaid/Medicare-related claim form to Medicaid using the same information as it was sent to Medicare. Indicate coinsurance, deductible, and allowed amounts as applied by Medicare.
3. If Medicare does not pay on any part of the services, bill the amount due for the services on a CMS-1500 claim form using procedure codes listed in the provider manual. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically. For paper claims, enter "key TPL input code M" in block 19 of the CMS-1500 form.

105.5.7 Billing Instructions for Medicare-Related Services

A. Partial Hospitalization Program – Medicare covers such services as education training, group therapy, activity therapy, etc. These services are billed to Medicare on a UB-04 claim using procedures codes (e.g. G0177, G0176, 90853, 90816, 90818, 90791, etc.).

1. Services **covered** by Medicare should be filed with Medicaid on a **Medical Medicaid/Medicare-related crossover claim form**, either electronically or on paper. Bundle all Medicare paid services together and use H0035-HE procedure code/modifier. Indicate the total coinsurance, deductible, allowed, and paid amounts as applied by Medicare.
2. Services **not covered** by Medicare should be filed with Medicaid as a straight Medicaid claim on a CMS-1500 claim form using the procedure codes listed in the provider manual since Medicaid covers these services. These claims must be submitted with an override code in order for Medicaid to consider payment and not reject the claim for Medicare coverage. For paper claims, enter *"key TPL input code M"* in block 19 of the CMS-1500 form. For an electronic override, submit a delay reason code of '11'. Please refer to the latest edition of the Provider Electronic Solutions User Manual for more information on submitting an override electronically.

B. Licensed Certified Social Worker (LCSW) – effective for claims processed February 23, 2008, and thereafter:

1. For the recipient with Medicaid/Medicare (non-QMB), the LCSW is covered by Medicare; but not Medicaid. After the payment has been received by Medicare; file Medicaid on **Medical Medicaid/Medicare-related crossover claim form** with the provider (clinic's) NPI and the clinic's secondary provider number. Do not file these claims using any of the LCSW's provider number.
2. For the recipient with QMB coverage, the LCSW is covered by Medicare and Medicaid. These claims will crossover from Medicare and Medicaid will process with the enrolled LCSW's provider number if billed appropriately to Medicare.

105.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
ASC Procedures List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

106 Targeted Case Management

Case management services are services that assist eligible individuals in gaining access to needed medical, social, educational and other services. Targeted Case Management (TCM) services assist specific eligible recipients, or targeted individuals, to access other services.

Targeted Case Management services may be provided to recipients who reside in their own home, the household of another, or in a supervised residential setting. No case management services will be provided to recipients in a hospital, skilled nursing facility, intermediate care facility, prison, jail, or other total care environment.

Targeted Case Management services are provided to eligible recipients in the following eight target groups:

Target Group	***Recipients***	***Description***
Target Group 1	Mentally ill adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with mental illness
Target Group 2	Mentally retarded adults	Medicaid-eligible individuals age 18 and over who have been diagnosed with mental retardation
Target Group 3	Handicapped children	Medicaid-eligible individuals age 0-21 who are considered handicapped
Target Group 4	Foster children	Medicaid-eligible individuals age 0-21 who are in the care, custody, or control of the state of Alabama
Target Group 5	Pregnant women	Medicaid-eligible women of any age in need of maternity services
Target Group 6	AIDS/HIV-positive individuals	Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive
Target Group 7	Adult protective service individuals	Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation
Target Group 8	Technology Assisted (TA) Waiver for Adults	Medicaid-eligible individuals age 21 and over who meet the eligibility criteria for the TA Waiver

The policy provisions for TCM providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 40.

106.1 Enrollment

Providers will submit a written request to the LTC Program Management Unit for enrollment to the Targeted Case Management (TCM) Services Program. The request must contain the TCM target group to be covered: the name, address, and phone number of the provider agency; the name, address, and phone number of the payee (if different from the provider); the name and phone number of the contact person; and the tax ID number of the payee.

Subcontract providers must have a contract with the primary provider. A copy of this contract will be submitted with the request to enroll as a TCM provider.

A memo will be forwarded to the LTC Provider/Recipient Services Unit with the assigned NPI, procedure code, and rate with the enrollment request information. The Provider/Recipient Services Unit will submit a request to load the pricing file on Level I or Level III, as appropriate, to the Fiscal Agent Liaison. The Fiscal Agent Liaison will load the information to the pricing file and submit the provider file to HP for enrollment.

The LTC Provider/Recipient Services Unit will notify the Program Management Unit when the enrollment process has been completed. The LTC Program Management Unit will notify the provider in writing of the effective date of enrollment.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a TCM provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for case management-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

TCM providers are assigned a provider type of 21 (Targeted Case Management). Valid specialties for TCM providers include the following:

- Mentally Ill Adults (209)
- Mentally Retarded Adults (229)
- Handicapped Children (650)
- Foster Child (217)
- Pregnant Women (210)
- AIDS/HIV Positive Individuals (211)
- Adult Protective Services (640)
- Technology Assisted (TA) Waiver Eligible Adults (590)

Enrollment Policy for TCM Providers

To participate in the Alabama Medicaid Program, Targeted Case Management providers must meet the following requirements:

- Demonstrate the capacity to provide the core elements of case management, including assessment, care and services plan development, linking and coordination of services, and reassessment and follow-up
- Demonstrate case management experience in coordinating and linking community resources as required by the target population
- Demonstrate experience with the target population
- Provide the administrative capacity to ensure quality of services in accordance with state and federal requirements
- Maintain a financial management system that provides documentation of services and costs
- Demonstrate the capacity to document and maintain individual case records in accordance with state and federal requirements
- Demonstrate the ability to ensure a referral process consistent with Section 1902(a)23 of the Social Security Act, freedom of choice of provider
- Demonstrate the capacity to meet the case management service needs of the target population
- Provide an approved training program certified by Medicaid to address the needs and problems of the recipients served
- Provide a quality assurance program for case management services approved and certified by Medicaid. The quality assurance program includes record reviews at a minimum of every six months.
- Fully comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990
- Fully comply with applicable federal and state laws and regulations

106.1.1 Minimum Qualifications for Individual Targeted Case Managers

Individual Targeted Case Managers must meet the following minimum educational qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field or social work program
- Possess certification as a registered nurse

Individual Targeted Case Managers for Pregnant Women (Target Group 5), and AIDS/HIV-Positive Individuals (Target Group 6), must have a Bachelor of Arts or Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education.

Individual Case Managers for Foster Children (Target Group 4) and Adult Protective Service individuals (Target Group 7) must be employed by DHR and meet the following qualifications:

- Possess a Bachelor of Arts or a Bachelor of Science degree, preferably in a human service field, or
- Possess certification as a registered nurse

In addition to the minimum educational requirements, Targeted Case Managers must complete training in a case management curriculum approved by Medicaid and other applicable state agencies. Specific requirements for each target group are listed in the following paragraphs.

106.1.2 Minimum Qualifications for Each Target Group

Minimum Qualifications for Target Group 1 Providers

TCM providers for Mentally Ill Adults (Target Group 1) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Department of Mental Health and Mental Retardation.

TCM providers for Mentally Ill Adults (Target Group 1) must be Regional Boards incorporated under Act 310 of the 1967 Alabama Acts & Comprehensive Community Health Centers. TCM providers for Mentally Ill Adults must be certified and provide services through a contract with the Department of Mental Health and Mental Retardation.

Minimum Qualifications for Target Group 2 Providers

TCM providers for Mentally Retarded Adults (Target Group 2) must meet the minimum educational qualifications listed in Section 106. 1.1 and must complete training in a case management curriculum approved by Medicaid and the Alabama Department of Mental Health and Mental Retardation.

TCM providers for Mentally Retarded Adults (Target Group 2) must be either Regional Boards incorporated under Act 310 of the 1967 Alabama Acts & Comprehensive Community Health Centers who have demonstrated the ability to provide targeted case management services directly, or the Alabama Department of Mental Health and Mental Retardation (DMH/MR). Providers must be certified by the Alabama DMH/MR.

Minimum Qualifications for Target Group 3 Providers

TCM providers for Handicapped Children (Target Group 3) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 4 Providers

TCM providers for Foster Children (Target Group 4) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Groups 5 and 6 Providers

TCM providers for Pregnant Women (Target Group 5) and AIDS/HIV-Positive Individuals (Target Group 6) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 7 Providers

TCM providers for Adult Protective Services (Target Group 7) must meet the minimum educational qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

Targeted Case Management Service Providers for Adult Protective Service Individuals (Target Group 7) must demonstrate experience with the target population in investigating abuse, neglect, or exploitation in domestic settings and in providing follow-up services to victims of abuse, neglect, or exploitation.

Minimum Qualifications for Target Group 8 Providers

TCM providers for Technology Assisted Waiver eligible adult individuals ((Target Group 8) must meet the minimum qualifications listed in Section 106.1.1 and must complete training in a case management curriculum approved by Medicaid.

106.2 Benefits and Limitations

This section describes benefits and limitations for Targeted Case Management providers. It contains the following subsections:

- Core Elements of Targeted Case Management
- Target Group Definitions
- Documentation Requirements
- Limitations

106.2.1 Core Elements of Targeted Case Management

Case management services assist Medicaid-eligible recipients in gaining access to needed medical, social, educational, and other services. The case manager provides these services through telephone contact with recipients, face-to-face contact with recipients, telephone contact with collaterals, or face-to-face contact with collaterals. Collaterals are the Medicaid-eligible client's immediate family and/or guardians, federal, state, or local service agencies (or agency representatives), and local businesses who work with the case manager to assist the recipient.

Targeted Case Management services consist of the following six core elements, which are defined in the paragraphs that follow:

- Needs assessment
- Case planning
- Service arrangement
- Social support
- Reassessment and follow-up
- Monitoring

Needs assessment

A TCM provider performs a written comprehensive assessment of the recipient's assets, deficits, and needs. The TCM provider gathers the following information:

- Identifying information
- Socialization and recreational needs
- Training needs for community living
- Vocational needs
- Physical needs
- Medical care concerns
- Social and emotional status
- Housing and physical environment
- Resource analysis and planning

Case planning

TCM providers must develop a systematic, recipient-coordinated plan of care that lists the actions required to meet the identified needs of the recipient based on the needs assessment. The plan is developed through a collaborative process involving the recipient, his family or other support system, and the case manager. It must be completed in conjunction with the needs assessment within the first 30 days of contact with the recipient.

Service arrangement

Through linkage and advocacy, the case manager coordinates contacts between the recipient and the appropriate person or agency. These contacts may be face to face, phone calls, or electronic communication.

Social Support

Through interviews with the recipient and significant others, the case manager determines whether the recipient possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case manager assists the recipient in expanding or establishing such a network through advocacy and linking the recipient with appropriate persons, support groups, or agencies.

Reassessment and Follow-up

Through interviews and observations, the case manager evaluates the recipient's progress toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the case manager contacts persons or agencies providing services to the recipient and reviews the results of these contacts, together with the changes in the recipient's needs shown in the reassessments, and revises the case plan if necessary.

Monitoring

The case manager determines what services have been delivered and whether they adequately meet the needs of the recipient. The plan of care may require adjustments as a result of monitoring.

106.2.2 Target Group Definitions

This section defines the eight target groups served by TCM providers.

Target Group 1 – Mentally Ill Adults

Target Group 1 consists of functionally limited individuals age 18 and over with multiple needs who require mental health case management. Such persons have a DSM-III-R diagnosis (other than mental retardation or substance abuse), impaired role functioning, and a documented inability to independently access and sustain involvement with needed services.

Target Group 2 – Mentally Retarded Adults

Target Group 2 consists of individuals who are 18 years of age or older with a diagnosis of mental retardation, as defined by the American Association of Mental Retardation (formerly AAMD). The individual's diagnosis must be determined by a Qualified Mental Retardation Professional (QMRP) and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation. Such persons may have other or secondary handicapping conditions.

Target Group 3 – Handicapped Children

Target Group 3 consists of individuals, age 0-21 considered to be handicapped as defined in the following six subgroups:

- Mentally retarded/related conditions
- Seriously emotionally disturbed
- Sensory impaired
- Disabling health condition(s)
- Developmentally delayed
- Multi-handicapped

Mentally Retarded/Related Conditions

All recipients in this subgroup must be age 0-17. A recipient is considered mentally retarded when a diagnosis of mental retardation is determined. This determination must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

Recipients with related conditions are individuals who have a severe chronic disability described by all of the following criteria:

- Attributable to Cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons
- Likely to continue indefinitely

- Results in substantial functional limitations in three or more of the following areas of major life activity:
  - Self-care
  - Understanding and use of language
  - Learning
  - Mobility
  - Self-direction or capacity for independent living

Seriously Emotionally Disturbed

A recipient is considered seriously emotionally disturbed if they meet at least one criterion from column 1, Mental Health Treatment History, or 2, Indicators or Mental Health Treatment Needs, and two criteria from column 3, Current Functioning Problem Areas.

Mental Health Treatment History	***Indicators of Mental Health Treatment Needs***	***Current Functioning***
Has undergone mental health treatment more intensive than outpatient care (emergency services or inpatient services) Has experienced structured, supportive residential treatment, other than hospitalization, for a total of at least two months in their lifetime Has been assigned to a program of psychotropic medication Has received mental health outpatient care for a period of at least six months, or for more than 20 sessions, or has been admitted for treatment on two or more occasions	Family history of alcohol or drug abuse Family history of mental health treatment Failure to thrive in infancy or early development indicated in medical records Victim of child abuse, neglect, or sexual abuse Pervasive or extreme acts of aggression against self, others, or property (homicidal or suicidal gestures, fire setting, vandalism, or theft) Runaway episode(s) of at least 24 hours' duration	Does not attend school (and has not graduated), is enrolled in a special education curriculum, or has poor grades Dysfunctional relationship with family and peers Requires help in basic, age-appropriate living skills Exhibits inappropriate social behavior Experiences serious discomfort from anxiety, depression, irrational fears, and concerns (indicated by serious eating or sleeping disorders, extreme sadness, or social isolation)

NOTE:

Consider current functioning problem areas of one-year duration or with substantial risk of over one year duration.

Sensory Impaired

Blind recipients have no usable vision after the best possible correction. They must rely on tactile and auditory senses to obtain information.

Partially sighted recipients have a visual acuity of 20/70 or less in the better eye with the best possible correction. They also have a peripheral field so restricted that it affects their ability to learn, or a progressive loss of vision which may in the future affect their ability to learn.

Deaf recipients have a hearing impairment that is so severe that they are impaired in processing linguistic information through hearing, with or without amplification. This impairment adversely affects educational performance.

Blind multihandicapped recipients have a visual impairment (either blind or partially sighted as defined above) and a concurring handicapping condition.

Deaf multihandicapped recipients have a hearing impairment (deaf as defined above) and a concurring handicapping condition.

Deaf-blind recipients have both hearing and visual impairments. The combination of sensory impairments causes such severe communication and other developmental and educational problems that the recipient cannot be properly accommodated in the educational programs offered by the Alabama School for the Blind or the Alabama School for the Deaf.

Disabling Health Condition(s)

Recipients are eligible for Targeted Case Management services if they have the following disabling conditions, which are severe, chronic, and physical in nature and require extensive medical and habilitative/rehabilitative services.

- Central nervous system dysraphic states such as spina bifida, hydranencephaly, and encephalocele
- Cranio-facial anomalies such as cleft lip and palate, Apert's syndrome, and Crouzon's syndrome
- Pulmonary conditions such as cystic fibrosis
- Neuro-muscular conditions such as cerebral palsy, arthrogryposis, and juvenile rheumatoid arthritis
- Seizure disorders such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type
- Hematologic/immunologic disorders such as hemophilia, sickle cell disease, aplastic anemia, and agammaglobulinemia
- Heart conditions such as aortic coarctation, and transposition of the great vessels
- Urologic conditions such as extrophy of bladder
- Gastrointestinal conditions such as Hirschsprung's Disease, omphalocele, and gastroschisis
- Orthopedic problems such as clubfoot, scoliosis, fractures, and poliomyelitis
- Metabolic disorders such as panhypopituitarism
- Neoplasms such as leukemia, and retinoblastoma

- Multisystem genetic disorders such as tuberosclerosis, and neurofibromatosis

Developmentally Delayed

A child age birth to three years is eligible for TCM services if they are experiencing developmental delays greater than or equal to 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

- Cognitive development
- Physical development, including vision and hearing
- Language and speech development
- Psychosocial development
- Self-help skills

A recipient is also eligible if they have been diagnosed with a physical or mental condition that has a high probability of resulting in a development delay.

Multihandicapped

An individual who has a combination of two or more handicapping conditions as described above is considered multi-handicapped. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions adversely affects development.

Target Group 4 – Foster Children

Target Group 4 consists of children age birth to 21 who receive preventive, protective family preservation or family reunification services from the State, or any of its agencies, as a result of State intervention or upon application by the child's parent(s), custodian(s), or guardian(s).

The group also consists of children age birth to 21 who are in the care, custody, or control of the State of Alabama, or any of its agencies, due to one of the following three situations.

- The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975
- The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute
- The voluntary placement agreement, voluntary boarding house agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian

Target Group 5 – Pregnant Women

Target Group 5 consists of Medicaid-eligible women of any age in need of maternity services.

Target Group 6 – AIDS/HIV-Positive Individuals

Target Group 6 consists of Medicaid-eligible individuals of any age who have been diagnosed with AIDS or are HIV-positive as evidenced by laboratory findings.

Target Group 7 – Adult Protective Service Individuals

Target Group 7 consists of individuals 18 years of age or older who meet either of the following criteria:

- At risk of abuse, neglect, or exploitation
- At risk of institutionalization due to their inability or their caretaker's inability to provide the minimum sufficient level of care in the home

Target Group 8 - Technology Assisted (TA) Waiver for Adults

Target Group 8 individuals consist of Medicaid eligible individuals age 21 and older, who meet the eligibility criteria for the Technology Assisted (TA) Waiver for Adults.

106.2.3 Documentation Requirements

The TCM provider must make available to Medicaid at no charge all information describing services provided to eligible recipients. The provider must also permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies.

The TCM provider must maintain complete and accurate medical, psychiatric and fiscal records that fully disclose the extent of the service. The records shall be retained for three years plus the current year to substantiate that the services billed to Medicaid were actually delivered to the Medicaid recipient and to substantiate the charges billed to Medicaid. However, if audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three year period, the TCM provider must retain the records until resolution.

Record retention for TCM files will remain three years plus the current year. Records for TCM provided through waivers shall be retained for three years during the initial waiver period and five years after renewal of the waivers.

Provider’s records must contain the following information:

- Name of recipient
- Dates of service
- Name of provider agency and person providing services
- Nature, extent, or units of services provided
- Place of service

TCM providers must maintain the following documentation in the recipient's record when billing for Foster Children (Target Group 4) and Adult Protective Service Individuals (Target Group 7):

- A current comprehensive service plan that identifies the medical, nutritional, social, educational, transportation, housing and other service needs that have not been adequately accessed
- A time frame to reassess service needs

Services must consist of at least one of the following activities:

- Establishment of a comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of -the recipient
- Assistance for the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan
- Assessment of the recipient and service providers to determine that the services received are adequate in meeting the identified needs
- Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events

Social Services Work Sampling Study

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), reimbursement rates are based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation and identifies that services have been provided.

106.2.4 Limitations

For Target Group 4 (Foster Children) and Target Group 7 (Adult Protective Service Individuals), an encounter rate consisting of a maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services. A unit of case management service consists of at least one telephone or face-to-face contact with the recipient, a family member, significant other, or agency from which the client receives or may receive services.

For all other target groups, a unit of service is reimbursed in increments of five minutes.

The case manager must document all contacts in the recipient’s record. Contacts must be for the coordination of services for a specific identified recipient.

Recipients receiving case management services through a waiver are not eligible for targeted case management.

Case management services for mentally retarded adults are provided to individuals with a diagnosis of mental retardation who are 18 years of age or older.

Case management services for all other target groups are not limited to a maximum number of hours per calendar year.

106.3 Prior Authorization and Referral Requirements

TCM procedure codes generally do not require prior authorization, except for the target groups noted below.

TCM providers must obtain prior authorization from HP to avoid duplicate payments for targeted case management services in the following target groups:

- Handicapped Children (Target Group 3)
- Foster Children (Target Group 4)

Direct all inquiries and requests relating to prior authorization for a specific target group to HP' Provider Communication Unit at 1(800) 688-7989.

Interagency Transfers

If a recipient in a target group requiring prior authorization requests to change case managers from one agency to another, the TCM provider must complete a Request for Interagency Transfer form. This form authorizes HP to reassign the prior authorization number to the receiving agency providing the continuation of case management services. Obtain the Request for Interagency Transfer forms from the Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

106.4 Cost Sharing (Copayment)

The copayment does not apply to services provided for targeted case management.

106.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

➢Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

TCM providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

106.5.1 Time Limit for Filing Claims

Medicaid requires all claims for TCM providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

106.5.2 Diagnosis Codes

See Section 106.5.3 (Procedure Codes and Modifiers) for the allowable diagnosis codes. The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

106.5.3 Procedure Codes and Modifiers

TCM providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional and institutional claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

The following procedure codes, modifiers, and diagnosis codes apply when filing claims for TCM services:

Target Group	*Procedure Code*	*Diagnosis Code*	*PA Required?*
5 (Pregnant Women	G9008-HD	V220 – V242 V270 – V289 V3100 – V3900 630 – 632 63300 – 63391 63400 – 63792 6380 – 6399 64000 – 64193 64200 – 64294 64300 – 64393 64400 – 64421 64510 – 64603 64610 – 64624 64630 – 64631 64640 – 64664 64670 – 64673 64680 – 64684 64690 – 64693 64700 – 64894 65100 – 65393 65400 – 65494 65500 – 66393 66400 – 67694	No
2 MR Adults	G9008-U2	317 – 319	No

Target Group	***Procedure Code***	***Diagnosis Code***	***PA Required?***
1 MI Adults	G9008-U1	29500 – 29595 29600 – 29666 2967 – 2967 29680 – 29699 2970 – 2989 29900 – 29991 30000 – 30029 3003 – 3007 30081 – 30089 3009 – 3010 30110 – 30113 30120 – 30122 3013 – 3014 30150 – 30159 3016 – 3017 30181 – 30189 3019 - 3019	No
3 MR Child	G9005-U3	319	Yes
3 SED Child	G9002-U3	3009	Yes
3 Sensory Impaired Child	G9008-U3	78199	Yes
3 Disabling Health Child	G9008-U3	780	Yes
3 Multi Handicapped Child	G9008-U3	7429	Yes
4 Foster Child	T2023-U4	2999	Yes
6 AIDS/ HIV	G9012-U6	042 07953	No
3 DD Child	G9006-U3	3159	Yes
8 TA Waiver	G9008-U5	V550	No
7 APSI	T2023-U7	797	No

106.5.4 Place of Service Codes

The following place of service codes apply when filing claims for TCM services:

POS Code	*Description*
11	Office
12	Home
24	Ambulatory Surgical Center
33	Custodial Care Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
62	Comprehensive Outpatient Rehabilitation Facility
71	State or Local Public Health Clinic
81	Independent Laboratory

106.5.5 Required Attachments

There are no required attachments for Targeted Case Management providers.

106.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
Electronic Media Claims (EMC) Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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107 Waiver Services

Medicaid covers Home and Community-Based Services (HCBS) through the Elderly and Disabled (E&D) Waiver, the State of Alabama Independent Living (SAIL) Waiver (formerly Homebound Waiver), the Technology Assisted (TA) Waiver for Adults, the HIV/AIDS Waiver, and the Alabama Community Transition (ACT) Waiver to categorically needy individuals who would otherwise require institutionalization in a nursing facility.

Medicaid covers the Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver), formerly MR Waiver and the Living at Home (LHW) Waiver to Medicaid-eligible individuals who would otherwise require the level of care available in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).

The purpose of providing HCBS to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care. Services that are reimbursable through Medicaid's EPSDT Program shall not be reimbursed as a waiver service. HCBS are provided through a Medicaid waiver for an initial period of three or five years and for five-year periods thereafter upon renewal of waiver by the Centers for Medicare and Medicaid Services (CMS) .

The E&D Waiver is a cooperative effort between the Alabama Medicaid Agency, and the Alabama Department of Senior Services (ADSS). The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36.

The SAIL Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama-Department of Rehabilitation Services (ADRS). The policy provisions for SAIL Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 57.

The ID and LHW Waivers are a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health (DMH). The policy provisions for ID and LHW Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapters 35 and 52 respectively.

The Alabama Medicaid Agency is the Operating Agency for the TA Waiver for Adults. The policy provisions for providers of the TA Waiver for Adults can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 54.

The HIV/AIDS Waiver is a cooperative effort among the Alabama Medicaid Agency and the Alabama Department of Public Health (ADPH). The policy provisions for HIV/AIDS Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 58.

The ACT Waiver is a cooperative effort among the Alabama Medicaid Agency and Alabama Department of Rehabilitative Services (ADRS). The policy provisions for the ACT Waiver providers can be found in the Alabama Medicaid Agency Administrative Code, Chapter 44.

NOTE:

Providers rendering private duty nursing services as a result of an EPSDT screening should refer to the Alabama Medicaid Provider Manual, Chapter 31 for policy provisions.

107.1 Enrollment

Applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual* should apply with the designated waiver Operating Agency for the E&D, SAIL, ID, Living at Home, HIV/AIDS and ACT Waivers. Applicants for the TA Waiver are enrolled directly through HP. The ADRS may contract directly with vendors of non-medical ACT Waiver services.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a waiver provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive direct reimbursement for waiver-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Providers of waiver services are assigned a provider type of 53 (Waiver Service). Valid specialties for these providers include the following:

- Elderly and Disabled Waiver (670)
- SAIL Waiver (660)
- ID Waiver (680)
- Living at Home Waiver (690)
- Technology Assisted (TA) Waiver for Adults (590)
- HIV/AIDS Waiver (620)
- ACT Waiver (661)

Enrollment Policy for Waiver Service Providers

To participate in the Alabama Medicaid Program, providers must meet the following requirements:

- Must have a contractual agreement with Medicaid directly or through an Operating Agency.
- Must meet the provider qualifications as outlined in the approved Waiver Document for the appropriate HCBS waiver.

Re-enrollment Policy for Waiver Service Providers

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

107.2 Benefits and Limitations

The following table lists the services covered by each type of waiver:

Waiver	***Services Covered***
Elderly and Disabled Waiver	Case Management Services Homemaker Services Personal Care Services Adult Day Health Services Respite Care Services (Skilled and Unskilled) Companion Services Home Delivered Meals (Frozen Shelf-Stable and Breakfast Meals)
SAIL Waiver	Case Management Services Personal Care Services Environmental Accessibility Adaptations Personal Emergency Response System (PERS) Initial Setup Personal Emergency Response System (PERS) Monthly Medical Supplies Minor Assistive Technology Assistive Technology Evaluation for Assisted Technology Assistive Technology Repairs Personal Assistance Services

Waiver	***Services Covered***
Home and community-based services for ID waiver	Residential Habilitation Training Residential Habilitation-Other Living Arrangement Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Prevocational Services Supported Employment Individual Job Coach Individual Job Developer Occupational Therapy Services Speech and Language Therapy Physical Therapy Behavior Therapy-(Levels 1-3) Companion Services In-Home Respite Care Out-of-Home Respite Care Institutional Respite Personal Care Personal Care on Worksite Personal Care Transportation Environmental Accessibility Adaptations Specialized Medical Equipment Specialized Medical Supplies Skilled Nursing(RN/LPN) Crisis Intervention Community Specialist
Home and community-based services for Living at Home Waiver	In-home Residential Habilitation Day Habilitation-(Levels 1-4) Day Habilitation w/transportation-(Levels 1-4) Supported Employment Individual Job Coach Individual Job Developer Prevocational Services In-Home Respite Out-of-Home Respite Personal Care Personal Care on Worksite Personal Care Transportation Physical Therapy Occupational Therapy Speech Therapy Behavior Therapy-(Levels 1-3) Skilled Nursing Environmental Accessibility Adaptations Specialized Medical Equipment Specialized Medical Supplies Community Specialist Crisis Intervention
Home and community-based services for Technology Assisted (TA) Waiver for Adults	Private Duty Nursing (RN/LPN) Personal Care/Attendant Service Medical Supplies and Appliances Assistive Technology
Home and community-based services for HIV/AIDS Waiver	Case Management Services Homemaker Services Personal Care Services Respite Care Services (Skilled and Unskilled) Skilled Nursing Services Companion Services

Waiver	*Services Covered*
Home and community-based services for ACT Waiver	Community Case Management Transitional Assistance Service Personal Care Services Homemaker Services Adult Day Health Home Delivered Meals (Frozen, Shelf-Stable, and Breakfast) Respite Care Services (Skilled and Unskilled) Skilled Nursing (RN/LPN) Adult Companion Services Home Modifications Assistive Technology Assistive Technology Repairs Assistive Technology Evaluation PERS (Installation and Monthly Fee) Medical Equipment, Supplies, and Appliances Personal Assistance Services

107.2.1 Financial Eligibility

Financial eligibility for the E&D waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Individuals receiving State or Federal Adoption Subsidy
- Optional categorically needy individuals at a special income level of 300 percent of the Federal Benefit Rate (FBR) who are receiving HCBS waiver services.

Financial eligibility for the ID waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- Low Income Families with Children
- Federal or State Adoption Subsidy Individuals

Financial eligibility for the SAIL waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial eligibility for the Living at Home Waiver is limited to the following individuals:

- Individuals receiving SSI
- Medicaid for Low Income Families (MLIF)
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State or Federal Adoption Subsidy

Financial eligibility for Technology Assisted Waiver for Adults and the HIV/AIDS Waiver is limited to the following individuals:

- Individuals receiving SSI
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300 percent of the SSI Federal Benefit Rate
- State Supplementation
- Individuals eligible for the Pickle Program (continued Medicaid)
- Deemed disabled widow and widowers from age 50 but not yet age 60
- Early widow and widowers age 60-64
- Disabled adult children who lose Supplemental Security Income benefits upon entitlement to or an increase in the child's insurance benefits based on disability
- Individuals who would be eligible for SSI if not for deeming of income of parent(s) or a spouse
- Medicaid for Low Income Families (MLIF)

Financial eligibility for the ACT waiver is limited to the following individuals:

- Individuals receiving SSI
- SSI related protected groups deemed to be eligible for SSI/Medicaid
- Individuals receiving State Supplementation
- Special Home and Community-Based waiver disabled individuals whose income is not greater than 300% of the SSI Federal Benefit Rate

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.2 Medical Eligibility

Medical eligibility criteria for the E&D, TA Waiver for Adults, HIV/AIDS, and ACT Waivers are based on current admission criteria for nursing facility care. Admission criteria are described in Chapter 26 of the non-state Provider Manual, Nursing Facility.

The target groups for SAIL Waiver Services must meet the admission criteria for a nursing facility. The HCBS provider must specifically provide services to individuals with physical disabilities not associated with the process of aging and with onset prior to age 60.

SAIL waiver services are provided, but not limited, to persons with the following diagnoses:

- Quadriplegia
- Traumatic brain injury
- Amyotrophic lateral sclerosis
- Multiple sclerosis
- Muscular dystrophy
- Spinal muscular atrophy
- Severe cerebral palsy
- Stroke
- Other substantial neurological impairments, severely debilitating diseases, or rare genetic diseases (such as Lesch-Nyhan Syndrome)

The target group, for ACT Waiver Services, is individuals currently residing in a nursing facility with a desire to transition to the community.

Eligibility criteria for HCBS for ID and LHW recipients are the same as eligibility criteria for an ICF-MR facility. ID and LHW persons who meet categorical medical and/or social requirements for Title XIX coverage will be eligible for HCBS under the waiver. Applicants found eligible are not required to apply income above the personal needs allowance reserved to institutional recipients toward payment of care. In addition to the financial and medical eligibility criteria, Medicaid is limited by the number of recipients who can be served by the waiver.

107.2.3 Limitations

Medicaid does not provide waiver services to recipients in a hospital or nursing facility. However, case management activities are available to assist recipients interested in transitioning from an institution into a community setting under the waivers. Case management activities are limited to a maximum of 180 days prior to discharge into the community.

Medicaid or its operating agencies may deny home and community-based services if it determines that an individual's health and safety is at risk in the community; if the individual does not cooperate with a provider in the provision of services; or if an individual does not meet the goals and objectives of being on the waiver program.

NOTE:

SAIL waiver recipients must be age 18 years or older. LHW & ID waiver recipients must be age 3 years or older. TA waiver recipients must be age 21 or with complex medical conditions who are ventilator dependent or who have tracheostomies. HIV/AIDS Waiver recipients must be age 21 or older.

107.2.4 Explanation of Covered Services

This section describes the covered services available through the HCBS Waiver Program. Please note that descriptions for services may differ from program to program.

Adult Day Health Services (S5102/Modifier UA - E&D) (S5102/Modifier TF UB-ACT)

Adult Day Health Service provides social and health care for a minimum of 4 hours per day in a community facility approved to provide such care. Adult Day Health Service includes health education, self-care training, therapeutic activities, and health screening.

Adult Day Health is provided by facilities that meet the minimum standards for Adult Day Health Centers as described in the HCBS Waiver for the Elderly and Disabled and the ACT Waiver. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

A unit is defined as a per diem rate.

Homemaker Services (S5130/Modifier UA - E&D) (S5130/Modifier U6 – HIV/AIDS) (S5130/Modifier TF UB-ACT)

Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning and personal services. Provided by a trained homemaker when the individual regularly responsible for these activities is temporarily absent or is unable to manage the home and care for himself.

A person providing homemaker services must meet the qualifications of a Homemaker Attendant as specified in the approved waiver document.

A unit is defined as 15 minutes.

Case Management Services (T1016/Modifier UA - E&D) (T1016/Modifier UB - SAIL) (T1016/Modifier U6-HIV/AIDS) (T1016/Modifier TF UB-ACT)

Case management is a system under which a designated person or organization is responsible for locating, coordinating, and monitoring a group of services. A case manager is responsible for outreach, intake and referral, diagnosis and evaluation, assessment, care plan development, and implementing and tracking services to an individual. The case manager is also responsible for authorization of waiver and non-waiver services included in the recipient's care plan, terminations, and transfers and maintenance of recipient records.

Case management is provided by a case manager employed by or under contract with the state agencies as specified in the approved waiver document. The case manager must meet the qualifications as specified in the approved waiver document.

Case management activities may also be used to assist individuals residing at least 90 days in institutional settings, such as hospital and nursing facilities, to transition into community settings. Transitional case management services may be provided up to 180 days prior to discharge from an institution. Transitional case management should not be billed until the first day a client is active on the waiver. If the individual fails to transition to the waiver, reimbursement will be at the administrative rate.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UA - E&D) (T1019/Modifier U6 – HIV/AIDS)

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

A person providing personal care services must be employed by a certified Home Health Agency or other agency approved by the Alabama Medicaid Agency and is supervised by a registered nurse, and meets the qualifications of a Personal Care Attendant as specified in the approved waiver document. This service cannot be provided by a family member.

A unit is defined as 15 minutes.

Personal Care Services (T1019/Modifier UB - SAIL) (T1019/Modifier TF UB- ACT) Personal Options (T1019/Modifier UB HX– SAIL) (T1019/Modifier TF HX ACT) (T1019/Modifier UA HX)

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Added: **(T1019/Modifier UA HX)**

Personal care services are those services prescribed by a physician in accordance with a plan of treatment to assist a patient with basic hygiene and health support activities. These services include assistance with bathing, dressing, ambulation, eating, supervision of the self-administering of medications, and securing health care from appropriate sources.

Personal care services may be provided by a relative or a friend when documentation shows that a relative or friend is qualified and there is proof of a lack of other qualified providers in a remote area.

For the SAIL Waiver, the number of units and services provided to each client is dependent upon individual need as set forth in the client's Plan of Care established by the case manager. Personal care services may be provided for a period not to exceed 100 units (25 hours) per week and not to exceed a total of 5,200 units (1300 hours) per waiver year (April 1 – March 31) in accordance with the provider contracting period. Services may be reduced based on need.

There is no unit limit for Personal Care for the ACT Waiver. Services are authorized based upon the specific medical needs of the ACT Waiver participant.

The Personal Options program develops a new service delivery system for participants receiving personal care services on the State of Alabama Independent Living (SAIL) and ACT waivers that will allow for more participant involvement in the direction and choice of the person employed as a personal care worker.

Medicaid will not reimburse for activities performed which are not within the Scope of Services.

A unit is defined as 15 minutes.

Respite Care (T1005/Modifier UA - E&D) (T1005/Modifier U6 - HIV/AIDS) (T1005/Modifier TF UB-ACT) Respite Care Unskilled (S5150/Modifier UA - E&D) (S5150/Modifier U6 - HIV/AIDS) (S5150/Modifier TF UB-ACT)

Respite care is given to individuals unable to care for themselves on a short-term basis due to the absence or the need for relief of those persons normally providing the care. Respite care is provided in the individual's home and includes supervision, companionship and personal care of the individual.

Respite care may be provided for up to a maximum of 720 hours per waiver year. Respite care may be provided by a companion/sitter, personal care attendant, home health aide, homemaker, LPN or RN, depending upon the care needs of the individual; this service cannot be provided by a family member.

There is no unit limit on Respite Care for the ACT Waiver. Services are authorized based upon the specific medical needs of the ACT Waiver participant.

A unit is defined as 15 minutes. The maximum number of units that can be billed is 2,880 per waiver year for the E&D Waiver and the HIV/AIDS Waiver.

Companion Services (S5135/Modifier UA - E&D)
S5135/Modifier U6 – HIV/AIDS) (S5135/Modifier TF UB- ACT)

Companion services provide support and supervision that is focused on safety and non-medical care such as the following:

- Reminding recipient to bathe, to take care of personal grooming and hygiene, and to take medication
- Observing or supervision of snack and meal planning
- Accompanying recipient to necessary medical appointments and grocery shopping
- Assisting with laundry and light housekeeping duties that are essential to the care of the recipient.

Under no circumstances should any type of skilled medical service be performed. Companion services are provided in accordance with a therapeutic goal and are not purely recreational in nature. A person providing companion services must meet the qualifications of a companion worker as specified in the approved waiver document.

A unit is defined as 15 minutes.

NOTE:

Companion services are only available to recipients who live alone, and may not exceed four hours daily.

Day Habilitation

(T2020/ Modifier UC/HW— ID-Level 1)

(T2020/Modifier UC/TF-ID-Level 2)

(T2020/Modifier UC/TG-ID-Level 3)

(T2020/Modifier UC/HK-ID-Level 4)

(T2020/Modifier UC/HW/SE-ID-Level 1-w/transportation)

(T2020/Modifier UC/TF/SE-ID-Level 2-w/transportation)

(T2020/Modifier UC/TG/SE-ID-Level 3-w/transportation)

(T2020/Modifier UC/HK/SE-ID-Level 4-w/transportation)

(T2020/Modifier UC/HN)

(T2020/Modifier UD/HW - LHW - Level 1)

(T2020/Modifier UD/TF - LHW - Level 2)

(T2020/Modifier UD/TG - LHW - Level 3)

(T2020/Modifier UD/HK – LHW – Level 4)

(T2020/Modifier UD/HW/SE – LHW – Level 1-w/transportation)

(T2020/Modifier UD/TF/SE – LHW – Level 2-w/transportation)

(T2020/Modifier UD/TG/SE- LHW – Level 3-w/transportation)

(T2020/Modifier UD/HK/SE – LHW – Level 4-w/transportation)

Day Habilitation is assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that takes place in a non-residential setting, separate from the home or facility in which the recipient resides.

Services are normally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day Habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. If a recipient attends Day Habilitation for less than four (4) hours as a result of a physician visit, and the transportation and escort is provided by the Day Habilitation Program staff, reimbursement will be permitted.

This service offers another mechanism by which a participant can attend day habilitation part of a day, and work in a supported employment setting with an individual job coach during the same day.

Day Habilitation Training services are provided by a Habilitation Aide and supervised by a Qualified Mental Retardation Professional (QMRP) in coordination with the individual's plan of care. The Habilitation Aide will be required to complete the training requirements as outlined in the waiver document.

*****The level utilized for Day habilitation services in the LHW is determined by the individual's ICAP score.

The provider for Day Habilitation services can be reimbursed based on nine levels of services.

A unit is defined as a per diem rate.

Residential Habilitation Training (T2016/Modifier UC–ID)

Residential Habilitation Training provides intensive habilitation training including training in personal, social, community living, and basic life skills.

Staff may provide assistance and training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

Residential Habilitation Training services may be delivered or supervised by a Qualified Mental Retardation Professional (QMRP) in accordance with the individual's plan of care. Residential Habilitation Training services can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

A Habilitation Aide is required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH. Retraining will be conducted as needed, at least annually.

A unit is defined as a per diem rate.

Respite Care - In Home (S5150/Modifier UC - ID)
(S5150/Modifier UD - LHW)

Respite Care - Out-of-Home (T1005/Modifier UC –ID)
(T1005/Modifier UD LHW)

Respite Care – Institutional (T2044/Modifier UC-ID)

Respite care is given to individuals unable to care for themselves on a short term basis due to the absence or the need for relief of persons normally providing the care. Respite care may be provided in the recipient's home, place of residence, or a facility approved by the State which is not a private residence.

Respite care out of the home may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, respite care out of the home may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out of home respite, no additional Medicaid reimbursement will be made for other services in the institution.

This service cannot be provided by a family member.

A unit is defined as 15 minutes. For institutional respite, a unit is defined as a per diem rate.

Residential Habilitation - Other Living Arrangement (OLA)
(T2017/Modifier UC –ID)
(T2017/Modifier UD - LHW)

Residential Habilitation Training in other living arrangements is a service under which recipients reside in integrated living arrangements such as their own apartments or homes. The basic concept of this service is that for some individuals, learning to be independent is best accomplished by living independently.

These services are delivered in the context of routine day-to-day living rather than in isolated "training programs" that require the individual to transfer what is learned to more relevant applications. Habilitation may range from a situation where a staff member resides on the premises to those situations where the staff monitors recipients at periodic intervals.

The staff may provide assistance/training in daily living activities such as shopping for food, meal planning and preparation, housekeeping, personal grooming, and cleanliness.

This service includes social and adaptive skill building activities such as the following:

- Expressive therapy, the prescribed use of art, music, drama, and movement to modify ineffective learning patterns, or influence changes in behavior
- Recreation/leisure instruction, teaching the skills necessary for independent pursuit of leisure time/recreation activities

Residential habilitation training services for individuals in other living arrangements may be delivered or supervised by a QMRP in accordance with the individual's plan of care. Residential habilitation training can also be delivered by a Habilitation Aide. The aide will work under supervision and direction of a QMRP.

A Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/ID. Retraining will be conducted as needed, at least annually.

The rate paid to providers for this service includes the cost to transport individuals to activities such as day programs, social events, or community activities when public transportation or transportation services covered under the State Plan are not available, accessible, or desirable due to the functional limitations of the recipient.

A unit is defined as 15 minutes.

Supported Employment (T2018/Modifier UC –ID)
(T2018/Modifier UD – LHW)

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment also includes activities needed to sustain paid employment by waiver recipients, including supervision and training.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

When supported employment services are provided at a work site in which persons with disabilities are employed, payment will be made only for the adaptations, supervision, and training required by waiver recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business settings.

Supported employment may be provided under the Individual Job Coach and Job Development services to further encourage full integration of waiver participants into worksites where individuals without disabilities are employed.

Supported employment services are not available to recipients eligible for benefits under a program funded by either Section 110 of the Rehabilitation Act of 1973, or Section 602 (16) and (17) of the Education of the Handicapped Act.

Routine transportation, as by van within a 15-mile radius, is included in the fee for these services. This does not preclude other arrangements such as transportation by family or public conveyance.

A unit is defined as a per diem rate.

Prevocational Services (T2014/Modifier UC–ID)
(T2014/Modifier UD – LHW)

Prevocational services are not available to recipients who are eligible for benefits under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602 (16) and (17) of the Education of the Handicapped Act.

Prevocational services prepare an individual for paid or unpaid employment, but are not job task oriented. Prevocational services include teaching such concepts as compliance, task completion, attention, problem solving, and safety.

Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Waiver recipients are compensated at a rate of less than 50 percent of the minimum wage.

A unit is defined as a per diem rate.

Physical Therapy (97110/Modifier UC-ID) (97110/Modifier UD-LHW)

Physical therapy includes services that assist in determining an individual's level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs.

Such services preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination, and activities of daily living.

This service also helps with progressive disabilities through means such as the use of orthotic prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

Physical Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Physical Therapist must meet all state licensure requirements and be designated as a regulated Physical Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Occupational Therapy Services (97535/Modifier UC –ID) (97535/Modifier UD – LHW)

Occupational therapy services include the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure or obtain necessary function.

Therapists may also provide consultation and training to staff or caregivers (such as recipient's family or foster family). The Occupational Therapist must meet all state licensure requirements and be designated as a regulated Occupational Therapist by the national accreditation body.

A unit is defined as 15 minutes.

Speech and Language Therapy (92507/Modifier UC –ID) (92507/Modifier UD – LHW)

Speech and language therapy services include screening and evaluation of individuals with speech and hearing impairments. Comprehensive speech and language therapy is prescribed when indicated by screening results.

This service provides treatment for individuals who require speech improvement and speech education. These are specialized programs designed for developing each individual's communication skills in comprehension, including speech, reading, auditory training, and skills in expression.

Therapists may also provide training to staff and caregivers (such as a recipient's family and/or foster family). The Speech/Language Therapist must meet all state licensure requirements.

A unit is defined as 15 minutes.

Personal Emergency Response System (PERS)
(S5160/Modifier UB - Installation - SAIL) (S5160/Modifier TF U – Installation-ACT)
(S5161/Modifier UB – Monthly - SAIL) (S5161/Modifier TF U – Monthly-ACT)

PERS is an electronic device that enables certain high-risk patients to secure help in the event of an emergency. The recipient may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated. PERS must be provided by trained professionals. Only one installation per recipient can be approved. Initial setup and installation of PERS must be on the individual's plan of care, prior authorized and approved by the Alabama Medicaid Agency or its designee.

A unit is defined as a monthly rate.

Personal Care (T1019/Modifier UC –ID) (T1019/Modifier UC/HW – ID) (T1019/Modifier UC HN) (T1019/Modifier UD – LHW) (T1019/Modifier UD/HW-LHW)

Personal care services are services provided to assist residents with activities of daily living such as eating, bathing, dressing, personal hygiene, and activities of daily living. Services may include assistance with preparation of meals, but not the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed-making, dusting, and vacuuming, which are essential to the health and welfare of the recipient.

While in general personal care will not be approved for a person living in a group home or other residential setting, under the ID Waiver and LHW, personal care may be approved by the Division of Mental Retardation for specific purposes that are not duplicative.

Effective October 1, 2006, personal care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate procedure code for this service, provided at the worksite, to distinguish it from other personal care activities.

The personal care attendant will work under the supervision of a QMRP and will be observed every 90 days. The personal care attendant is also required to complete the training requirements prior to providing services.

Personal care may be self-directed to allow participants and their families to recruit, hire, train, supervise, and if necessary to discharge, their own personal care workers.

A unit is defined as 15 minutes.

Personal Care Transportation (T2001/Modifier UD – LHW) (T2001/Modifier UC – ID)

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of the personal care service. In order for this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. The Personal Care Transportation service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in *People First* and other community building activities. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported.

The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer.

Personal Care Transportation shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost-effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

A unit is defined as a mileage rate.

Companion Services (S5135/Modifier UC –ID)

Companion services are non-medical supervision and socialization provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation and shopping, but may not perform these activities as discrete services.

The provision of companion services does not entail hands-on medical care.

Companions may perform light housekeeping tasks that are incidental to the care and supervision of the recipient.

This service is provided in accordance with a therapeutic goal in the plan of care and is not merely recreational in nature. This service must be necessary to prevent institutionalization of the recipient.

The person providing companion service must meet the qualifications of a companion worker as specified in the waiver document. They also must have completed all training requirements.

A unit is defined as 15 minutes.

Behavior Therapy

(H2019/Modifier UC/HP - ID - Level 1)

(H2019/Modifier UC/HN – ID- Level 2)

(H2019/Modifier UC/HM – ID-Level 3)

(H2019/Modifier UD/HP – LHW – Level 1)

(H2019/Modifier UD/HN – LHW – Level 2)

(H2019/Modifier UD/HM – LHW – Level 3)

Behavior Therapy Service provides systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self direction or community integration, whose health is at risk and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may include consultation provided to families, other caretakers and habilitation service providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried and its continued use must be reviewed and re-justified every thirty days.

The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a BSP and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to the supervision requirements described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

The maximum units of service per year of both professional and technician level units combined cannot exceed 600 and the maximum units of service of professional level cannot exceed 400.

Providers of service must maintain a service log that documents specific days on which services are delivered. Group therapy will not be reimbursed.

Providers at Level 1 must have either a Ph.D. or M.A. and be certified as a Behavior Analyst by the Behavior Analysis Certification Board.

Providers at level 2 must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years of experience working with persons with developmental disabilities. Level 2 providers with a doctorate do not require supervision and may provide all of the service functions. Master's degree individuals require supervision equaling two hours per week by a level 1 provider or level two Ph.D. provider may provide all of the service functions. Level 3 providers must be either a QMRP (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst and work only in the technical service area. With two years experience and authorization by the Administering Agency, the Board Certified Behavior Analyst Associate may qualify as a level 2 provider and work in both the service component areas (professional and technical) with supervision.

All level 1 and 2 providers certified or not, must complete an orientation training provided by DMH.

A unit is defined as 15 minutes.

Environmental Accessibility Adaptations (S5165/Modifier U – SAIL) (S5165/Modifier UC –ID) (S5165/Modifier TF U –ACT) (S5165/Modifier UD – LHW)

Environmental modifications are those physical adaptations to the home, required by the individual's plan of care, that are necessary to ensure the health, welfare and safety of the individual or enable the individual to function with greater independence in the home. This service must be necessary to prevent institutionalization of the individual.

Such adaptations may include the installation of ramps and grab-bars and/or the widening of doorways in order to accommodate the medical equipment and supplies necessary for the welfare of the individual.

Environmental Modifications exclude adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver recipient, such as floor covering, roof repair, central air conditioning, etc. Adaptations that add to the square footage of the home, any type of construction affecting the structural integrity of the home, changes to the existing electrical components of the home, or permanent adaptations to rental property are excluded from this Medicaid-reimbursed benefit. All services provided must comply with applicable state or local building codes. Environmental accessibility adaptations must be prior authorized and approved by the Alabama Medicaid Agency or its designee and must be listed on the client's plan of care.

Total costs of environmental accessibility adaptations under the LHW shall not exceed $5,000 per year, per individual.

Under the SAIL and ACT Waivers the maximum amount for this service is $5,000 per recipient for the entire stay on the waiver. Any expenditure in excess of $5000 must be approved by the State Coordinator and the Medicaid designated personnel. This service may also be provided under the SAIL and ACT Waivers to assist an individual to transition from an institutional level of care to the SAIL or ACT Waivers. The modifications should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver expenditures. If the individual fails to transition to the SAIL or ACT Waivers, reimbursement will be at the administrative rate.

A unit is defined as a per diem rate.

Specialized Medical Equipment
(T2029/Modifier UD - LHW) (T2029/Modifier UC-ID)

Specialized medical equipment includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their ability to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Included items are those necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items which are not of direct medical or remedial benefits to the recipient. Providers of this service must maintain documentation of items purchased for each individual. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to $5,000 per year, per individual.

A unit is defined as a per diem.

Medical Supplies
(T2028/Modifier UC-ID) (T2028/Modifier UD-LHW)

Specialized medical supplies are those which are specified in the plan of care and are necessary to maintain the recipient's health, safety and welfare, prevent further deterioration of a condition, or increase a recipient's ability to perform activities of daily living. Supplies reimbursed under this service shall not include common over-the-counter personal care items, supplies otherwise furnished under the Medicaid State plan, and items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture and design.

Providers of this service must maintain documentation of items purchased for each individual. Costs for medical supplies are limited to $1800 per year, per individual.

A unit is defined as a per diem rate.

Assistive Technology (T2029/Modifier UB – SAIL)
(T2029/Modifier U5 - TA Waiver for Adults) (T2029/Modifier TF UB –ACT)

Assistive technology includes devices, pieces of equipment, or products that are modified or customized and are used to increase, maintain or improve functional capabilities of individuals with disabilities.

Assistive technology services also include any service that directly assists a disabled individual in the selection, acquisition, or use of an assistive technology device, including evaluation of need, acquisition, selection, design, fitting, customization, adaptation, and application. Items reimbursed with waiver funds are in addition to any medical equipment furnished under the State Plan and exclude those items which are not of direct medical or remedial benefit to the recipient. This service must be necessary to prevent institutionalization or to assist an individual to transition from an institutional level of care to the SAIL or ACT Waivers. All items shall meet applicable standards of manufacture, design and installation and must be listed on the client's plan of care. This service along with transitional assistive technology requires prior authorization and approval by the Alabama Medicaid Agency or its designee. Upon completion of the service, the client must sign and date a form acknowledging receipt of the service.

The amount for this service under the SAIL Waiver is $15,000.00 per waiver recipient for the entire stay on the waiver. Any expenditure in excess of $15,000.00 must be approved by the state coordinator and the designated Medicaid personnel. Vehicle modifications can only be authorized if it can be demonstrated that all Non-Emergency Transportation (NET) Services have been exhausted.

For the ACT Waiver, the combined amount for Assistive Technology, Assistive Technology Repair, and Evaluation for Assistive Technology, cannot exceed $15,000.

A unit is defined as a per diem rate.

Skilled Nursing (S9123/Modifier UC–RN; S9124/Modifier UC–LPN – ID) (S9123/Modifier UD – RN; S9124/Modifier UD–LPN – LHW) (S9123/Modifier U6 – HIV/AIDS) (S9123/Modifier TF UB-RN-ACT; S9124/Modifier TF UB-LPN-ACT)

Skilled nursing services are services listed in the plan of care that are within the scope of the Alabama Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. This service must be necessary to prevent institutionalization of the recipient.

This service may also be self-directed when provided to a participant on the ID Waiver or family which is self-directing personal care services. Service includes training and supervision related to medical care and/or assistance with ordinarily self-administered medications to be provided by the personal care worker.

ID/LHW - A unit is defined as 1 hour.

HIV/AIDS - A unit is defined as 15 minutes

ACT Waiver- A unit is defined as 15 minutes

Medical Supplies (T2028/Modifier UB – SAIL) (T2028/Modifier TF UB-ACT)

Medical supplies are necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition such as decubitus ulcers. These supplies do not include common over-the-counter personal care items such as toothpaste, mouthwash, soap, shampoo, Q-tips, deodorant, etc.

These medical supplies will only be provided when authorized by the recipient's physician and shall meet applicable standards of manufacture, design and installation. Providers of this service will be those who have a signed provider agreement with Medicaid and the Department of Rehabilitation Services. Medical supplies are limited to $1800.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient.

A unit is defined as a per diem rate.

Evaluation for Assistive Technology (T2025/Modifier UB - SAIL) (T2025/Modifier TF UB –ACT)

This service will provide for an evaluation and determination of the client's need for assistive technology. The evaluation must be physician-prescribed and be provided by a physical therapist licensed to do business in the state of Alabama who is enrolled as a provider with the Alabama Department of Rehabilitation Services (ADRS).

When applicable, a written copy of the physical therapist's evaluation must accompany the prior authorization request, and a copy must be kept in the recipient's file. This service must be listed on the recipient's plan of care before being provided. Reimbursement for this service will be the standard cost per evaluation, as determined by Alabama Medicaid and ADRS. This service must be necessary to prevent institutionalization of the recipient.

This service may also be provided to assist an individual to transition from an institutional level of care to the home and community based waiver. The service should not be billed until the first day the client is transitioned and has begun to receive waiver services in order to qualify as billable waiver funds. If the individual fails to transition to the SAIL Waiver, reimbursement will be at the administrative rate.

For the ACT Waiver, the combined total of Assistive Technology, Assistive Technology Repair, and Assistive Technology Evaluation cannot exceed $15,000.

A unit is defined as a per diem rate.

Assistive Technology Repairs (T2035/Modifier UB - SAIL) (T2035/Modifier TF UB –ACT)

This service will provide for the repair of devices, equipment or products that were previously purchased for the recipient. The repair may include fixing the equipment or devices, or replacement of parts or batteries to allow the equipment to operate. This service is necessary to ensure health and safety and prevent institutionalization. All items must meet applicable standards of manufacture, design and installation. Repairs must be arranged by the case manager and documented in the plan of care and case narrative. Prior authorization is not required for this service. Reimbursement for repairs shall be limited to $2,000 annually per recipient. Repair total must not exceed the amount originally paid for the equipment or device.

For the ACT Waiver, the combined total of Assistive Technology, Assistive Technology Repair, and Assistive Technology Evaluation cannot exceed $15,000.

A unit is defined as a per diem rate.

Minor Assistive Technology (T2028 UB SC- SAIL)

Minor Assistive Technology (MAT) includes supplies, devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. All MAT supplies must be prescribed by a physician, be medically necessary and be specified in the Plan of Care. MAT is necessary to maintain the recipient's health, safety, and welfare and to prevent further deterioration of a condition and does not include common over the counter personal care items.

Minor Assistive Technology is limited to $500.00 per recipient per year. The OA must maintain documentation of items purchased for the recipient. Providers of this service will be those who have a signed provider agreement

with the Alabama Medicaid Agency and the Department of Rehabilitation Services.

Vendors providing MAT devices should be capable of supplying and training in the use of the minor assistive technology/device.

A unit is defined as a daily rate.

Waiver Frozen Meals (S5170/Modifier UA - E & D) (S5170/Modifier TF UB-ACT)
Waiver Shelf-Stable Meals (S5170/Modifier SC - E & D) (S5170/Modifier TF SC- ACT)
Breakfast Meals (S5170 - E & D) (S5170/Modifier TF UA- ACT)

Home Delivered meals are provided to an individual who is unable to meet his/her nutritional needs. It must be determined that the nutritional needs of the individual can be addressed by the provision of home delivered meals. (The individual must be age 21 or older to receive this service on the E&D waiver.)

This service will provide at least one (1) nutritionally sound meal per day to adults unable to care for their nutritional needs because of a functional disability dependency, who require nutritional assistance to remain in the community and do not have a caregiver available to prepare a meal for them. Meals provided by this service will not constitute a full daily nutritional regimen.

This service will be provided as specified in the plan of care, which may include: seven (7) or fourteen (14) frozen meals per week. In addition to frozen meals, the service may include the provisions of two (2) or more shelf-stable meals (not to exceed six meals per six-month period) to meet emergency nutritional needs when authorized in the recipient's care plan.

In the event of an expected storm or disaster, the Meals Coordinator will authorize an approved Disaster Meal Service Plan.

A unit is defined as:

Seven-(7) pack of frozen meals equal to 1 unit.

Two (2) shelf-stable meals equal to 1 unit.

Seven-(7) pack of breakfast meals equal to 1 unit.

Personal Assistance Services (S5125/Modifier UB – SAIL) (S5125/Modifier TF UB- ACT)

Personal Assistant Services (PAS) are a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. These activities would be performed by the individual, if that individual did not have a disability. Such services shall be designed to increase the individual's independence and ability to perform every day activities on and off the job.

This service will support that population with physical disabilities who are seeking competitive employment either in their home or in an integrated work setting. An integrated work setting is defined as a setting typically found in the community, which employs an individual with disabilities and there is interaction with non-disabled individuals who are in the same employment setting.

This service must be sufficient in amount, duration, and scope such that an individual with a moderate to severe level of disability would be able to obtain the support needed to both live and get to and from work.

A unit is defined as 15 minutes.

Personal Care/Attendant Service (T1019/Modifier U5 – TA Waiver for Adults)

Personal Care/Attendant Service (PC/AS) provides in-home and out-of-home (job site) assistance with eating, bathing, dressing, caring for personal hygiene, toileting, transferring from bed to chair and vice versa, ambulation, maintaining continence, medication management and other activities of daily living (ADLs). It may include assistance with independent activities of daily living (ADLs) such as meal preparation, using the telephone, and household chores such as laundry, bed-making, dusting and vacuuming, which are incidental to the assistance provided with ADLs or essential to the health and welfare of the client rather than the client's family.

PC/AS is designed to increase an individual's independence and ability to perform daily activities and to support individuals with physical disabilities in need of these services as well as those seeking or maintaining competitive employment either in the home or an integrated work setting.

A unit is defined as 15 minutes.

Medical Supplies and Appliances (T2028/Modifier U5 – TA Waiver for Adults)

This service includes medical equipment and supplies that are not covered in the Medicaid State Plan. The medical equipment or supplies must be included in the recipient's plan of care, and they must be necessary to maintain the recipient's ability to remain in the home. This service must be necessary to avoid institutionalization of the recipient. Invoices for medical equipment and supplies must be maintained in the case record

A unit is defined as a per diem rate.

Private Duty Nursing (S9123/Modifier U5 – RN; S9124/Modifier U5 – LPN - TA Waiver for Adults)

The Private Duty Nursing Service is a service which provides skilled medical observation and nursing services performed by a Registered Nurse or Licensed Practical Nurse who will perform their duties in compliance with the Nurse Practice Act and Alabama State Board of Nursing. Private Duty Nursing under the waiver will not duplicate Skilled Nursing under the mandatory home health benefit in the State Plan. If a waiver client meets the criteria to receive the home health benefits, home health should be utilized first and exhausted before Private Duty Nursing under the waiver is utilized. The objective of the Private Duty Nursing Service is to provide skilled medical monitoring, direct care, and intervention for individuals 21 and over to maintain him/her through home support. This service is necessary to avoid institutionalization and the individual must meet criteria outlined in the approved waiver document prior to receipt of services.

A unit is defined as 1 hour.

Community Specialist (H2015-UD – LHW)

(H2015-UC – ID)

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resource locating, monitoring and assessment.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management.

This service may be self-directed for participants who self-direct Personal Care. The community specialist will inform and consult, intervene, and trouble shoot any problems the participant may have with self-directing their services.

A unit of service is defined as 15 minutes.

Crisis Intervention (H2011–UD - LHW)

(H2011-UC - ID)

Crisis Invention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual's removal from his current living arrangement.

When need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved by the regional community service office of the DMH prior to the service being initiated.

Crisis intervention services will not count against the $25,000 per person per year cap in the waivers, since the need for the service cannot accurately be predicted and planned for ahead of time.

A unit of service is defined as 15 minutes.

Transitional Assistance Service (T2038/Modifier TF UB- ACT)

Transitional Assistance Services consists of the following items, when appropriate and necessary for the participant's discharge from a nursing facility and safe transition to the community:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential household furnishings and moving expense required to occupy and use a community domicile, including: furniture, window coverings, food preparation items, and bed/bath linens;
3. Set-up fees or deposits for utility or services access, including telephone, electricity, heating and water;
4. Household services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

Transitional Assistance Service cannot exceed $1,500.

107.2.5 Characteristics of Persons Requiring ICF-ID Level of Care Through the ID Waiver (formerly MR Waiver) and Living at Home Waiver

Services provided in an intermediate care facility for the mentally retarded in Alabama are those services that provide a setting appropriate for a functionally mentally retarded person in the least restrictive productive environment currently available.

Generally, persons eligible for the ICF-MR level of care provided through the ID and LH Waiver need such a level of care because the severe, chronic nature of their mental impairment results in substantial functional limitations in three (3) or more of the following areas of life activity:

- Self Care
- Receptive and expressive language
- Learning
- Self-direction
- Capacity for independent living
- Mobility

ICF-MR care requires the skills of a QMRP to provide directly or supervise others in the provision of services. ICF-MR services address the functional deficiencies of the beneficiary to allow the beneficiary to experience personal hygiene, participate in daily living activities appropriate to his functioning level, take medication under appropriate supervision (if needed), receive therapy, receive training toward more independent functioning, and experience stabilization as a result of being in the least restrictive, productive environment that promotes the individual's developmental process.

Determining Eligibility for ID and LH Waiver

Determination regarding eligibility for care under the ID & LH Waiver is made by a Qualified Mental Retardation Professional (QMRP). An interdisciplinary team (described below) recommends continued stay. The recommendation is certified by a QMRP and a physician.

Qualifications of Interdisciplinary Review Team

An interdisciplinary team consisting of a nurse, social worker, and a member of appropriate related discipline, usually a psychologist, recommends continued stay.

The nurse will be a graduate of a licensed school of nursing with a current state certification as a Licensed Practical Nurse (LPN) or Registered Nurse (RN). This person will have knowledge and training in the area of mental retardation or related disabilities with a minimum of two years' experience.

The social worker will be a graduate of a four-year college with an emphasis in social work. This person will have knowledge and training in the area of mental retardation or related disabilities with a minimum of two years' experience.

The psychologist will possess a Ph.D. in Psychology. This person will be a licensed psychologist with general knowledge of test instruments used with the mentally retarded or related disabilities with a minimum of two years' experience.

Other professional disciplines may be represented on the assessment team as necessary depending on the age, functional level, and physical disability of the recipients:

- Special Education
- Speech Pathologist
- Audiologist
- Physical Therapist
- Optometrist
- Occupational Therapist
- Vocational Therapist
- Recreational Specialist
- Pharmacist
- Doctor of Medicine
- Psychiatrist
- Other skilled health professionals

Individual Assessments

Medicaid requires an individual plan of care for each ID & LH waiver service recipient. The Individual Habilitation Plan (IHP) is subject to review by Medicaid and CMS.

The DMH/ID (or its contract service providers) uses assessment procedures to screen recipients for eligibility for the Waiver services as an alternative to institutionalization. Assessment procedures are based on eligibility criteria for ICF-MR developed jointly by DMH/ID and Medicaid.

Review for "medical assistance" eligibility may be performed by a qualified practitioner in the DMH/ID, by its contract service providers, or by qualified (Diagnostic and Evaluation Team) personnel of the individual or agency arranging the service.

Recipients are re-evaluated on an annual basis. Written documentation of all assessments is maintained in the recipient's case file and is subject to review by Medicaid and CMS.

A written assessment is a method for determining a recipient’s current long-term care needs. This comprehensive instrument is used to access each individual recipient’s functional, medical, social, environmental, and behavioral status. Information obtained should be adequate enough to make a level of care decision and for case managers to develop an initial plan of care.

Re-evaluations are done on an annual basis or when needed. Written documentation of all assessments is maintained in the recipient’s case file and is subject to review by Medicaid and CMS.

107.2.6 Informing Beneficiaries of Choice

Medicaid is responsible for ensuring that beneficiaries of the waiver service program are advised of feasible service alternatives and receive a choice regarding which type of service they wish to receive (institutional or home- and/or community-based services).

Medicaid advises applicants for NF, ICF, ICF-MR services, or their designated responsible party, of feasible alternatives to institutionalization at the time of their entry into the waiver system. All applicants found eligible will be offered the alternative unless there is reasonable expectation that the services required would cost more than institutional care.

When residents of long-term care facilities become eligible for home and community-based services under this waiver, the resident will be advised of the available services and given a choice of service providers.

107.2.7 Cost for Services

The costs for services to individuals who qualify for home and community-based care under the waiver program will not exceed, on an average per capita basis, the total expenditures that would be incurred for such individuals if home and community-based services were not available.

The cost for services to individuals who qualify for home and community-based care under the LAH waiver program will not exceed a cap of $25,000 per client per year with the exception that crisis intervention services are not included in the cap.

107.2.8 Records Used for Medicaid Audits

Providers must maintain financial accountability for funds expended on HCBS and provide a clearly defined audit trail.

Providers must retain records that fully disclose the extent and cost of services provided to eligible recipients for a three-year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials. If these records are not available within the state of Alabama, the provider will pay the travel cost of the auditors.

The state agencies as specified in the approved waiver document as operating agencies of home and community-based services will have their records audited at least annually at the discretion of the Alabama Medicaid Agency. Payments for services are adjusted to actual cost at the end of each waiver year.

The Alabama Medicaid Agency will review at least annually the recipient's care plans and services rendered by a sampling procedure. The review will include appropriateness of care and proper billing procedures.

The state agencies as specified in the approved waiver document provide documentation of actual costs of services and administration. The quarterly cost report includes all actual costs incurred by the operating agency for the previous quarter and includes costs incurred for the current year-to-date. The state agencies submit this document to Medicaid before the first day of the third month of the next quarter.

Failure to submit the actual cost documentation can result in the Alabama Medicaid Agency deferring payment until this documentation has been received and reviewed.

The providers of the HCBS waivers will have their records audited at least annually at the discretion of Medicaid. Medicaid will recover payments that exceed actual allowable cost.

Medicaid reviews recipients' habilitation and care plans and services rendered by a sampling procedure. The review includes appropriateness of care and proper billing procedures.

Providers of the E&D and SAIL HCBS waivers are required to file a complete uniform cost report of actual statistics and costs incurred during the entire preceding year. The cost reports for E&D must be received by Medicaid on or before December 31. Cost reports for the SAIL Waiver must be received on or before June 1. Extension may be granted only upon written request. Failure to submit the actual cost documentation may result in the AMA deferring payment until this documentation has been received and reviewed.

Providers of the LHW, TA Waiver for Adults, ID, HIV/AIDS, and ACT Waivers are not required to submit uniform cost reports. The method of payment is on a fee-for-service basis.

Quarters for E&D are defined as follows:

Quarter	***Reporting Period***	***Due Date***
1st	October – December	Due before March 1
2nd	January – March	Due before June 1
3rd	April – June	Due before September 1
4th	July – September	Due before December 1

Quarters for SAIL are defined as follows:

Quarter	***Reporting Period***	***Due Date***
1st	April - June	Due before September 1
2nd	July - September	Due before December 1
3rd	October - December	Due before March 1
4th	January- March	Due before June 1

107.2.9 HCBS Payment Procedures

Each covered HCB waiver service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled.

The basis for the fees are usually based on audited past performance with consideration given to the health care index and renegotiated contracts. The interim fees may also be changed if a provider can show that an unavoidable event(s) has caused a substantial increase or decrease in the provider's cost.

For each recipient, the claim will allow span billing for a period up to one month. There may be multiple claims in a month; however, no single claim can cover services performed in different months. For example, 10/15/02 to 11/15/02 would not be allowed. If the submitted claim covers dates of service part or all of which were covered in a previously paid claim, the claim will be rejected.

Payment will be based on the number of units of service reported on the claim for each procedure code.

Accounting for actual cost and units of services provided during a waiver year must be captured on CMS Form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

- A waiver year consists of twelve consecutive months starting with the approval date specified in the approved waiver document.

- An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-case payments, such as depreciation, occur when transactions are recorded by the state agency.
- The services provided by an operating agency is reported and paid by dates of service. Thus, all services provided during the twelve months of the waiver year will be attributed to that year.

The provider's costs shall be divided between benefit and administrative cost. The benefit portion is included in the fee for service. The administrative portion will be divided in twelve equal amounts and will be invoiced by the provider directly to the Alabama Medicaid Agency. Since Administration is relatively fixed, it will not be a rate per claim, but a set monthly payment. As each waiver is audited, this cost, like the benefit cost, will be determined and lump sum settlement will be made to adjust that year's payments to actual cost.

The Alabama Medicaid Agency's Provider Audit/Reimbursement Division maintains the year-end cost reports submitted by the Alabama Department of Senior Services (ADSS).

Providers must retain records that fully disclose the extent and cost of services provided to the eligible recipients for a five (5) year period. These records must be accessible to the Alabama Medicaid Agency and appropriate state and federal officials.

There must be a clear differentiation between waiver services and non-waiver services. There must be a clear audit trail from the point a service is provided through billing and reimbursement. The OA, Alabama Medicaid Agency and Centers for Medicare and Medicaid Services (CMS) must be able to review the Plan of Care to verify the exact service and number of units provided, the date the service was rendered, and the direct service provider for each recipient. There must be a detailed explanation of how waiver services are segregated from ineligible waiver costs.

NOTE:

The rates for each service for each operating agency may differ. For the E&D waiver, operating agencies have 120 days from the end of a waiver year to file their claims. The operating agency for the SAIL waiver has 180 days from the end of a waiver year to file. Since the actual cost incurred by the operating agency sets a ceiling on the amount it can receive, no claims for the dates of service within that year will be processed after the adjustment is made. For the LHW, ID, HIV/AIDS, and ACT Waivers, the operating agency must file all claims for services within 12 months from the date of service. For the TA Waiver for Adults, the providers must file all claims for services rendered within 12 months from the date of service provision.

107.2.10 Records for Quality Assurance Audits

The operating agencies for the E&D, ID, LHW, ACT, and HIV/AIDS waivers are required to maintain all records pertaining to the waiver recipients. They should also maintain the following information for audit purposes:

- Daily activity logs
- Narratives
- Evaluations and reevaluations

- Complaints and grievances
- Billing and payment records
- Plan of Care
- Delivery of services
- Any other important tools used to determine the success of the waiver services

This information is used to ensure that the state is in accordance with the approved waiver document and services are appropriate for the individual being served.

This information shall be made available to Medicaid and any other party in the contractual agreement at no cost.

NOTE:

Records for Quality Assurance audits for the TA Waiver for Adults conducted by the in-house Medicaid reviewer will be maintained at the Alabama Medicaid Agency.

107.2.11 Appeal Procedure (Fiscal Audit)

Medicaid conducts fiscal audits of all services. At the completion of a field audit there will be an exit conference with the provider to explain the audit findings. The provider will have the opportunity agree or disagree with the findings.

Medicaid reviews the field audit and provider comments and prepares a letter to make the appropriate findings official. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official audit letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Provider Audit Division, Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624.

Medicaid forwards decisions made as a result of the informal conference to the provider by letter. If the provider believes that the results of the informal conference are still adverse, the provider will have 15 days from the date of the letter to request a fair hearing.

Quality Assurance (QA) reviews are performed on an annual basis by Medicaid. At the end of this review there will be an exit conference with the providers to explain the findings. The provider will have an opportunity to agree or disagree.

Medicaid reviews the findings and prepares an official letter. If the provider feels that some of the findings are not justified, the provider may request an informal conference with Medicaid. To request the informal conference, the provider must submit a letter within 30 days of the date of the official review letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Quality Assurance Division, Alabama Medicaid Agency, 501 Dexter Avenue, P.O. Box 5624, Montgomery, AL 36103-5624.

If the provider is not satisfied with the findings of the informal conference, the provider may request a fair hearing.

107.3 Prior Authorization and Referral Requirements

Certain procedure codes for waivers require prior authorization. Refer to Section 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

Application Process

The case manager receives referrals from hospitals, nursing homes, physicians, the community, and others for persons who may be eligible for HCBS.

The plan of care, which is developed by the case manager and applicant's physician, is part of this assessment. The plan of care includes the following:

- Objectives
- Services
- Provider of services
- Frequency of services

The Alabama Medicaid Agency requires providers to submit an application in order to document dates of service provision to long term care recipients maintained by the long term care file. Application approvals will be done automatically through systematic programming. Quality Improvement and Standards Division will perform random audits on a percentage of records to ensure that documentation exists to support the medical level of care criteria, physician certification, as well as other state and federal requirements.

Case managers and/or designated staff of the HCBS waiver Operating Agency(ies) will assess the client to determine the risk for institutionalization and determine if the medical level of care is met according to Medicaid criteria.

Assessment data will be entered and submitted electronically through the use of the Alabama Medicaid Agency Interactive website. If problems are encountered such as mismatched Social Security Numbers and/or Medicaid numbers, date conflicts, invalid NPIs, or financial ineligibility, the auto-application will be denied and returned. Information will be provided to the user of the appropriate action(s) to take to correct the problem and will be allowed to resubmit the application.

The application, upon completion of processing, will systematically assign approval dates in one-year increments. For initial assessments, once the application is submitted with an indication of an initial assessment, the system will apply the begin date as the date of submission plus one year, which is extended to the last day of the month. For re-determinations, the application is submitted with an indication of a re-determination and the system will pick up the end date already on the file and extend for one year.

No charges for services rendered under the waiver program prior to the approval payment dates will be paid.

Application Process for TA Waiver for Adults

The Alabama Department of Rehabilitation Services (ADRS) targeted case manager will receive referrals from hospitals, nursing homes, physicians, the community and others for persons who may be eligible for home and community based services.

An assessment document will be completed by the targeted case manager, in conjunction with the applicant's physician. This document will reflect detailed information regarding social background, living conditions, and medical problems of the applicant. A copy of this document will be submitted to the Alabama Medicaid Agency for approval.

The targeted case manager, in conjunction with the applicant's physician will develop a plan of care. The plan of care will include objectives, services, provider of services, and frequency of service. The plan of care must be submitted to the Alabama Medicaid Agency for approval. Changes to the original plan of care are to be made as needed to adequately care for an individual. Reasons for changes must be documented on the client's care plan, which is subject to the review of the Alabama Medicaid Agency. The plan of care must be reviewed by the targeted case manager as often as necessary and administered in coordination with the recipient's physician.

The targeted case manager will coordinate completion of the medical need admissions form with the applicant's physician and the financial application form for submission to the Alabama Medicaid Agency's Long Term Care Division.

The LTC Division will submit the medical application to the Associate Medical Director for review to determine if the individual meets the criteria for nursing facility care, in accordance with Rule No 560-X-10-.10 of the Alabama Medicaid Administrative Code. The LTC Division will submit the "Waiver/Slot Confirmation Form" to the District Office for processing financial determination.

If approved, the applicant and the targeted case manager will be notified in writing.

If denied, the applicant and the targeted case manager will be notified and the reconsideration process will be explained in writing as described in Rule No. 560-X-10-.14 of the *Alabama Medicaid Administrative Code*.

When an application is approved by the Alabama Medicaid Agency, a payment date is also given for the level of care for which a recipient has been approved. No charges for services rendered under the Waiver Program prior to this approved payment date will be paid.

A current assessment document, along with a new plan of care, and medical need admission form must be submitted by the targeted case manager to the Alabama Medicaid Agency at each re-determination of eligibility which shall be at least every twelve (12) months.

Fair Hearings

An individual whose application to the waiver program is denied may request a hearing through the appropriate operating agency (the Alabama Department of Public Health the Alabama Department of Senior Services the Alabama Department of Rehabilitation Services or the Alabama Department of Mental Health. An individual whose application to the TA Waiver for Adults is denied may request a fair hearing through the Alabama Medicaid Agency.

An individual who is denied HCBS may request a fair hearing in accordance with Chapter 3 of the *Alabama Medicaid Administrative Code*.

Applicants will be notified in writing within ten days of denial or termination of service.

A written request for a hearing must be filed within 30 days following notice of action for which an individual is dissatisfied.

107.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by Waiver service providers.

107.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Waiver service providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claims processing turnaround
- Ability to immediately correct claim errors
- Online adjustments capability
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted. TA Waiver for Adults providers must file claims on a UB-04 claim form when filing hard copy. Medicare-related claims must be filed using the Institutional/Medicare-related claim form for TA Waiver recipients.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

107.5.1 Time Limit for Filing Claims

The operating agencies for the E&D waiver have 120 days at the end of the waiver year to process claims. The operating agency for the SAIL waiver has 180 days at the end of the waiver year to process claims. Living at Home Waiver, Technology Assisted Waiver for Adults, ID, HIV/AIDS Waiver, and ACT Waiver claims are to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

107.5.2Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

107.5.3 Procedure Codes

The following procedure codes apply when filing claims for Elderly and Disabled Waiver services:

Code	***Description***	***PA Required?***
T1016-UA	Case Management	No
T1019-UA	Personal Care	No
S5102-UA	Adult Day Health	No
T1005-UA	Respite Care – Skilled— Billed per hour	No
S5150-UA	Respite Care – Unskilled	No
S5130-UA	Homemaker	No
S5135-UA	Companion	No
S5170-UA	Waiver Frozen Meals	No
S5170-SC	Waiver Shelf-Stable Meals	No
S5170	Waiver Breakfast Meals	No

The following procedure codes apply when filing claims for SAIL Waiver services. These services are limited to recipients age 18 and over.

Code	***Description***	***PA Required?***
T1016-UB	Case Management	No
T1019-UB	Personal Care Services	No
S5165-UB	Environmental Accessibility Adaptations	Yes
T2028-UB	Medical Supplies – (exempt from TPL)	No
T2028-UB & SC	Minor Assistive Technology	No
S5160-UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-UB	Assistive Technology	Yes
S5125-UB	Personal Assistance Services	No
T2025-UB	Evaluation for Assistive Technology	No
T2035-UB	Assistive Technology Repairs	No

The following procedure codes apply when filing claims for Intellectual Disabilities services

Code	***Description***	***PA Required?***
T2020-UC & HW	Day Habilitation Services- Level 1	No
T2020-UC & TF	Day Habilitation Services-Level 2	No
T2020-UC & TG	Day Habilitation Services-Level 3	No
T2020-UC & HK	Day Habilitation Services-Level 4	No
T2020-UC & HW & SE	Day Habilitation Services w/ transportation- Level 1	No
T2020-UC & TF & SE	Day Habilitation Services w/transportation-Level 2	No
T2020-UC & TG & SE	Day Habilitation Services w/transportation-Level 3	No
T2020-UC & HK & SE	Day Habilitation Services w/transportation-Level 4	No
T2020-UC & HN	New Day Habilitation	No
T2016-UC	Residential Services	No
S5150-UC	In-home Respite Care	No
T1005-UC	Out-of-Home Respite	No
T2044-UC	Institutional Respite	No
T2017-UC	Residential Services - Other Living Arrangements	No
T2018-UC	Supported Employment Services	No
T2018-UC & HN	Individual Job Coach	No
T2018-UC & HO	Individual Job Developer	No
T2014-UC	Prevocational Services	No
97110-UC	Physical Therapy	No
97535-UC	Occupational Therapy	No
92507-UC	Speech and language Therapy	No
T1019-UC	Personal Care	No
T1019-UC & HN	Self-Directed Personal Care	No
T1019-UC & HW	Personal Care on Worksite	No
T2001-UC	Personal Care Transportation	No
S5135-UC	Companion Services	No
H2019-UC & HP	Behavior Therapy-Level 1	No
H2019-UC & HN	Behavior Therapy-Level 2	No
H2019-UC & HM	Behavior Therapy-Level 3	No
S5165-UC	Environmental Accessibility Adaptations	No
S9123-UC	Skilled Nursing-RN	No
S9123-UC & HW	Self-Directed-RN	No
S9124-UC	Skilled Nursing-LPN	No
S9124-UC & HW	Self-Directed-LPN	No

Code	***Description***	***PA Required?***
T2028-UC	Medical Supplies	No
T2029-UC	Specialized Medical Equipment	No
H2015-UC	Community Specialist	No
H2015-UC & HW	Self-Directed Community Specialist	No
H2011-UC	Crisis Intervention	No

The following procedure codes apply when filing claims for Living at Home Waiver services:

Code	**Description (All services exempt from TPL and MC)**	**PA Required?**
T2017-UD	In-Home Residential Habilitation	No
T2020-UD & HW	Day Habilitation (Level 1)	No
T2020-UD & TF	Day Habilitation (Level 2)	No
T2020-UD & TG	Day Habilitation (Level 3)	No
T2020-UD & HK	Day Habilitation (Level 4)	No
T2020-UD & HW & SE	Day Habilitations w/transportation – Level 1	No
T2020-UD & TF & SE	Day Habilitations w/transportation – Level 2	No
T2020-UD & TG & SE	Day Habilitations w/transportation - Level 3	No
T2020-UD & HK & SE	Day Habilitations w/transportation – Level 4	No
T2018-UD	Supported Employment	No
T2018-UD & HN	Individual Job Coach	No
T2018-UD & HO	Individual Job Developer	No
T2014-UD	Prevocational Services	No
S5150-UD	Respite In-Home	No
T1005-UD	Respite Out-of-Home	No
T1019-UD	Personal Care	No
T1019-UD & HW	Personal Care on Worksite	No
T2001-UD	Personal Care Transportation	No
97110-UD	Physical Therapy	No
97535-UD	Occupational Therapy	No
92507-UD	Speech Therapy	No
H2019-UD & HP	Behavior Therapy-Level 1	No
H2019-UD & HN	Behavior Therapy-Level 2	No
H2019-UD & HM	Behavior Therapy-Level 3	No
S9123-UD	Skilled Nursing - RN	No
S9124-UD	Skilled Nursing - LPN	No
S5165-UD	Environmental Accessibility Adaptations	No

Code	Description (All services exempt from TPL and MC)	PA Required?
T2028-UD	Specialized Medical Supplies	No
T2029-UD	Specialized Medical Equipment	No
H2015-UD	Community Specialist	No
H2011-UD	Crisis Intervention	No

The following procedure codes apply when filing claims for TA Waiver for Adults services:

Code	***Description***	***PA Required?***
S9123-U5	Private Duty Nursing - RN	No
S9124-U5	Private Duty Nursing - LPN	No
T1019-U5	Personal Care/Attendant Service	No
T2028-U5	Medical Supplies and Appliances	No
T2029-U5	Assistive Technology	Yes

The following procedure codes apply when filing claims for HIV/AIDS Waiver services:

Code	***Description***	***PA Required?***
T1016-U6	Case Management Services	No
T1019-U6	Personal Care Services	No
T1005-U6	Respite Care Services – Skilled	No
S5150-U6	Respite Care Services - Unskilled	No
S5130-U6	Homemaker Services	No
S9123-U6	Skilled Nursing	No
S5135-U6	Companion Service	No

The following procedure codes apply when filing claims for ACT Waiver services:

Code	***Description***	***PA Required?***
T1016-TF UB	Case Management	No
T1019-TF UB	Personal Care Services	No
S5165-TF UB	Environmental Accessibility Adaptations	Yes
T2028-TF UB	Medical Supplies – (exempt from TPL)	No
S9123-TF UB	Skilled Nursing (RN)	No
S9124-TF UB	Skilled Nursing (LPN)	No
S5160-TF UB	Personal Emergency Response Systems/Initial (exempt from TPL)	Yes
S5161-TF UB	Personal Emergency Response Systems/Monthly Service Fee	No
T2029-TF UB	Assistive Technology	Yes
S5125-TF UB	Personal Assistance Services	No
T2038-TF UB	Transitional Assistance Service	No
S5130-TF UB	Homemaker Service	No
S5102-TF UB	Adult Day Health	No
T1005-TF UB	Respite Services (Skilled)	No
S5150-TF UB	Respite Services (Unskilled)	No
S5170-TF UB	Home Delivered Meals	No
S5170-TF SC	Home Delivered Meals (Shelf Stable)	No
S5170-TF UA	Home Delivered Meals (Breakfast)	No
S5135-TF UB	Adult Companion Service	No

107.5.4 Place of Service Codes

The following place of service codes apply when filing claims for Waiver service:

POS Code	Description
12	Home (Residential) —ID Waiver, SAIL Waiver, LHW, TA Waiver for Adults, ACT Waiver, and the HIV/AIDS Waiver
21	Inpatient Hospital-SAIL Waiver, HIV/AIDS Waiver, ACT Waiver
31	Skilled Nursing Facility or Nursing Home-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
32	Nursing Facility-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
51	Inpatient Psychiatric Facility-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
54	Intermediate Care Facility/Mentally Retarded-SAIL Waiver, HIV/AIDS Waiver, and ACT Waiver
99	Other Unlisted Facility —MR Waiver, Elderly & Disabled Waiver, LHW, TA Waiver for Adults, SAIL, HIV/AIDS, and ACT Waiver

107.5.5Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to Claims with Third Party Denials.

Refer to Section 5.7, Required Attachments, for more information on attachments.

107.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Patient 1st	Chapter 39
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
UB92 Claim Filing Instructions	Section 5.3

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108 Early Intervention Services

Early Intervention (EI) Services are specialty-oriented services delivered to infants/toddlers enrolled in Alabama's Early Intervention System (AEIS). Alabama's eligibility definition for Early Intervention is: a child birth to three years of age with a diagnosed mental or physical condition which has a high probability of resulting in developmental delay or who is experiencing a 25% delay in one or more of the five developmental areas: cognitive, physical to include vision/hearing, communication, social/emotional and adaptive. EI services include the following services provided in the natural environment unless otherwise denoted on the Individualized Family Service Plan (IFSP):

Early Intervention Services include:

- Intake Evaluation
- Basic Living Skills
- Audiology
- Family Support
- Physician Evaluation and Management Services
- Occupational Therapy (OT)
- Physical Therapy (PT)
- Psychological Testing
- Speech and Language Pathology
- Vision Services
- Treatment Plan Review

Eligible infants/toddlers receive EI Services through providers who contract with Medicaid to provide services to the eligible population.

108.1 Enrollment

HP enrolls EI providers who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Standards For Serving Young Children With Disabilities and Their Families In Alabama* (EI personnel standards), the *Alabama Medicaid Administrative Code,* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an EI provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursement for EI-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

- EI providers are assigned a provider type of 63 (Services).

Valid providers for Early Intervention through contractual agreements include the following:

- Alabama Institute for Deaf and Blind (AIDB)
- Children's Rehabilitation Services (ADRS/CRS)
- Department of Mental Health/Mental Retardation (DMH/MR)
- Division of Early Intervention (ADRS/EI)

NOTE:

CRS Specialty Clinics are not part of Early Intervention.

Enrollment Policy

Providers are qualified personnel who provide services within the natural environment unless otherwise denoted on the IFSP and provide services through a team approach.

Providers must meet recognized standards for infants/toddlers under AEIS and include the following disciplines, at a minimum:

- Audiologists
- Family Therapists
- Nurses
- Registered Dietitians
- Occupational Therapists
- Orientation & Mobility Specialists
- Physical Therapists
- Psychologists
- Social Worker
- Service Coordinators
- Special Instructors
- Speech & Language Pathologists
- Vision Specialists

108.2 Benefits and Limitations

All providers must participate in the development of the IFSP. All services must be provided as outlined on the IFSP.

Case management/service coordination is an integral part of Alabama's EI System. Case managers/service coordinators provide services such as evaluation/assessment, IFSP development, and coordination of services. Please see Chapter 106 addressing Targeted Case Management for Handicapped Children.

IFSP Team

The IFSP teams are usually comprised of family support personnel, parents/family members, and other EI personnel as they relate to the identified needs of the infant/toddler. The team will establish a written IFSP. The IFSP team then implements this plan.

108.2.1 Covered Services

EI Services do not include services rendered under other Medicaid programs.

EI Services are covered when provided by a Medicaid-enrolled early intervention provider and are subject to retrospective review which may result in monies being recouped.

Types of covered services provided include, but are not limited to:

- Intake Evaluation
- Basic Living Skills
- Therapy (physical, speech/language, occupational)
- Family Support
- Audiology services
- Physician Evaluation and Management services
- Psychological testing
- Vision services
- Treatment Plan Review

An IFSP is required for each infant/toddler and Family Support Personnel is responsible for arranging specialty and needed services for the family.

The following is a description of each EI service. Please see the EI Services Grid for Billing Unit, Daily Maximum, Maximum Units and Billing Restrictions.

Deleted: ~~90791~~

Added: **90801**

Added: **for dates of..01/01/2013 and thereafter)**

Intake Evaluation (90801 with TL modifier for dates of service prior to 01/01/2013) (T1023 with TL modifier for dates of service 01/01/2013 and thereafter)

Definition

Initial evaluation to determine child's eligibility for EI. Child will undergo an evaluation of all five developmental areas with a second procedure to confirm delay in at least one of the developmental areas. The evaluator(s) will determine child's functioning level and provide written report which will indicate child's functioning level in terms of percentage of delay or no delay. Eligibility determination will be made by a multidisciplinary team. Ongoing assessment will be conducted to determine the child's continued eligibility for EI.

Key service functions include the following:

- A voluntary family assessment conducted in a personal interview
- Evaluation of the child's functioning level in the five developmental areas: cognitive, physical (includes vision & hearing), communication, social/emotional and adaptive
- Review of pertinent medical records or other developmental information
- Screening of vision and hearing
- Written report

Qualified staff

Evaluations & assessments may be performed by individuals who meet the test protocol for administering such tests as the Battelle, Bailey, Hawaii, E-LAP, DOCS, IDA, etc. These individuals include:

- Targeted case manager
- Family Support personnel (completion of the AEIS SI Core Curriculum is not required)
- Certified social worker licensed under Alabama law
- Occupational, Physical or Speech therapist licensed under Alabama law
- Audiologist licensed under Alabama law
- Individuals meeting ICC personnel standards for Family Training/Counseling/Home visits
- Registered nurse licensed under Alabama law
- Registered dietitian licensed under Alabama law
- Psychologist licensed under Alabama law
- School psychologist or psychometrist meeting Alabama's ICC personnel standards
- Individuals who have a bachelor's degree in ECSE/VI/HI with an Alabama Class B certification or who meet Alabama's ICC personnel standards (e.g. special instructors, family trainers, home visitors, service coordinators, social workers, etc.)
- Orientation & Mobility specialists as certified by the Association for Education & Rehabilitation of the Blind and Visually Impaired

Location

Service may be delivered in the child's natural environment or service provider location.

Basic Living Skills (H0036 with TL modifier)

Definition

Functional evaluation of the child in the child's natural environment. The purchasing, leasing or otherwise providing for the acquisition of assistive technology devices. Selecting, designing, adapting, or maintaining an AT device, in order to assist with basic living skills. Any training and/or technical assistance in developing or maintaining basic living skills to improve functional capacity.

Key service functions include the following:

- Evaluating the child's functioning level and determining need of assistive device
- Acquiring the device and providing maintenance or adaptation to the device.
- Providing child, family and providers on the appropriate use of the device so that the child receives the maximum benefit.
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Occupational, Physical or Speech therapist licensed under Alabama law
- Certified social worker licensed under Alabama law
- Rehabilitation technology specialist
- Other individuals as defined by the ICC Personnel standards

Location

Service may be delivered in the child's natural environment or service provider location.

Audiology (92507, 92508, 92531-92547, 92601, 92602, V5273, and V5299—all codes must be submitted with TL modifier)

Definition

Identification of children with auditory impairment. A determination of range, nature and degree of hearing loss and communication functions of the child. The provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training. The determination of the child's need for individual amplification, including selecting, fitting and dispensing appropriate listening and vibrotactile devices and evaluating the effectiveness of those devices.

Key service functions include the following:

- Identifying auditory impairment based on appropriate audiologic screening techniques
- Determining the range and degree of hearing loss and communication functions
- Providing auditory training, aural rehabilitation, speech reading and listening device orientation
- Selecting, fitting and dispensing appropriate listening and vibrotactile devices and evaluating the effectiveness of those devices
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Audiologist licensed under Alabama law
- Speech therapist licensed under Alabama law
- Hearing Aid Dealers
- Licensed Doctor of Medicine

Location

Service may be delivered in the child's natural environment or service provider location.

Family Support (H2027 with TL modifier)

Definition

Services provided to assist the family of an eligible child in understanding the special needs of the child and enhancing the child's development.

Preparing a social/emotional developmental assessment of the child within the family context. Making home visits to evaluate a child's living conditions and patterns of parent-child interaction. Working with the family's living situation (home, community and other locations where early intervention services are provided) that affect the child's maximum utilization of early intervention services.

Providing families with information, skills and support related to enhancing the skill development of the child. Working with the child to enhance the child's development. The planned interaction of personnel, materials, time and space that leads to achieving the outcomes in the child's IFSP. Promoting the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction.

Providing families with a single point of contact for EI services. Assisting and enabling the child/family eligible for EI to receive the rights, procedural safeguards and services authorized under the Individuals With Disabilities Education Act (IDEA), Part C.

Completing all EI procedural safeguard requirements to allow a child (referral) to go through the evaluation/assessment process to determine eligibility for early intervention. Discussion of what is available through early intervention and all rights will be reviewed with the family. Coordination of the evaluation to determine eligibility and results will be part of the intake process. Discussion of other resources if the child is found to be ineligible for EI.

Key service functions include the following:

- Training the family regarding specific information regarding the child's disability
- How to carry out activities as indicated on the IFSP
- Counseling related to the child's disability and the family's ability to cope with the child's condition
- Home visits are a support to accomplished activities under the IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP
- Identifying and coordinating community resources and services to enable the child and family to receive maximum benefit from EI services
- Providing individual and family-group counseling with parents and other family members, and appropriate social skill building activities with the child and parents
- Social/emotional developmental assessment
- Home visits to evaluate a child's living conditions
- Enhancing the developmental skills of the child
- Teaming with other therapeutic disciplines to conduct activities that support outcomes in the child's IFSP
- Providing structured intervention and a routine, functional approach to children diagnosed with autism spectrum disorder

- Coordinating the evaluations/assessments for the determination of the initial EI eligibility and ongoing eligibility
- Facilitating and participating in the development, review and evaluation of the IFSP to include all team members
  - Facilitating the timely delivery of services
  - Assisting families in gaining access to the EI services and other services identified in the IFSP
  - Coordinating and monitoring the delivery of appropriate EI services
  - Contact with family via telephone, home visit, etc.
  - Review of EI procedural safeguards
  - Providing the family with other resources and appropriately closing the child if the child is determined ineligible for EI

Qualified staff

Individuals must meet the ICC approved personnel standards. For those individuals required to complete the AEIS SI Core Curriculum, this must be accomplished prior to providing this service under Medicaid.

- Individuals with a Bachelor's degree in ECSE, VI or HI and an Alabama Class B teacher certification or who meet Alabama's ICC personnel standards (e.g. special instructors, family trainers, home visitors, service coordinators, social workers, etc.)
- Licensed Professional Counselor
- Marriage & Family Therapy Associate per Board approved rules
- Individual with a Master's degree in Rehabilitation Counseling
- Psychologist licensed under Alabama law
- Certified social worker licensed under Alabama law
- Individuals who have a bachelor's degree in a related human services field; such as, allied health, behavioral science, child/human/family development, child life families studies, communication disorders, education, health and recreation, health services administration, psychology, rehabilitation, social science, social welfare, sociology*
- Registered nurse under Alabama law*
- *Both groups of qualified staff must also complete "Journey Through EI in Alabama" (within 6 months of employment) and "Applications of Journey Through EI in Alabama (within first year of employment)

Location

Service may be provided in the child's natural environment or in the service provider location

Physician Evaluation and Management Services (99382 with TL modifier)

Definition

Services provided by a physician to determine a child's developmental status and need for early intervention services.

Key services functions include the following:

- To evaluate the child's on-going eligibility for AEIS.
- To determine if the child has a physical or mental condition that would make the child eligible, if no such diagnosis previously existed and the child was no longer experiencing a 25% delay to maintain eligibility for AEIS.
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Licensed doctor of medicine

Location

Service may be provided in the child's natural environment or in service provider location.

Occupational Therapy (97003, 97004, 97110, 97530, 97532, and 97533 — all codes must be submitted with the TL modifier)

Definition

Services to address the functional needs of the child related to adaptive development, adaptive behavior and play and sensory, motor and postural development. These services are designed to improve the child's functional ability to perform tasks in the home and community settings.

Key service functions include the following:

- Identification, assessment and intervention
- Adaptation of the environment, and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills
- Prevention or minimization of the impact of initial or future impairment, delay in development or loss of functional ability
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Occupational therapist licensed under Alabama law

Location

Service may be provided in the child's natural environment or service provider location.

Physical Therapy (97001, 97002, 97110, 97112, 97530, 97532, 97533, and 97760 — all codes must be submitted with the TL modifier)

Definition

Services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation.

Key service functions include the following:

- Screening, evaluation and assessment of infants and toddlers to identify movement dysfunction
- Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Physical therapist licensed under Alabama law

Location

Service may be provided in the child's natural environment or in the service provider location

Psychological testing (96101 and 96102 with TL modifier)

Definition

Administering psychological and developmental tests and other assessment procedures. Interpreting assessment results. Obtaining, integrating and interpreting information about the child behavior and child and family conditions related to learning, mental health and development. Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training and education programs.

Key service functions include the following:

- Administering developmental tests
- Interpreting assessment results
- Planning psychological services and counseling to family related to the child's development
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Psychologist licensed under Alabama law
- School psychologist certified by the Alabama State Department of Education for AA Certificate and/or holds the National Certification in School Psychology
- School Psychometrist certified by the Alabama State Department of Education for the A Certificate and/or listed in the Alabama Roster of Approved Psychologists and Psychometrists for Testing Children Referred for Placement in Special Education Classes

Location

Service may be provided in the child's natural environment or in the service provider location

Speech-Language Pathology (92506, 92507, and 92508 — all codes must be submitted with the TL modifier)

Definition

Identification of children with communicative or oropharyngeal disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in the development of communication skills. Provision of services for the habilitation, rehabilitation or prevention of communicative or oropharyngeal disorders and delays in the development of communication skills.

Key service functions include the following:

- Identifying and evaluating delays in the development of communication skills
- Providing services to address the developmental delays of the child's communication skills
- Speech services include a variety of techniques, to include, but not limited to: speech, cued speech, auditory-verbal therapy, etc.
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Staff will meet the ICC approved Personnel Standards for AEIS

Location

Service may be provided in the child's natural environment or in service provider location.

Vision services (99173 with TL modifier)

Definition

Evaluation & assessment of visual functioning, including the diagnosis and appraisal of specific visual disorder, delays and abilities. Referral for medical or other professional services necessary for the habilitation and rehabilitation of visual functioning disorders or both. Communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Key service functions include the following:

- Determining the visual functioning level of the child
- Orientation and mobility training for all environments
- Visual training
- Independent living skills training
- Providing developmental and functionally appropriate services
- Teaming as appropriate with other IFSP team members in achieving the outcomes in the child's IFSP
- Progress reports and physical participation in IFSP meetings
- Service will be provided per the IFSP

Qualified staff

- Individuals with a bachelor's degree in the Education of the Visually Impaired and have an Alabama Class B teacher certificate
- Orientation & Mobility specialists as certified by the Association for Education & Rehabilitation of the Blind and Visually Impaired
- Licensed doctor of Optometry or Ophthalmologist
- Occupational or Physical therapist licensed under Alabama law

Location

Service may be provided in the child's natural environment or in service provider location.

Treatment Plan Review (H0032 with TL modifier)

Definition

Review and/or revision of a client's IFSP by qualified staff members. Treatment outcomes will be written in family friendly terms, based on the family's priorities and concerns. A variety of disciplines may be involved based on the results of the multidisciplinary evaluation and assessment that determined the child's eligibility for EI. The meeting for this review will only occur if the family is present.

- The IFSP is reviewed with the family
- Treatment outcomes are functional in nature
- Modification or revision of treatment outcomes or services are made as necessary and coordinated through the Family Support Personnel
- After the initial IFSP is written, the plan will be reviewed, at a minimum, every six months
- The 6 month review can be done via telephone with the parent by the therapist or special instructor.

Qualified staff

See staff listed under previous EI services

Location

Service may be provided in the child's natural environment or in service provider location.

108.2.2 Reimbursement

Claims may be submitted for reimbursement for multiple early intervention services to a recipient on any given day. However, a provider may only submit one claim per day for a particular service to a recipient. For example, an infant may receive family support, special instruction and speech therapy all on the same day. Each face to face contact with the infant would constitute an encounter. Each discipline will be able to submit a claim for reimbursement: family support, the special instructor and speech therapist would submit for their individual services to the child per the IFSP. If a provider is qualified to provide more than one EI service then each claim for reimbursement and documentation should clearly distinguish which service was rendered and there should be a clear delineation of types of services to the infant/toddler.

*Covered services are face-to-face contacts during which a professional team member provides an EI service to an infant/toddler. They are identified based on the data from the individual EI records.

* An exception to face-to-face contacts is the 6 month review of the treatment plan. The 6 month review plan is allowable to be billed when the service plan is reviewed by telephone. It may still be done face-to-face if preferred by the parent.

The definition of a professional team member depends upon the type of service being delivered.

108.2.3 Maintenance of Records

The provider must make available to the Alabama Medicaid Agency at no charge all information regarding claims for services provided to eligible recipients. The provider will permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies. The provider maintains complete and accurate fiscal records that fully disclose the extent and cost of services.

The provider maintains documentation of progress notes and dates of service.

The provider maintains all records for a period of at least three years plus the current fiscal year. If audit, litigation, or other legal action by or on behalf of the state or federal government has begun but is not completed at the end of the three-year period, the provider retains the records until the legal action is resolved. The provider must keep records in a format that facilitates the establishment of a complete audit trail in the event the items are audited.

108.3 Prior Authorization and Referral Requirements

Early Intervention codes do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

A Patient's First referral is **not** required for EI Services.

108.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by EI Providers.

108.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

EI Providers that bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Online adjustment functions
- Enhanced access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

108.5.1 Time Limit for Filing Claims

Medicaid requires all claims for EI services to be filed within one year from the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

108.5.2 Procedure Codes and Modifiers

Medicaid uses the Healthcare Common Procedure Coding System (HCPCS). HCPCS is composed of the following:

Deleted: ~~Locally assigned codes…uses national codes.~~

- American Medical Association's Current Procedural Terminology (CPT)
- Nationally assigned codes developed for Medicare

The CPT manual lists most procedure codes required by Medicaid. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Added: The following…Early Intervention providers.

The following procedure codes have been approved for billing by Early Intervention providers.

Deleted: ~~**Place of Service** section~~

EI Services Grid

(All these Procedure Codes **require** a TL modifier)

Procedure Code	***Billing Unit***	***Daily Maximum***	***Maximum Units-Annual***	***Description***	***Same Day Services Not Allowed (Billing Restrictions)***
90801 end date 12-31-12 T1023	Episode	3	6	Intake Evaluation	All other EI services except TCM and Family Support Personnel NOTE: Two different disciplines may bill for this service on the same day.
H0036	1	2	24	Basic Living Skills	May not be billed by two different disciplines on the same day with the same provider specialty
92507 92508 92531-92547 92601 92602 V5273 V5299	1 1 1 1 1 1 1	1 1 1 1 1 1 1	104 104 48 96 96 1 12	Audiology services	May not be billed by two different disciplines on the same day with the same provider specialty
H2027	15 min	24	600	Family Support	May not be billed by two different disciplines on the same day with the same provider specialty. SW may not be provided in conjunction with services from AL Dept of Human Resources
99382	30 min	4	10	Physician Evaluation and Management Services	May not be billed by two different disciplines on the same day with the same provider specialty
97003 97004 97110 97530 97532 97533	1 1 15 min 15 min 15 min 15 min	1 1 4 4 4 4	1 1 192 192 192 192	Occupational Therapy	May not be billed by two different disciplines on the same day.

Deleted: ~~90791~~

Added: 90801

Added: end date 12-31-12

Added: T1023

Procedure Code	***Billing Unit***	***Daily Maximum***	***Maximum Units-Annual***	***Description***	***Same Day Services Not Allowed (Billing Restrictions)***
97001 97002 97110 97112 97530 97532 97533 97760	1 1 15 min 15 min 15 min 15 min 15 min 15 min	1 1 4 4 4 4 4 4	1 1 192 192 192 192 192 192	Physical Therapy	May not be billed by two different disciplines on the same day.
96101 96102	1 hour 1 hour	5 5	48 48	Psychological testing	May not be billed by two different disciplines on the same day with the same provider specialty
92506 92507 92508	1 1 1	1 1 1	6 104 104	Speech-Language Pathology	May not be billed by two different disciplines on the same day with the same provider specialty
99173	1	1	52	Vision services	May not be billed by two different disciplines on the same day with the same provider specialty
H0032	30 min	7	21	Treatment Plan Review	Individuals must be part of the IFSP team and only one person per discipline can bill for this service on any given day

*The units of measure for Diagnostic Testing Codes 96101 and 96102 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.

Added: **Place of Service** section

108.5.1 Place of Service

Claims should be filed with Place of Service (POS) Code 11 (office) or 12 (home).

108.5.2 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

108.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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109

109 Pace

The Program of All-Inclusive Care for the Elderly (PACE) is a unique model of managed care service delivery for the frail elderly living in the community. It is a state plan program of comprehensive care that allows the frail elderly to live in their communities. The program brings together all the medical and social services needed for someone who otherwise might be in a nursing home. A team, including a physician, registered nurse, social worker, therapists and other health professionals, assesses the participant's needs, develops a comprehensive plan of care and provides for total care. Generally, services are provided in an adult day health center, but they may also be given in a participant's home, a hospital, a long-term care facility or a nursing home. Most PACE participants are dually eligible for Medicare and Medicaid benefits. Enrollment in PACE is voluntary and not limited to an individual who is either a Medicare or Medicaid recipient. All participants must be certified as meeting nursing facility level of care according to the criteria established by the state Medicaid Agency prior to enrollment. Once enrolled, PACE becomes the sole source of all Medicare and Medicaid-covered services, as well as any other items, or medical, social or rehabilitation services the PACE interdisciplinary team (IDT) determines a participant needs.

The PACE program receives a fixed monthly capitated payment from Medicare and Medicaid for each participant, depending on their Medicare and Medicaid eligibility. The payments remain the same during the contract year, regardless of the services a participant may need. The PACE provider assumes full financial risk for each participant enrolled in the program.

The purpose of providing PACE care to individuals at risk of institutional care is to protect the health, safety, and dignity of those individuals while reducing Medicaid expenditures for institutional care.

The policy provisions for PACE providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 53 and Part 460 of the Code of Federal Regulations.

109.1 Enrollment

109.1.1 CMS Enrollment and Agreement

An entity that wishes to become a PACE Organization (PO) must complete an application that describes how the entity meets all the requirements to be a PO. The application must first be submitted to Alabama Medicaid Agency (AMA) for review and approval, and then to CMS. AMA will provide the entity with an assurance that is to be submitted with the application sent to CMS by the entity, stating that the entity is qualified to be a PO and that AMA is willing to enter into an agreement with the entity. CMS will then evaluate the application based

on the information contained in the application, as well as information obtained by onsite visits conducted by AMA and/or CMS. CMS will notify the entity within 90 days from receipt of the application that the application is approved or denied, or that additional information is required. If additional information is requested, CMS will have an additional 90 days from receipt of the requested information to make a final decision. Once an application is approved, an agreement must be signed by the organization, the AMA, and an authorized official of CMS. The agreement is effective for one contract year, but may be extended each year unless any party chooses to terminate the agreement. At a minimum, the agreement must include the information required in 42 CFR 460.32.

109.1.2 AMA Enrollment

Once the three-way agreement has been signed by all parties, the entity is to submit a provider application to HP for enrollment as a Medicaid provider. HP will contact the appropriate staff of the Medicaid PACE Unit to verify that the entity has been approved to be a PACE provider.
HP enrolls PACE providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code* and the *Alabama Medicaid Provider Manual.*

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.
Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a PACE provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for PACE related services.

NOTE:
The 10-digit NPI is required when filing a claim.

PACE providers are assigned a provider type of 64 (PACE Organization). The valid specialty for PACE providers is PACE Organization (645).

109.2 Benefits and Limitations

109.2.1 Federal Eligibility Requirements

As required by 42 CFR 460.150, an individual shall meet the following basic requirements to be eligible to enroll in PACE:

- be 55 years or older
- reside in an approved PACE service area
- meet the state's Medicaid criteria for nursing facility level of care, and
- meet any additional program specific eligibility conditions imposed under the PACE program agreement, including the individual shall be safely served in the community

Medical Eligibility

The Medicaid Agency has delegated authority for initial and annual level of care determination to the PACE provider. Medicaid eligibility for PACE is based on current admission criteria for nursing facility care. Admission criteria are described in *Chapter 26, Nursing Facility, of the Alabama Medicaid Provider Manual and in the Alabama Medicaid Administrative Code, Chapter 10, 560-X-10-.10.* As the Operating Agency and State Administering Agency for PACE, Alabama Medicaid Agency (AMA) maintains ultimate authority and oversight of this process. AMA will prospectively review all initial and annual redetermination admission level of care determinations for certification before the participant is enrolled/continues to be enrolled in the PACE program. Redetermination of the participant eligibility follows the same procedure as a new enrollment.

NOTE:

Initial enrollment in PACE and annual redetermination requires that the patient meet two criteria listed on PACE Form 12-001 (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 assessments submitted for PACE must include supporting documentation.
Four 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.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is a Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy or ileostomy.

NOTE:

If an individual has a serious mental illness or has mental retardation, the individual will not be eligible for PACE unless the individual has medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meets the criteria as set in Chapter 26, Nursing Facility, of the Alabama Medicaid Provider Manual.

The process for admission includes medical and financial eligibility determination:

- In accordance with 42 CFR 460.152(a) (3), prior to enrollment in PACE, Medicaid shall certify that the PACE applicant meets the state's nursing facility level of care criteria.
- The PACE organization shall submit the level of care screening tool each year to verify that the enrollee continues to meet nursing facility level of care requirements as required in 42 CFR 460.160 (b).
- The determination of level of care will be made by an RN of the PACE organization (PO), certification signed by the PO physician and forwarded on to the AMA PACE Unit RN. This is done prior to submission of Form 204/205 and Form 376. The Form 204/205 and Form 376 are to be mailed to the AMA PACE Unit RN. The PACE Unit RN will complete the Form 376 when the LOC has been approved, and will then forward Form 204/205 along with Form 376 to the appropriate Eligibility staff. For cases in which medical eligibility cannot be determined by the PACE Unit RN, the documents will be submitted to the Director of Managed Care for a determination to be made. For cases in which the Director is unable to make a determination, the documents will be submitted to the Alabama Medicaid Agency physician who will review and assess the documentation submitted.
- The earliest date of entitlement for Medicaid is the first day of the month of application for assistance, provided the individual meets all factors of eligibility for that month. The individual who is eligible on the first day of the month is entitled to Medicaid for the full month. It is the responsibility of the PO to verify Medicaid eligibility for participants on a monthly basis. There will be no retroactive benefits applied to initial enrollments in PACE.
- Financial determination is made by the Alabama Medicaid Agency, or the Social Security Administration (SSA). Upon determination of financial and medical eligibility the PO will submit required data electronically via the LTC software to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file. Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code, Chapter 25.*

All PACE organizations are required to accurately complete and maintain the following documents related to level of care in the participants file (EMR) for Medicaid/CMS retrospective reviews.

- PACE Form 12-001. A written assessment used to determine a participant's current care needs. This assessment is used to assess each individual participant's functional, medical, social, environmental and behavioral status. Information obtained should be adequate enough to make a level of care decision with supporting documentation for all criteria selected. If criterion G, unstable medical condition is one of the established medical needs, the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 90 days preceding enrollment.
- IDT assessments
- Plan of Care
- Any and all documentation that would support the Level of Care criteria selected on PACE Form 12-001.

Financial Eligibility

Eligibility for enrollment in PACE is not restricted to an individual who is either a Medicaid recipient or a Medicare beneficiary. Individual's eligible for enrolling in the PACE program are those included in one of the categories listed below:

- Eligible for full Medicaid;
- Eligible for Medicare Part A;
- Enrolled under Medicare Part B;
- Dual eligibles for Medicaid and Medicare

Financial determinations are made by the Alabama Medicaid Agency, or the Social Security Administration (SSA), as appropriate.

Recipients can have Medicare, Medicaid, be dually eligible for Medicare/Medicaid or disabled with income not greater than 300% of the SSI Federal Benefit Rate.

Medicaid does not guarantee future eligibility. For this reason it is very important that providers must verify recipient eligibility on a monthly basis prior to providing a service. For more information refer to Chapter 3, Verifying Recipient Eligibility in the *Alabama Medicaid Provider Manual.*

Enrollment Denials

For any enrollment denial based on level of care, Alabama Medicaid will advise the PO in writing of its decision and the opportunity to request reconsideration of the decision via an Informal Conference so that they may present further information to establish medical eligibility. To request the Informal Conference the PO must submit a letter within 30 days of the date of the letter. This letter must specify the findings that are contested and the basis for the contention. This letter should be addressed to Alabama Medicaid Agency, PACE Program Unit, P.O. Box 5624, Montgomery, AL 36103-5624.

If the Informal Conference results in an adverse decision, the PO is advised of the right to a Fair Hearing. To request the Fair Hearing the PO must submit a letter within 60 days of the date of the letter. This letter should be addressed to Alabama Medicaid Agency, PACE Program Unit, P.O. Box 5624, Montgomery, AL 36103-5624. If the Informal Conference results in a favorable decision, the enrollment procedures are followed.

Prior Approval

Prior approval of the medical level of care must be determined by AMA Medical Review staff. Documentation in support of the Level of Care and PACE Form 12-001 must be submitted to AMA PACE staff. An approval/denial will be faxed to the PACE provider within five working days of receipt of the request. The medical Level of Care must be approved prior to a financial determination. Refer to section 109.6 for additional information regarding PACE assessment requirements.

Enrollment Requirements

- When the participant meets the eligibility requirements and wants to enroll, he/she shall sign an Enrollment Agreement that contains the minimal information under 42 CFR 460.154

- The PACE organization must give a participant, upon signing the enrollment agreement, all of the information set forth in 42 CFR 460.156

- In accordance with 42 CFR 460.158, a participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed Enrollment Agreement

- In accordance with 42 CFR 460.160, the PACE enrollment continues until the participant's death, regardless of changes in health status, unless the participant voluntarily disenrolls in accordance with 42 CFR 460.162, or is involuntarily disenrolled in accordance with 42 CFR 460.164

- As indicated in 42 CFR 460.154 (p), each individual enrolling in PACE shall accept PACE as his or her sole source for services. This requirement must be included in the PACE Enrollment Agreement and the individual or legally responsible person must acknowledge acceptance of this requirement by signing a form approved by AMA

NOTE:

If a recipient is enrolled in a HCBS waiver program, receiving nursing facility services or in the Patient 1st managed care program, the PO must contact the appropriate operating agency or Alabama Medicaid staff for the associated program well enough in advance of the effective enrollment date in PACE, in order to allow enough time for the process of end dating the other benefit plan segment. If not done, this could delay enrollment of the recipient until the next calendar month.

Initial Level of Care Review

In accordance with 42 CFR 460.152 (a) (3) and as described above, prior to enrollment in PACE, Medicaid shall certify that the PACE applicant meets the state's nursing facility level of care criteria.

Annual Level of Care Review

The PACE organization shall submit the level of care screening tool each year to verify that the enrollee continues to meet nursing facility level of care requirements as required in 42 CFR 460.160 (b). The PACE Organization will submit documents to AMA for redetermination review up to 45 days before the annual date but no later than the 15th of the month before the annual date.

Physical, Functional and Psychosocial Assessment/Plan of Care

Following certification by Medicaid that an eligible recipient meets nursing facility level of care requirements, the PACE interdisciplinary team (IDT), under the direction of the PACE medical director and in accordance with 42 CFR 460.104, must conduct a comprehensive assessment of the participant. The IDT must meet the following assessment requirements:

- An initial in-person comprehensive assessment must be completed promptly following enrollment by the:
    - Primary Care Physician
    - Registered Nurse
    - Social Worker
    - Physical therapist
    - Occupational therapist
    - Recreational therapist or activity coordinator
    - Dietician; and
    - Home care coordinator

At least semi-annually, an in-person assessment and treatment plan must be completed by the:

- Primary care physician
- Registered nurse
- Social worker
- Recreational therapist/activity coordinator and
- Other team members actively involved in the development or implementation of the participant's plan of care (e.g., home care coordinator, PT, OT or dietitian

- Annually, an in-person assessment and treatment plan must be completed by the:
  - Physical therapist
  - Occupational therapist
  - Dietician and
  - Home care coordinator

Following the required assessments, the PACE program must develop a plan of care for each participant as required by 42 CFR 460.106. PACE organizations consolidate discipline specific plans into a single plan of care semi-annually through discussion and consensus of the IDT. The consolidated plan is then discussed and finalized with the PACE participant and/or his or her significant others.

Reassessments and treatment plan changes are completed when the health or psychosocial situation of the participant changes.

Reference Alabama Medicaid Agency Administrative Code Chapter 53, section 560-X-53-.07 for Participant Assessment and Plan of Care policy provisions.

Signature Requirement

Under Alabama's Uniform Electronic Transactions Act, effective January 1, 2002, Alabama law recognizes the validity of electronic signatures. For all Medicaid PACE Forms, the signature must be an original signature or an approved electronic signature of the recipient's attending physician/PACE physician. Provider certification is made via standardized electronic protocol.

Health and Safety Assessment

The primary consideration underlying the provision of services and assistance to this state's frail and elderly is their desire to reside in a community setting. However, enrollment in a Program of All Inclusive Care for the Elderly may be denied based upon the inability of the program to ensure the health, safety, and well-being of the individual under any of the following circumstances, based on assessment of the individual's mental, psychosocial and physical condition and functional capabilities:

- The individual is considered to be unsafe when left alone, with or without a Personal Emergency Response System
- The individual lacks the support of a willing and capable caregiver who must provide adequate care to ensure the health, safety and well-being of the individual during any hours when PACE services are not being provided
- The individual's needs cannot be supported by the system of services that is currently available
- The individual's residence is not reasonably considered to be habitable
- The individual's residence or residential environment is unsafe to the extent that it would reasonably be expected to endanger the health and safety of the individual, the individual's caregivers, or the PACE Organization's staff if PACE services are to be provided in the residence
- The individual's behavior is disruptive or threatening or is otherwise harmful (e.g., suicidal, injurious to self or others, or destructive of environment)
- There is a high risk or an existing condition of abuse, neglect or exploitation as evidenced by an assessment

The PACE program shall conduct a comprehensive health and safety assessment to ensure that the applicant's health, safety or welfare will not be jeopardized by living in the community. The assessment must include:

- An on-site evaluation of the applicants residence
- An evaluation of the applicant's social support system, including the willingness and capabilities of all informal caregivers; and
- An evaluation of whether the applicant can be safely transported to the PACE center

PACE Participant Rights

A PACE organization must have a written participant bill of rights designed to protect and promote the rights of each participant. Those rights include, at a minimum, the ones specified in 42 CFR 460.112:

- Respect and nondiscrimination
- Information disclosure
- Choice of providers within the PACE organization's network
- Access to emergency services
- Participation in treatment decisions
- Confidentiality of health information
- Complaints and appeals

Services

The PACE services for all participants, regardless of the source of payment, must include items and services as indicated under 42 CFR 460.90, 42 CFR 460.92 and 42 CFR 490.94 and Alabama Medicaid Agency Administrative Code, section 560-X-53.06.

Provision of Service

- As required by 42 CFR 460.32(a) (1), the PACE program must define its service area. The service area must be approved by AMA and CMS.
- As defined by 42 CFR 460.98(c), the minimum services that must be furnished at each PACE program include primary care, including physician and nursing services; social services, restorative therapies, including physical therapy and occupational therapy, personal care and supportive services, nutritional counseling, recreational therapy and meals, which serve as the focal point for coordination and provision of most PACE services.
- The PACE program must establish an interdisciplinary team (IDT) to provide care and case manage all of the services provided or arranged by the PACE program for each participant. The IDT must be composed of at least the following members:

    a) Primary care physician

    b) Registered Nurse

    c) Master's-level social worker

    d) Physical therapist

    e) Occupational therapist

    f) Recreational therapist or activity coordinator

    g) Dietician

    h) PACE center manager

    i) Home care coordinator

    j) Personal care attendant or his/her representative; and

    k) Driver or his/her representative

In-Home and Referral Services

As required by 42 CFR 460.94, the PACE program must arrange for all in-home and referral services that may be required for each participant. In-home and referral services are furnished by a PACE organization or by a contracted provider with the PACE program in the manner as set forth in 42 CFR 460.70 and in compliance with 460.71.

Emergency Care Services

The PACE program must provide emergency care services in accordance with 42 CFR 460.100.

An emergency medical condition means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the participant
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services Care Plan

The PACE program must establish and maintain a written plan to handle emergency care at the PACE center and when the PACE participant is not at the PACE center. The plan must include procedures to access emergency care both in and out of the PACE service area. The PACE program must ensure that participants and caregivers know when and how to access emergency care services when not at the PACE center. The plan must ensure that CMS, AMA, and PACE participants are held harmless if the PACE Organization does not pay for emergency services.

Access to Emergency Care

In the case of an emergency medical condition, the PACE participant has the right to access the closest and most readily accessible qualified provider, in or out of the PACE service area, including hospital emergency room services.

Out-of-Service-Area Emergency Care

Emergency care while the PACE participant is out of the service area is covered by the PACE program and no prior approval is required.

Out-of-Service-Area Follow-up Care

Urgent care and care furnished to the PACE participant to stabilize his or her emergency medical condition that is provided outside the PACE service area must be prior approved by the PACE program.

Retrospective Reviews of Emergency Care

Evaluation of the participant's decision to use emergency services must be based on the prudent layperson standard and no higher standard may be adopted by the PACE program.

Cost of Emergency Care

Charges for all emergency care must be paid by the PACE program.

109.3 Participant Disenrollment from PACE

Voluntary Disenrollment

In accordance with 42 CFR 460.162, a PACE participant may voluntarily disenroll from PACE at any time without cause. The disenrollment date will not be effective until the participant is appropriately reinstated into other Medicaid programs and alternative services are arranged.

The PO is to notify AMA in writing by the 10th of each month of any voluntary disenrollments for the previous month. A copy of the request to voluntarily disenroll is to be submitted with the monthly report. Voluntary disenrollments are to also be reported on quarterly reports submitted to CMS and AMA.

Involuntary Disenrollment

A PACE participant may be involuntarily disenrolled for any of the following reasons established in 42 CFR 460.164:

- Failure to Pay: Any participant who fails to pay, or make satisfactory arrangements to pay any premiums due, to the PACE organization after a thirty-day grace period
- Disruptive or Threatening Behavior: A participant engages in disruptive or threatening behavior. Such behavior is defined as the following:
  - Behavior that jeopardizes the participant's own health or safety, or the safety of others; or a participant with decision-making capacity who consistently refuses to comply with his/her individual plan of care or the terms of the PACE enrollment agreement. Note that a PACE organization may not involuntarily disenroll a PACE participant on the grounds that the participant has engaged in noncompliant behavior related to an existing mental or physical condition unless the participant's behavior is jeopardizing his/her health or safety or that of others. Noncompliant behavior includes repeated noncompliance with medical advice and repeated failure to keep appointments
- Relocation out of the service area: The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances
- Non-renewal or Termination of Program Agreement: The PACE organization's program agreement with CMS and AMA is not renewed or is terminated
- The participant is determined to no longer meet the Medicaid's nursing facility level of care requirements and is not deemed eligible

Procedures for Involuntary Disenrollment

In the event that a participant is involuntarily disenrolled, the PACE organization shall comply with 42 CFR 460.164.

To involuntarily disenroll a participant, the PACE Organization must obtain the prior review and approval of AMA. The request to disenroll a participant and documentation to support the request must be sent to the AMA PACE Unit. The request and corresponding documentation will be reviewed and a final determination will be made regarding the appropriateness of the involuntary disenrollment. AMA will notify the PACE Organization of approval or denial of the involuntary disenrollment in writing.

The PACE organization must assist the individual in obtaining other care and services to meet his/her medical, functional, psychological, social and personal care needs.

The PO is to notify AMA in writing by the 10th of each month of any completed involuntary disenrollments for the previous month. Involuntary disenrollments are to also be reported on quarterly reports submitted to CMS and AMA.

Effective Date of Disenrollment

The PACE organization is required to ensure that the disenrollment date is coordinated between Medicare and Medicaid for participants who are dually eligible (42 CFR 460.166).

The PACE participant must continue to use and the PACE organization must continue to provide, PACE services up to the effective date of termination (42 CFR 460.166)

The disenrollment date must not become effective until the participant is appropriately reinstated into other Medicare and Medicaid programs and alternative services are arranged (42 CFR 460.168)

Fiscal Agent Enrollment/Disenrollment Notification

When there is both medical and financial approval, the enrollment date will be entered through the Long Term Care (LTC) notification software by the PACE provider. This software enables the provider to submit LTC enrollment/disenrollment notifications on behalf of PACE participants. Enrollment must be completed by the end of the month prior to the effective date for PACE. Example: participant enrolling effective March 1st must have the enrollment information entered in the LTC software program by February 28th. The system is set to automatically default to the first of the following month and PACE providers are not authorized to backdate.

Participants disenrolled from the PACE program must have disenrollment information submitted using the LTC Admission Notification Software within 48 hours. This would include disenrollment due to death, termination from the program or transfer to a Medicaid Waiver program.

Alabama LTC Admission Notification software is available at no charge to Alabama Medicaid providers. It provides installation procedures and a contact number for the HP Electronic Media Claims (EMC) Help Desk, whose commitment is to assist Alabama Medicaid providers with electronic eligibility, claims, and medical eligibility application submission. Access to the LTC Admission Notification Manual can be done via the

Alabama Medicaid web page at at the following link: http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7_AMMIS_LTC_Admission_Notification_Manual_5-11-12.pdf and/or the Alabama Medicaid Provider Portal (https://www.medicaid.alabamaservices.org/alportal) by navigating to "Information" and click on "AL Links".

For additional support or questions contact the *EMC Helpdesk at-1-800-456-1242.*

109.4 Additional Requirements

Compliance

Providers shall comply with all applicable federal, state and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Reports to AMA

A PACE Organization is responsible for collecting data, maintaining records, and submitting reports as required by CMS and AMA as outlined in 42 CFR 460, Subpart L. Quarterly reports are to be submitted to CMS through the HPMS system. A copy of the quarterly reports is to be submitted to AMA by secure email. Monthly reports for voluntary and involuntary disenrollments are to be submitted to AMA by secure email. AMA will notify the PACE Organization in writing if it is determined that additional information, or additional reports, are needed.

The following quarterly reports must be submitted to AMA by the 20th of the month following the end of the quarter:

- Routine Immunizations
- Grievances
- Appeals
- Enrollments
- Disenrollments
- Prospective Enrollees
- Readmissions
- Emergency (unscheduled) Care
- Unusual Incidents
- Participant Deaths

Quality Assessment and Performance Improvement Program

The PACE program must develop, implement, maintain, and evaluate an effective data-driven quality assessment and performance improvement (QAPI) program, with the minimum requirements as under 42 CFR 460.134.

AMA will conduct site visits annually in conjunction with CMS, or as needed, to review the quality of service provision by the PACE Organization. The annual site visit review will include a clinical and administrative component and a review of compliance with life safety codes.

Medical Record Documentation

Per 42 CFR 460.210(b) the PACE organization must maintain a single comprehensive medical record for each participant. The medical record shall contain the following:

- Appropriate identifying information
- Documentation of all services furnished, including the following:
    - A summary of emergency care and other inpatient or long-term care services
    - Services furnished by employees of the PACE center
    - Services furnished by contractors and their reports
- Interdisciplinary assessments, reassessments, plans of care, treatment, and progress notes that include the participant's response to treatment
- Laboratory, radiological and other test reports
- Medication records
- Hospital discharge summaries, if applicable
- Reports of contact with informal support (e.g., caregiver, legal guardian or next of kin)
- Enrollment Agreement
- Physician orders
- Discharge summary and disenrollment justification, if applicable
- Advance Directives, if applicable
- A signed release permitting disclosure of personal information.

Medical Record Retention

In accordance with 42 DFR 460.200, medical records must be maintained in an accessible location for at least six years after the last entry or six years after the date of disenrollment. The records must be available upon request for audit by an authorized representative of the Alabama Medicaid Agency, the state Medicaid Fraud Control Unit and representatives of CMS.

109.5 Capitated Payment and Amounts

The state provides a monthly capitated payment for each PACE participant who is eligible for Medicaid assistance, in accordance with 42 CFR 460.180. The capitation payment amount is specified in the PACE program agreement and is based on the amount AMA would otherwise have paid under the state plan if the recipients were not enrolled in PACE. The capitation payment must be accepted in full for Medicaid participants. The PACE Organization may not bill, charge, collect or receive any other form of payment for the participant unless based on the exceptions listed in 42 CFR 460.182(c).

Payment for Medicare and Medicaid Dually Eligible Recipients

In accordance with 42 CFR 460.180 and 42 CFR 460.182, a PACE program is eligible to receive monthly capitated payments from Medicaid for recipients who are Medicaid eligible or dually eligible for both Medicare and Medicaid when:

- The organization has been approved by AMA as a PACE provider
- The organization has been approved by CMS as a PACE provider; and
- All parties have properly executed the three-way agreement between CMS, AMA and the PACE organization

Private Pay Participants

Federal regulations (42 CFR 460.186) allow the PACE organization to accept private-pay participants and to collect a premium from individuals who are Medicare-only beneficiaries. A PACE organization may not charge a private pay participant an amount greater than the Medicaid capitated payment amount.

109.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are required to bill Medicaid claims electronically.

PACE providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claims correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

The PACE Organization will use the following procedure codes:

- T1015 for PACE participants in the community
- T1015 with modifier TF for PACE participants in the nursing facility

The date of service should be the first day of the month and only one unit should be entered.

109.7 Cost Sharing (Copayment)

Copayment does not apply to services provided by PACE providers.

109.8 Time-Limit for Filing for payment

Medicaid requires all claims for PACE to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

109.9 Diagnosis Codes

The *International Classification of Diseases*- 9th Revision-*Clinical Modification (*ICD-9-CM) manual lists required diagnosis codes. These manuals are updated annually, and the providers should use the current version. The ICD-9-CM manual may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

109.10 Place of Service Code

The following place of service code applies when filing claims for PACE:

POS Code	Description
99	Other place of service

109.11 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
Verifying Recipient Eligibility	Chapter 3

109.12 Resources to learn more about PACE

Code of Federal Regulations
42 CFR Part 460
www.gpoaccess.gov

National PACE Association
www.npaonline.org

CMS Website Resources:

CMS PACE Application:
https://www.cms.gov/PACE/06_ProviderApplicationand RelatedResources.asp

Application Review Guide
https://www.cms.gov/PACE/Downloads/reviewguide.pdf

109.13 CMS PACE Manual

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html

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A Well Child Check-Up (EPSDT)

The purpose of EPSDT services is:

- To actively seek out all eligible families and educate them on the benefits of preventive health care
- To help recipients effectively use health resources and encourage them to participate in the screening program at regular intervals
- To provide for the detection of any physical and mental problems in children and youth as early as possible through comprehensive medical screenings in accordance with program standards
- To provide for appropriate and timely services to correct or ameliorate any acute or chronic conditions

This appendix offers information about the EPSDT program. It consists of the following sections:

Section	***Contents***
Understanding EPSDT	Provides an overview of EPSDT, including descriptions of screening types and services offered under EPSDT
Performing Screenings	Provides information on becoming an EPSDT screening provider, verifying recipient eligibility, critical components of screenings, and how to submit claims for EPSDT screenings
Providing and Obtaining Referrals	Describes the process for providing referrals to specialists and obtaining referrals from screening providers. This section includes instructions for Patient 1st and non-Patient 1st recipients.
Coordinating Care	Describes the administrative requirements of the EPSDT program, including consent forms and retention of medical records.
Off-site Screenings	Provides an overview of the off-site screening program, including enrollment requirements, components required, eligibility verification, referral process and reimbursement information.
Vaccines for Children	Describes the Vaccines for Children program, including enrollment instructions, which procedure codes to bill, how to bill for administration fees, and a copy of the immunization schedule.

A.1 Understanding EPSDT

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age.

The EPSDT program was expanded in the Omnibus Budget Reconciliation Act of 1989 to allow additional services. The acronym EPSDT stands for:

Early	A Medicaid-eligible child should begin to receive high quality preventive health care as early as possible in life.
Periodic	Preventive health care occurring at regular intervals according to an established schedule that meets reasonable standards of medical, vision, hearing, and dental practice established by recognized professional organization.
Screening	A comprehensive, unclothed head-to-toe physical examination to identify those who may need further diagnosis, evaluation, and/or treatment of their physical and mental problems.
Diagnosis	The determination of the nature or cause of physical or mental disease, conditions, or abnormalities identified during a screening.
Treatment	Any type of health care or other measures provided to correct or ameliorate defects, physical and mental illnesses, or chronic conditions identified during a screening.

Periodicity Schedule

Periodic screenings must be performed in accordance with the schedule listed below. This schedule is based upon the recommendations of the American Academy of Pediatrics Guidelines for Health Supervision III.

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- Annually (per calendar year) through 20 years of age beginning with third birthday

NOTE:

Medicaid will reimburse for only one screening per calendar year for children over the age of three. Screening benefit availability may be verified through AVRS, HP Provider Electronic Solutions software, or the Provider Assistance Center at HP. Please refer to Chapter 3, Verifying Recipient Eligibility, for more information.

If a periodic screening has not been performed on time according to the periodicity schedule (for instance, if the 2 months' periodic screening was missed), a screening may be performed at an “in between” age (for example, at 3 months) and billed as a periodic screening. In other words, the child should be brought up to date on his/her screening according to his/her age. Re-screenings should occur within 2 weeks (before or after) of the established periodicity schedule. This policy applies to recipients 0-24 months of age.

EPSDT screenings fall under six broad categories:

Type of Screening	***Description***
Initial Screening	Initial screenings indicate the first time an EPSDT screening is performed on a recipient by an EPSDT screening provider.
Periodic Screening	Periodic screenings are well child checkups performed based on a periodicity schedule. The ages to be screened are 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child’s third birthday.
Interperiodic Screening	Interperiodic screenings are considered problem-focused and abnormal. These are performed when medically necessary for undiagnosed conditions outside the established periodicity schedule and can occur at any age.
Vision Screening	Vision screenings must be performed on children from birth through age two by observation (subjective) and history. Objective testing begins at age three, and should be documented in objective measurements.
Hearing Screening	Hearing screenings must be performed on children from birth through age four by observation (subjective) and history. Objective testing begins at age five, and should be recorded in decibels.
Dental Screening	Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Beginning with age one, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A.2 Using PT+3 with EPSDT services

A patient education method (PT+3) has recently been developed for working with illiterate or marginally literate individuals. The PT+3 allows providers to make the most of patient contacts as opportunities to provide developmentally appropriate information for recipients and their families.

The acronym PT+3 means:

- P = Personalize the problem
- T = "TAKLE" the problem:
  - T = set a Therapeutic Tone,
  - A = Assess the knowledge level of the patient,
  - K = provide Knowledge,
  - L = Listen for feedback,
  - E = Elaborate or reeducate as needed.
- +3 = Summarize the teaching session into three essential points.

PT+3 is a standardized protocol that provides the skills and structure for health care providers to assist young or marginally literate patients in learning and remembering essential points from a health care encounter. PT+3 is designed to increase patient knowledge and compliance. Patients seem to like and understand the simplified information and providers like the process. Using PT+3 saves time for providers and enhances the medical visit for the recipient. PT+3 enables individuals to remember the most important aspects of the medical visit.

Specially designed low literacy materials are available for children (EPSDT Brochures), teens, ("How to Talk to Your Children"), and adults ("Facts about Birth Control") and are free to providers including EPSDT, Patient 1st, and Medicaid family planning providers who receive training in the use of the PT+3 method of education. For more information regarding PT+3, please fax your request to (334) 353-5203, attention "Outreach & Education." Please include your name and telephone number.

A.3 Performing Screenings

This section describes becoming an EPSDT screening provider, verifying recipient eligibility, scheduling screenings, critical components of screenings, and submitting claims for EPSDT screenings.

A.3.1 Becoming an EPSDT Screening Provider

Participation as an EPSDT screening provider is voluntary. To become an EPSDT screening provider, a provider must be an approved Alabama Medicaid provider and must have a 10-digit NPI. New providers should refer to Chapter 2, Becoming a Medicaid Provider, for instructions on receiving an application.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Current Medicaid providers who wish to become an EPSDT screening provider should contact the HP Provider Enrollment Unit at the following address to obtain EPSDT screening provider enrollment forms, or you may download the information from Internet:

HP Provider Enrollment
P.O. Box 241685
Montgomery, Alabama 36124-1685
1 (888) 223-3630

Provider Types Eligible for Participation

Only certain Alabama Medicaid provider types may become approved EPSDT screening providers. In some cases, these providers are restricted to where they can perform screenings:

This Provider Type	***May Perform Screenings at the Following Locations:***
Physicians	Anywhere a physician is authorized to practice
Nurse practitioners	At a physician's office, Rural Health Clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital
Registered Nurses	At a rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital **NOTE:** Two-year degree RNs who wish to perform EPSDT screenings must first complete a Medicaid-approved pediatric health assessment course (PAC) or show proof of completion of a similar program of study. BSN's are exempt from taking a PAC.
Physician Assistants	At a physician's office, rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital

Providers are not limited to those who are qualified to provide the full range of medical, vision, hearing, and dental screening services. Although a qualified provider may be enrolled to furnish one or more types of screening services, the Alabama Medicaid Agency encourages qualified providers to provide the full range of medical, vision, hearing, and dental screening services to avoid fragmentation and duplication of services.

NOTE:

Medical screenings, including the physical, must be performed by a physician, certified nurse practitioner, registered nurse, or physician's assistant, who is approved to perform well child check-ups. Other trained personnel may perform some screening components (for instance, measurements or finger sticks).

Potential EPSDT off-site providers must submit specific documents (see Section A.5) and be approved to participate as an off-site provider.

A.3.2 Verifying Recipient Eligibility

Reimbursement will be made only for eligible Medicaid recipients. Eligibility and benefit limits should be verified **prior to rendering** services to **ANY** Medicaid recipient.

NOTE:

Every effort should be made to assure that medical, vision, and hearing screenings, including immunizations, are accomplished in one visit, and that fragmentation or duplication of screening services is prevented. Section A.7, Vaccines for Children, describes the immunization schedule.

Recipient eligibility should be verified before providing services for several reasons:

- It will inform you of recipient eligibility
- You will be informed if the recipient is assigned to a managed care provider and who the managed care provider is and his/her telephone number
- You may inquire further to determine how many screenings have been performed to determine benefit availability
- It will provide you with the 13th digit of the recipient's Medicaid number for claim filing purposes

Refer to Chapter 3, Verifying Recipient Eligibility, for the various options available and for general benefit information and limitations.

A.3.3 Outreach

Outreach activities are critical to successful health screening services. The outreach process assures that eligible families are contacted, informed, and assisted in securing health-screening services.

The Alabama Medicaid Agency, in conjunction with the Department of Human Resources, informs the applicant of EPSDT services. For those recipients who do not participate in Patient 1st, a list of current EPSDT screening providers are made available for selection by the recipient. SSI (Category 4) eligible recipients are informed of EPSDT services. Until a child is assigned to a managed care provider (usually notified by mail), the Medicaid-eligible child is permitted to see any Alabama Medicaid provider for EPSDT services without a referral from a managed care provider (i.e., Patient 1st provider).

Once the child has been assigned to a managed care provider, all subsequent visits to other providers must have a prior approved written referral (Form 362) from the managed care provider. However, the following recipients are exempt from the managed care program:

- Foster children
- Dual eligibles (Medicare & Medicaid)
- SOBRA-eligible adults
- Those in institutions and/or group homes
- Recipients in the Lock-in program (restricted to one physician and one pharmacy).

For more information regarding managed care systems, refer to Chapter 39, Patient 1st of this manual or call the Provider Assistance Center at (800) 688-7989.

The Alabama Medicaid Agency's goal is to provide effective outreach services for Medicaid-eligible recipients. EPSDT outreach efforts are aimed at two groups: (a) new Medicaid recipients and (b) all Medicaid-eligible recipients under 21 years of age who have not had a well child screening in the last 12 months. These recipients are notified annually. The recipient is informed about EPSDT services through an outreach letter and is encouraged to make an appointment for an EPSDT screening. Once the recipient is assigned a managed care provider, it is the managed care provider's responsibility to ensure screenings (well child checkups) are performed on time. For those recipients who do not participate in a managed care system, the EPSDT screening provider is responsible for ensuring the screenings are performed on time.

A.3.4 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

The scope of services include and are designed to support and assist your office personnel with identifying, contacting, coordinating, and providing follow up for visits with your office for children who are behind on their EPSDT screenings, immunizations, vision/hearing screenings, dental screenings, identify recipients who have high utilization of emergency room visits; follow up services for newborn hearing screenings, elevated blood lead levels, abnormal newborn screening results; follow up on referrals, missed appointments, identify children at greatest risk for targeted outreach, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, EPSDT Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "General", then select "About". A list of EPSDT Care Coordinators by county and telephone numbers is available to support your office personnel.

A.3.5 Scheduling Screenings

The Alabama Medicaid Agency requires that persons requesting screening services receive the services within 120-180 days from the date the request was made. These persons should be given priority by the screening agency when scheduling appointments.

EPSDT selected providers and Primary Medical Providers (PMP) receive a periodic re-screen list each month. The provider should utilize the periodic re-screen list to notify the EPSDT-eligible recipient when the medical screening is due. An appointment should be made for the next screening on the periodicity schedule. These functions are an integral part of the full screening provider's responsibility and are essential for care coordination. Providers have a total of 120 days from due date or award date (listed on printout) to accomplish screening, necessary referral, and treatment for the recipients listed on the printout.

EPSDT-eligible Medicaid beneficiaries who request well child checkups must be provided regularly scheduled examinations and assessments at the intervals established by Medicaid policy.

Scheduling of initial and periodic screenings is the responsibility of the screening provider. Managed care providers are responsible for overall care coordination for medical, vision, hearing, and dental screenings for recipients who participate in a managed care program. The EPSDT screening provider is responsible for overall care coordination as listed above for those recipients who do not participate in a managed care system.

The EPSDT screening provider should not perform a screening if written verification exists or if notified by another provider that the child has received the most recent age appropriate screening. Also, the EPSDT screening provider should receive prior approval from the managed care provider (if applicable). An additional interperiodic screening may be performed if requested by the parent or if medically necessary.

Please refer to Section A.5, Care Coordination, for more information on screening provider responsibilities.

A.3.6 Critical Components of Screenings

This section describes critical components of periodic, interperiodic, and vision/hearing/dental screenings. It also describes recommended health education counseling topics by age group.

Periodic Screenings

Component	***Description***
Unclothed physical exam	This is a comprehensive head-to-toe assessment that must be completed at each screening visit and include at least the following: • Temperature, and height/weight ratio • Head circumference through age two • Blood pressure and pulse at age three and above • Measure body-mass index when clinically indicated Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
Comprehensive family/medical history	This information must be obtained at the initial screening visit from the parent(s), guardian, or responsible adult who is familiar with the child's history. The history must include an assessment of both physical and mental health development and the history must be updated at each subsequent visit.
Immunization status	Immunizations and applicable records must be updated according to the current immunization schedule of the Advisory committee on Immunization Practices (ACIP). Dates and providers must be recorded in the medical record indicating when and who gave the vaccines, if not given by the screening provider. The state law has been changed so that private and public healthcare providers may share immunization data. Medicaid recipients shall be deemed to have given their consent to the release by the state Medicaid Agency of information to the State Board of Health or any other health care provider, by virtue immunization data should be recorded in the medical record.

Component	***Description***
TB skin test	Children who should be considered for tuberculin skin testing at ages 4-6 and 11-16 years Children whose parents immigrated (with unknown TST status) from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown TST status) should be an indication for a repeat TST Children without specific risk factors who reside in high-prevalence areas; in general, a high-risk neighborhood or community does not mean an entire city is at high risk; rates in any area of the city may vary by neighborhood or even from block to block; physicians should be aware of these patterns in determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates Children at increased risk for progression of infection to disease: Those with other medical conditions including diabetes mellitus, chronic renal failure, malnutrition and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these persons are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosupressive therapy for any child with an underlying condition that necessitates immunosupressive therapy. Bacille Calmette-Guérin (BCG) immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus. Initial TST initiated at the time of diagnosis or circumstance, beginning at 3 months of age.* Table 2. Definitions of Positive Tuberculin Skin Test (TST) Results in Infants, Children, and Adolescents* TST should be read at 48 - 72 hours after placement **Induration >5mm** Children in close contact with known or suspected infectious cases of tuberculosis disease: Households with active or previously active cases if treatment cannot be verified as adequate before exposure, treatment was initiated after the child's contact, or reactivation of latent tuberculosis infection is suspected Children suspected to have tuberculosis disease: Chest radiograph consistent with active or previously active tuberculosis Clinical evidence of tuberculosis disease ‡ Children receiving immunosuppressive therapy ‡ or with immunosuppressive conditions, including HIV infection
TB skin test (cont.)	**Reaction ≥15mm** Children 4 years of age or older without any risk factors *These definitions apply regardless of previous Bacille Calmette-Guérin (BCG) immunization: erythema at TST site does not indicate a positive test. HIV indicates human immunodeficiency virus. + Evidence by physical examination or laboratory assessment that would include tuberculosis in the working differential diagnosis (e.g. Meningitis). ‡ Including immunosuppressive doses of corticosteroids

Component	***Description***
Developmental surveillance and assessment	A comprehensive developmental history is required, if appropriate, to determine the existence of motor, speech, language, and physical problems or to detect the presence of any developmental lags. An age-appropriate developmental assessment is required at each screening. Information must be acquired on the child's usual functioning as reported by the child's parent, teacher, health care professional, or other knowledgeable individual. **Developmental assessments must be performed by a RN, BSN; CRNP, PA, or M.D.**
Nutritional status screening	Nutritional status must be assessed at each screening visit. Screenings are based on dietary history, physical observation, height, weight, head circumference (ages two and under), hemoglobin/hematocrit, and any other laboratory determinations carried out in the screening process. A plotted height/weight graph chart is acceptable when performed in conjunction with a hemoglobin or hematocrit if the recipient falls between the 10th and 95th percentile.
Health education including anticipatory guidance	Health education and counseling for parent(s) or guardian and the youth (if age appropriate) are required at each screening visit. Health education is designed to assist the parent in understanding what to expect in terms of development. Health education also provides information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Providers may use the PT+3 teaching method for anticipatory guidance counseling. PT+3 should be documented in the medical record (i.e., progress notes) listing the three points emphasized.
Objective Developmental Screenings	SEE BELOW

Objective Developmental Screenings

EPSDT providers are allowed to bill for an objective developmental screening in addition to an EPSDT screening at the 9 month, 18 month, 24 month and 48 month well-child visit. EPSDT providers also have the option of providing the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity and validity level and is culturally sensitive. The following code, which is limited to five (5) units per date of service (five different screening tools used), may be used to bill for this screening:

96110 - Developmental testing; limited (eg. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report.

In order to bill this code, providers must use a standardized screening tool. Examples of screening tools allowed for this code include, but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire/Social Emotional (ASQ-SE)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener (BINS)
- Parents Evaluation of Development (PEDS)

- Early Language Accomplishment Profile (ELAP)
- Brigance Screens II
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Vanderbilt Rating Scales
- Behavior Assessment Scale for Children-Second Edition (BASC-II)

Providers must document the screening tool utilized, with interpretation and report, in the child's medical record.

Vision Testing/Screenings

Vision screenings are available either as a result of the EPSDT referral or as a result of a request/need by the recipient. A subjective screening for visual problems must be performed on children from birth through age two by history and observation. Gross examinations should be documented as grossly normal or abnormal. Objective testing begins at age three. Visual acuity screening must be performed through the use of the Snellen test, Allen Cards, photo refraction, or their equivalent. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, perform a subjective assessment. The reason(s) for not being able to perform the test must be documented in the medical record. Proceed with billing the vision screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the vision screening. Be sure to complete the vision screening within 30-45 days from the original screening date.

If a suspected visual problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child check-ups, **including routine vision** and **hearing screenings**. Post payment reviews are performed to determine appropriate utilization of services.

Trained office staff may perform a vision screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a vision screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a vision screening
- Employee performs a vision screening under supervision on a minimum of three patients successfully.

Hearing Testing/Screenings

Hearing screenings are available either as a result of an EPSDT referral or as a result of a request/need by the recipient. A subjective screening for hearing problems must be performed on children from birth through age four by history and observation. Gross examination should be documented as grossly normal or abnormal. Objective testing begins at age five. Hearing screenings must be performed through the use of a pure tone audiometer at 500 and 4,000 Hz at 25 decibels for both ears. If a child fails to respond at either frequency in either ear, a complete audiogram must be done. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, do a subjective assessment. The reason(s) for not being able to complete the test must be documented in the medical record. Proceed with billing the hearing screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the hearing screening. Be sure to complete the hearing screening within 30-45 days from the original screening date.

If a suspected hearing problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Trained office staff may perform a hearing screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a hearing screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a hearing screening
- Employee performs a hearing screening under supervision on a minimum of three patients successfully.

Providers **must** use an “EP” modifier to designate all services related to EPSDT well-child check-ups, **including routine vision** and **hearing screenings**. Post payment reviews are performed to determine appropriate utilization of services.

Dental Services

Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental screenings must be performed on children from birth through age two by observation/inspection and history. Beginning with age one, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A periodic oral examination is recommended once every six months for eligible Medicaid recipients under 21 years of age. Dental services include emergency, preventive, and therapeutic services as well as orthodontic treatment when medically necessary. A referral, or documentation that recipient is under the care of a dentist is required at age one and older. Follow-up is no longer mandatory. Any time a need for dental care is identified, regardless of the child’s age, the child should be referred to a dentist.

Beginning with age one, providers should educate and document that caretakers have been advised of the importance (anticipatory guidance) of good oral healthcare and the need to make a dental appointment. Additional documentation suggestions include providing the caretaker with one of the following phone numbers: dentist, Agency's Dental Program phone number to assist with locating a dentist (334) 242-5472, or the Recipient Inquiry Unit (RIU) number to assist with locating a dentist (800) 362-1504.

Effective 01/01/2009, Pediatric providers (MDs, DOs, PAs, and NPs) will be able to bill in accordance with Medicaid reimbursement policies for oral assessment and application of fluoride varnish for recipients age 6 months through 35 months of age. Providers may bill assessment code DO145 (oral exam less than 3 years old, counseling with primary caregiver). DO145 can be billed once by pediatric medical provider and once by the dental provider for recipients 6 months through 35 months of age. Varnishing code D1206 (topical fluoride application) will be limited to 3 per calendar year, not to exceed a maximum of 6 fluoride varnish applications between 6 months and 35 months of age. Frequency is not allowed less than 90 days. Providers are required to bill diagnosis code V72.2 (dental examination). Once a recipient has an established dental home (described in Chapter 13 section 13.2), a pediatrician cannot bill D1206.

Dental care under the Program is available either as a result of the EPSDT referral or as a result of request/need by the recipient. Conditions for each situation are as follows:

1. EPSDT Referral – If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is age one or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and treatment. After the recipient's dental care is initiated, the consultant's portion of the Referral Form (Form 362) must be completed by the dentist and the appropriate copy must be returned to the screening provider.
2. Recipient Seeking Treatment – If a recipient who has not been screened through the EPSDT Program requires dental care, care may be provided without having a Referral Form. Dental care provided on request of the recipient is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT screening provider to obtain a complete medical assessment.

NOTE:

Dental health care services are available for eligible children under age 21, as part of the EPSDT program. To obtain information about dentists, you may call the Dental Program at (334) 353-5263.

Laboratory Screenings

Laboratory screening procedures must be performed in coordination with other medical screening services at the same visit, whenever possible. If verifiable results are available from another provider that any required laboratory procedure was performed within 30 days prior to the screening visit and there is no indication of a diagnosis that would warrant that the test be redone, it is not necessary to perform the test again. However, the test results or a copy of the test results should be documented in the medical record.

NOTE:

Providers have the option of obtaining the Hgb or Hct and the lead test during the nine month or twelve month well child check-up (EPSDT screening).

The following is a list of tests and procedures of laboratory screenings:

Laboratory Test	***Description***
Newborn Screening	Newborn screening is mandated by **Statutory Authority Code of Alabama 1975, Section 22-20-3**. Every hospital or facility providing delivery services is required to screen all infants for these potentially devastating disorders. The Alabama Department of Public Health (ADPH) is responsible for administrative oversight of the Newborn Screening Program. Infants are screened for 29 primary and 45 secondary disorders which include Endocrine Disorders (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia), Cystic Fibrosis (CF), Sickle Cell Disease, Hearing Loss, and Metabolic Disorders (Amino, Fatty, and Organic Acid). In April 2012, ADPH implemented voluntary screening to detect Critical Congenital Heart Disease. The Alabama Newborn Screening website has a complete list of disorders at www.adph.org/newbornscreening. Early diagnosis of these conditions may reduce morbidity, premature death, mental retardation, and other developmental disabilities. All initial screening tests are conducted by ADPH's Bureau of Clinical Laboratories (BCL). Infants 12 months of age and younger with no record of a newborn screen should be tested as soon as possible. Screening for hemoglobinopathies (sickle cell disease/trait or thalassemia) is only included on the initial newborn screen. If initial results are not satisfactory for infants from birth to 12 months of age a repeat test must be performed. Children over 12 months of age who have never been tested need only be screened when ordered by a physician. ADPH's BCL has established standards and cutoffs for newborns and infants, and therefore **cannot accept specimens on infants older than 12 months of age**. Please see the Newborn Screening Collection Guidelines at http://www.adph.org/newbornscreening/assets/ADPHBCLCollectionGuidelines.pdf Routine second testing is recommended between two and six weeks of age, with four weeks being optimal. This second screen is critical in detecting a condition that may not have been picked up on an initial screen. Confirmation of abnormal newborn screening results is always necessary. An infant with a positive screen should be referred for diagnostic testing. The Alabama Newborn Screening Program works in partnership with pediatric sub-specialists to ensure all babies identified with abnormal results receive appropriate follow-up. These specialists are located at the University of Alabama in Birmingham (UAB), University of South Alabama in Mobile, and the St. Jude Clinic in Huntsville. In addition, there are seven community-based Sickle Cell Organizations who provide counseling and follow-up for infants identified with sickle cell disease and trait. The Cystic Fibrosis Care Center at UAB provides CF care to include genetic counseling at Children's of Alabama. It should be noted physicians should not bill for laboratory tests performed by the BCL. However, procedure codes 36415 and 36416 with modifier 90 may be billed for the specimen collection when referred to an outside laboratory. All screening tests are conducted by Alabama Department of Public Health's Bureau of Clinical Laboratories.

Laboratory Test	***Description***
Public Health: Alabama Voice Response System (AVRS):	The Alabama Voice Response System (AVRS) is a Newborn Screening Information System, offered by the Alabama Department of Public Health. The AVRS provides 24-hour, seven days a week telephone reporting of screening results in 30 seconds or less directly through a toll free number, (800) 566-1556, and has the capability of providing faxed copies of results. The AVRS requires pre-registration with the screening program and positive identification of the caller through two security checks. Physicians are prompted by the system to enter their state license number (preceded by zeros, if needed, to make a seven digit number), in addition to the entry of a four-digit personal identification number or PIN. Physicians may register with the program by completing the registration form found on the Alabama Newborn Screening website at: www.adph.org/NEWBORNSCREENING/ or by calling the Newborn Screening Program at 334-206-7065. Applicants will be notified when their form has been processed. Each physician chooses his or her individual PIN and records the number on the pre-registration form. The PIN must be four numeric characters. It is the responsibility of each physician to safeguard his or her PIN. If a PIN is lost, stolen, forgotten, or if a physician suspects someone has gained access to it, immediately call the Alabama Newborn Screening Program at 334-206-7065 and a new PIN will be issued. Physicians must have available the specimen kit number found on the filter paper collection form preceded by the year of the infant's birth **or** the mother's social security number. Information is provided by recorded voice messages. The infant's name and date of birth are spelled and verified by user response before any test results are given. Along with the test result, information is provided concerning the need for repeat testing or medical follow-up. Additional information may also be obtained by contacting the Newborn Screening Program at 334-206-7065 or 1-866-928-6755.
Iron Deficiency Anemia Screening	Hematocrit or hemoglobin values must be determined at a medical screening visit between 1-9 months of age. However, providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. Hematocrit or hemoglobin must be determined, between 11-20 years of age, and as deemed medically necessary based on physical examination and nutritional assessment.
Urine screening	Effective 10/01/2008 the urinalysis component of an EPSDT screening is no longer a requirement. A urinalysis should only be performed if clinically indicated. Urine screening must be performed at the medical screening visit at five years of age and at each visit between 11 and 20 years of age depending on the success in obtaining a voided urine specimen. If specimen is unobtainable, SNA (Specimen Not Available) should be documented. The required screening procedure is a dipstick that shows the measurement of protein and glucose. Urine obtained from recipients between 11 and 20 years of age should be checked for leukocytes.
Chlamydia Screening	Chlamydia Screening is recommended for all sexually-active females aged <25 years annually.

NOTE:

The hgb or hct are included in the screening reimbursement and should not be billed separately.

Laboratory Test	***Description***
Lead toxicity screening	All children must have a blood lead toxicity screening at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at 9 or 12 months of age. A lead toxicity screening is also required for any child 36 to 72 months of age who has not previously received a blood lead toxicity screening or who presents with symptoms of possible lead poisoning. All children should receive lead toxicity screenings since all children are vulnerable to blood lead poisoning. Children's blood lead levels increase most rapidly at 9-12 months of age and peak at 18-24 months of age. The screening test of choice is blood lead measurement (replaces the erythrocyte protoporphyrin (EP) test.
Other lab tests	There are several other tests to consider in addition to those listed above. Their appropriateness is determined by an individual's age, sex, health history, clinical symptoms, and exposure to disease. These may include, for example, a pinworm slide, urine culture, VDRL, GC cultures and stool specimen for parasites, ova, and blood. **Note:** The test for VDRL, gonorrhea cultures, intestinal parasites, and pinworms may be done by the Alabama Department of Public Health clinical laboratory, at NO cost to the EPSDT screening provider. The State lab slip must have "EPSDT Program" documented across the top. Other Medicaid approved laboratories may be used to run sickle cell and lead screening tests.

Deleted: ~~**Risk Questionnaire** section~~

Deleted: ~~**Interpretation of Lead Toxicity Screening Results** section~~

Added: Case management services…order is required.

NOTE:

The State Laboratory will supply microvettes, mailing containers and forms for obtaining blood lead levels at no cost to providers upon request. Please contact (334) 260-3400 to obtain additional information.

Deleted: ~~For clinical consultation…Birmingham, (800) 292-6678~~

Public Health Department Services

EPSDT care coordination is initiated for children with a confirmed blood lead level of > 10 μg/dL. Case management services may be requested if the physician determines the family requires additional education in the home. A physician's order is required. EPSDT care coordinators assess the family's social and environmental needs, develop case plan with goal of reducing blood lead levels, educate family regarding lead risk behaviors, schedule blood lead level retest, and refer to appropriate resources regarding lead screening guidelines. An environmental investigation is initiated for children with a confirmed venous blood lead level of ≥ 15 ug/dL. Environmentalists perform an environmental investigation on a residence to identify lead hazards and recommend interim control or abatement measure if necessary.

Added: **Blood Lead Screening and Management Guidelines** section

Blood Lead Screening and Management Guidelines

Added: **Screening Guidelines** section

Screening Guidelines

All children should receive blood lead level (BLL) screenings at 12 and 24 months of age. Providers have the option obtaining the lead level and Hct or Hgb at 9 or 12 months of age.

A BLL screening is also required for a child who:

- Is 36 to 72 months of age and has not previously received a BLL screening.
- Has a change in risk status.
- Presents with symptoms of possible lead poisoning. (Examples: severe anemia, seizures, constipation, abdominal pain, changes in behavior.)

Added: **Lead Risk Assessment Questionnaire** section

Lead Risk Assessment Questionnaire

Providers should assess a child's risk of blood lead poisoning beginning at 9 month of age. Children determined to be at high risk of blood lead poisoning should receive parental education, nutritional counseling, and a BLL screening as appropriate. Administering the Risk Assessment Questionnaire instead of a BLL screening does not meet Medicaid requirements. A venous specimen is preferred, although capillary samples are acceptable.

BLL (ug/dL)	COMMENTS
5-9	CONFIRM with venous sample within **3 months**
10-14	CONFIRM with venous sample within **3 months**
15-19	CONFIRM with venous sample within **1 months**
20-44	CONFIRM with venous sample within **5 days**
45-59	CONFIRM with venous sample within **48 hours**
60-69	CONFIRM with venous sample within **24 hours**
>70	CONFIRM with venous sample **immediately**

Added: **Venous Samples – Confirmed Diagnostic Comments** section

Venous Samples - Confirmed Diagnostic Comments

< 5	EDUCATE families about preventing lead exposure SCREEN BLL at 12 and 24 months of age, or as indicated by risk status.
5-9	OBTAIN confirmatory diagnostic (venous) test within 3 months, even if the initial sample was venous. CONTINUE follow-up testing every 3 months until 2 consecutive tests are < 5 µg/dL. EDUCATE families concerning lead absorption and sources of lead exposure (ADPH pamphlet available). Case management services EXPLAIN that there is no safe level of lead in the blood. PROVIDE nutritional counseling. COMPLETE history and physical exam. TEST for anemia and iron deficiency. PROVIDE neurodevelopmental monitoring. SCREEN all siblings under age 6. OBTAIN abdominal X-ray (if particulate lead ingestion is suspected) with bowel decontamination if indicated.

10-14	REFER for targeted case management via mailing ADPH-FHS 135, *Elevated Blood Lead Environmental Surveillance Form, to the address on the bottom of the form within 5 days of notification of results. PROVIDE parental education and nutritional counseling. RETEST within 3 months with venous sample.*
15-19	REFER for targeted case management and environmental investigation via mailing ADPH-FHS-135, *Environmental Surveillance Form,* to the address on the bottom of the form within 5 days of notification of results. PROVIDE parental education and nutritional counseling. RETEST within 3 months with venous sample.
20-44	REFER for targeted case management and environmental investigation via mailing ADPH-FHS-135, *Environmental Surveillance Form,* to the address on the bottom of the form within 3 days of notification of results. PROVIDE parental education and nutritional counseling. RETEST within 3 months with venous sample or more often as determined by physician.
45-59	REFER for treatment (chelation therapy*) to physician within 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. PROVIDE parental education and nutritional counseling. RETEST within 1 month with venous sample or more often as determined by physician.
60-69	REFER for treatment (chelation therapy*) to physician with 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. PROVIDE parental education and nutritional counseling. RETEST within 2 weeks with venous sample or more often as determined by physician.
>70	REFER for treatment (chelation therapy*) to physician within 24 hours if asymptomatic; otherwise, refer for medical treatment immediately. REFER for targeted case management and environmental investigation via faxing ADPH-FHS-135, *Environmental Surveillance Form,* to 334-206-2983 immediately upon notification of results. PROVIDE parental education and nutritional counseling. RETEST weekly with venous sample or more often as determined by physician.

Added: 10-14, Refer for targeted…determined by physician.

***Child should only return to a lead-safe environment after chelation therapy.**

Added: ***Child should only…after chelation therapy.**

Added: CLINICAL NOTE

CLINICAL NOTE:

Most children with lead poisoning are asymptomatic. Symptomatic children with elevated blood lead levels should be evaluated immediately. Symptoms may include coma, seizures, bizarre behavior, ataxia, apathy, vomiting alteration of consciousness, and subtle loss of recently acquired skills. Lead encephalopathy has been reported with levels as low as 70 µg/dL.

Environmental Lead

Environmental Lead Investigations is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Please refer to Chapter 101, County Health Departments, for more information.

Normal and Abnormal Diagnoses

An abnormal diagnosis should only be billed when a health problem is identified and is referred for further diagnosis and treatment services. These services may be self-referrals.

A normal diagnosis should be billed when no health problem is identified or when identified health problems are treated immediately (acute or one time problem) during the screening (same day) and no referral is made for further diagnosis and treatment services. A normal diagnosis should also be billed when the only referrals are for *routine* vision, hearing or dental services. Diagnosis codes that may be utilized to indicate a “normal” screening are, but are not limited to: V20.0-V20.2 and V70.0.

Interperiodic Screenings

EPSDT-eligible children may receive medical, vision, hearing, and dental services that are medically necessary to determine the existence of a suspected physical or mental illness or condition, regardless of whether such services coincide with the periodicity schedule for these services. Screenings that are performed more frequently or at different intervals than the established periodicity schedules are called **interperiodic screenings**. An interperiodic screening may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings are performed for undiagnosed medically necessary conditions outside the established periodicity schedule. Interperiodic EPSDT screenings are problem-focused and abnormal.

Interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary.

By performing an interperiodic screening and issuing and EPSDT referral form, physician office and other benefits will be "saved" for acute illnesses or other sickness. An interperiodic screening should be performed (where a history and problem-focused physical exam occurs) for suspected medical, vision, hearing, psychological, or dental problems in order for an EPSDT referral to be issued for further diagnosis and/or treatment. In this manner, the recipient will be referred for consultation and/or to a specialist for medically necessary and appropriate diagnostic tests and/or treatment. Vision/hearing screenings are to be performed/billed on the same date of service as an initial or periodic screening only. Vision/hearing screenings are limited to one each annually, beginning at age 3 for vision and 5 for hearing. However if a suspected vision/hearing/ dental/medical problem should manifest itself, an interperiodic screening should be performed in order for an EPSDT referral to be issued to a specialist or consultant. For more information regarding vision and hearing screenings, please refer to section A.3.5. For more information regarding dental, please refer to Chapter 13 Dentist. For dental EPSDT referral requirements, please refer to Chapter 13.

An interperiodic screening may be performed based upon a request by the parent(s) or guardian(s), or based on the provider's professional judgment relative to medical necessity. The Alabama Medicaid Agency considers **any** encounter with a health care professional who meets the qualifications for participation in the EPSDT program to be an interperiodic screen, regardless of whether the health care professional is enrolled as a provider with the Agency.

A health developmental or educational professional who comes in contact with the child outside the formal health care system may also determine whether an interperiodic screening is medically necessary. The screening provider must document the person referring the child, and a description of the suspected problem, in the record.

Documentation requirements for interperiodic screenings are:

- Consent
- Medical-surgical history update;
- Problem-focused physical examination
- Anticipatory guidance/counseling related to the diagnosis made.

Interperiodic screenings must always be filed with the patient’s other insurance first. If the primary insurance is a HMO or the provider is a FQHC, IRHC or PBRHC, the interperiodic screening code must be submitted. Once the claim has been paid/denied, Medicaid may then be billed utilizing the interperiodic screening code with an EP modifier appended. When filing for an interperiodic screening, always append an EP modifier or the visit will count against benefit limits.

If the primary insurance is not a HMO, bill the appropriate “office visit” code. Once the claim has been paid/denied from the patient’s other insurance, a claim may be filed with Medicaid utilizing the same “office visit” code with an EP modifier appended. When billing an office visit code for an interperiodic code, always append the EP modifier or the visit will count against benefit limits.

NOTE:

If any other treatments are provided the same day (injections, lab, etc.), a “1” or “4” must also be reflected in Block 24h, on each line item, or the claim will deny.

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

99233 EP for Inpatient interperiodic screenings

The new interperiodic screening codes will count against office /hospital visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child’s primary insurance must be billed first, and then Medicaid as the payor of last resort.

SCREENING CODES

PROCEDURE CODE	DESCRIPTION
99381 EP EPSDT NEW PATIENT	NEW PATIENT UNDER 1 YEAR OF AGE
99382 EP EPSDT NEW PATIENT	NEW PATIENT 1YEAR TO 4 YEARS OF AGE
99383 EP EPSDT NEW PATIENT	NEW PATIENT 5 YEARS TO 11 YEARS OF AGE
99384 EP EPSDT NEW PATIENT	NEW PATIENT 12 YEARS TO 17 YEARS OF AGE
99385 EP EPSDT NEW PATIENT	NEW PATIENT 18 YEARS TO 20 YEARS OF AGE
99391 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT UNDER 1 YEAR
99392 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 1 YEAR TO 4 YEARS OF AGE
99393 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 5 YEARS TO 11 YEARS OF AGE
99394 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 12 YEARS TO 17 YEARS OF AGE
99395 EP EPSDT ESTABLISHED PATIENT	ESTABLISHED PATIENT 18 YEARS TO 20 YEARS OF AGE
99211 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM MINOR
99212 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM SELF-LIMITED OR MINOR.
99213 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM LOW TO MODERATE SEVERITY.LOW COMPLEXITY MEDICAL DECISION MAKING.
99214 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM MODERATE TO HIGH SEVERITY. MODERATE COMPLEXITY MEDICAICAL DECESION MAKING.
99215 EP INTERPERIODIC	ESTABLISHED PATIENT PRESENTING WITH PROBLEM MODERATE TO HIGH SEVERITY. HIGH COMPLEXITY DECISION MAKING.

NOTE:

Effective 1/1/2011, periodic screening codes 99382 EP- 99385 EP and 99392 EP- 99395 EP may not be billed in a hospital setting (inpatient or outpatient facility settings).

Intensive Developmental Diagnostic Assessment

An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants' age zero to under two years, and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

NOTE:

Medical necessity is subject to retrospective review by the Alabama Medicaid Agency. Please refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for more information.

Interagency Coordination

The State of Alabama, in conjunction with the Interagency Coordinating Council and the Alabama Department of Rehabilitation Services will implement a system of services to the eligible population (20 USC Section 1471 et seq, Part H), with the assistance of agencies, programs, providers, and the families of eligible infants and toddlers with special needs.

The Alabama Medicaid Agency is one of nine state agencies that hold positions on the Interagency Coordinating Council. The Early Intervention Law legislates a statewide system of early intervention services for eligible infants and toddlers that is comprehensive and coordinated among all disciplines and providers involved, and encourages the development of a system of service delivery that includes parents' participation and input. Services that provide early intervention are to be coordinated across agency and provider lines.

The definition of a child eligible for early intervention includes infants and toddlers under age three inclusive, who are either (1) experiencing developmental delay equal to or greater than 25 percent as measure by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development; or (2) they have a diagnosed physical or mental condition which has a high probability of resulting n developmental delay are eligible for early intervention services. Early intervention services can include the following:

Audiology	Service coordination
Family training/counseling & home visits	Occupational therapy
Health	Nursing
Medical services for diagnostic/evaluation	Vision services
Nutrition	Physical therapy
Psychological services	Social work
Special instruction	Speech/language pathology
Assistive technology devices & services	Transportation

The Early Intervention Service Coordinator who receives the Child Find referral will contact the EPSDT or Patient 1st provider to obtain the EPSDT screening information and any other pertinent information. In order to coordinate services, once a well child check-up (EPSDT) has been completed and a developmental delay has been indicated, contact Child Find, (**800) 543-3098**. Please refer to the Early Intervention Child Find Referral Form at the end of this Appendix or visit Medicaid's website at: www.medicaid.alabama.gov.

NOTE:

You may refer a family to Alabama's Early Intervention System (AEIS) in addition to referring the child and family to other appropriate services. AEIS staff is located in seven districts in the state. Please call the toll free number if you are interested in information about local EI resources.

Recommended Health Education Counseling Topics

2 weeks-3 months
Nutrition - Spitting up
Hiccoughs
Sneezing, etc.
Safety
Need for affection
Immunizations
Skin and scalp care
Bathing frequency
How to use a thermometer
When to call the doctor

4-6 months
Nutrition
Safety
Teething and drooling/dental hygiene
Fear of strangers
Lead poisoning
Immunizations

7-12 months
Nutrition
Immunizations
Safety
Dental hygiene
Night crying
Separation anxiety
Need for affection
Discipline
Lead poisoning

13-18 months
Nutrition
Safety
Immunizations
Dental hygiene
Temper tantrums
Obedience
Speech development
Lead poisoning

19-24 months
Nutrition
Safety
Need for peer relationship
Sharing
Toilet training
Dental hygiene
Need for attention and patience
Lead poisoning

3-5 years
Nutrition
Safety
Dental hygiene
Assertion of independence
Type of shoes
Need for attention
Manners
Lead poisoning

6-13 years	**14-21 years**
Nutrition	Nutrition
Safety	Dental
Dental care	Safety (automobile)
School readiness	Understanding body anatomy
Onset of sexual awareness	Male/female relationships
Peer relationship (male and female)	Contraceptive information
Preputertal body changes	Obedience and discipline
Substance abuse	Parent-child relationships
Contraceptive information (if sexually active)	Alcohol, drugs, and smoking
	Occupational guidance
	Substance abuse

Providers may use the PT+3 teaching method for anticipatory guidance counseling. Providers should document PT+3 counseling was utilized and list the three points emphasized.

Billing Requirements

The table below provides billing information for EPSDT screening claims:

Topic	***Explanation***
Copayment	EPSDT recipients, under 18 years of age, are not subject to co-payments.
Prior Authorization	Screenings are not subject to prior authorization.
Referral	Please refer to Section A.4, Providing and Obtaining Referrals, for more information.
Time Limit for Filing Claims	One year from the date of service
Visit Limitations	An office visit is not billable on the same day with an EPSDT screening by the same provider or provider group.
Diagnosis Codes	The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.
Procedure Codes and Modifiers	The following procedure codes should be used when billing comprehensive EPSDT screening services: 99381-99385 with modifier EP Initial EPSDT Screening 99391-99395 with modifier EP Periodic EPSDT Screening 99173 with modifier EP Vision Screening – Annual 92551 with modifier EP Hearing Screening – Annual Effective January 1, 2007 the interperiodic screening codes have changed. The following procedure codes (in service locations other than inpatient hospital) must be used: 99211EP-99215EP You must use an EP modifier in order to bypass office visit benefit limits. For interperiodic screenings performed in an inpatient hospital setting, the following procedure code must be used: 99233EP You must use an EP modifier in order to bypass hospital visit benefit limits. Interperiodic screening codes should have abnormal diagnosis codes. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Topic	*Explanation*
Intensive Developmental Diagnostic Assessment (Multidisciplinary team)	The following procedure codes should be used when billing for an intensive development diagnostic assessment (a multidisciplinary comprehensive screening) for children under two years of age (limited to two per recipient per lifetime) 96110 – Developmental testing; limited (eg, Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report. (Formerly known as Intensive developmental diagnostic assessment, normal findings) 96111 – Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report. (Formerly known as Intensive developmental diagnostic assessment, abnormal findings)
Third Party Coverage	Providers are required to file with available third party resources prior to filing Medicaid. Preventive pediatric services and prenatal care are excluded from this requirement unless the recipient has managed care coverage or Medicaid pays the provider a global fee.
Reimbursement	Governmental screening providers (including physicians) will be paid on a negotiated rate basis, which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge, which is not to exceed the maximum allowable rate established by Medicaid.
EPSDT Indicator Reference	The EPSDT Indicator will be either a “Y” or “N”, as applicable, when using electronic claims only.

NOTE:

Well child check-up visits (initial, periodic, and interperiodic screenings) do not count against recipient's benefit limits of 14 physician office visits per calendar year. There is no co-pay for recipients under 18 years of age.

A.3.7 Patient 1st, Primary Care Case Management (PCCM) Referral Services

To participate in the PCCM program, physicians are required to:

- Provide an ongoing physician/patient relationship
- Provide primary care services, including prevention, health maintenance and treatment of illness and injury
- Coordinate all patient referrals to specialists and other health services
- Offer 24-hour availability of primary care or referral for other necessary medical services
- Use a preferred drug list
- Follow program procedures
- Participate in the enrollee grievance process
- Meet other minimum program criteria

Physicians who agree to serve as primary medical providers are paid fee components to provide case management services for their patients.

Please refer to the Alabama Medicaid Provider Manual, Chapter 39 for more information regarding the Patient 1st program.

NOTE:

The Patient 1st program does not extend or supersede any existing program benefit or program requirement.

A.3.8 Billing for Patient 1st Referred Services

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing. If a service does not require a Patient 1st referral it is not necessary to get a referral from the PMP and it is not necessary to retain a referral form in the recipient's medical record. A list of the Patient 1st services "requiring" and "not requiring" a written signed referral are listed in the Alabama Medicaid Provider Manual in Chapter 39.

When billing for referred services the PMP name/10-digit NPI, and indicator "4" must be reflected on either the CMS-1500 (blocks 17, 17a, and 24J) by the specialty physician or on the UB-04 (block 78 and the indicator "A1" in block 24) if a hospital or outpatient clinic is providing the specialty services. If all fields are not properly coded, Medicaid will reject the claim. (Refer to Chapters 5, Filing Claims, and 39, Patient 1st, of the Provider Manual for claim instructions).

If a service performed by the billing provider does **not** require a Patient 1st referral, do not enter the name of a referring physician and/or the 10-digit NPI on the CMS-1500 (blocks 17 and 17a) or on the UB-04 Claim Form (block 78).

Please refer to Chapter 5, Filing Claims, for information regarding filing claims from a Patient 1st referral.

A.4 Providing and Obtaining Referrals

One of the primary purposes of the EPSDT services is to ensure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. A Medicaid eligible child who has received an EPSDT screening (well child check-up) may receive additional medically necessary health care. These services are considered above the normal benefit limitations and require a referral from an EPSDT screening provider and Patient 1st PMP, if applicable. Some of these referred services require prior authorization from the Alabama Medicaid Agency. The Alabama Medicaid Referral Form (Form 362) must be appropriately completed by the screening physician including the screening date that the problem was identified and the reason for referral.

Providers are not required to complete written referrals (Patient 1st or EPSDT) to the other providers in the same group, provided that all documentation by all physicians in that group for a specific recipient is included in one common record (electronic or paper). The medical record documentation shall clearly indicate that the PMP did a screening, identified the problem, and the referral was made to self or specialist within that group.

Providers are required to complete written referrals to other specialists in the same group if a common medical record is not used. Referrals to specialists and other physicians outside of the group are required to have a written Patient 1st and/or EPSDT referral.

A cascading referral is used in situations where more than one consultant may be needed to provide treatment for an identified condition(s). When this situation arises, the original referral form is generated by the assigned primary medical provider.

If the first consultant determines a recipient should be referred to another consultant/specialist, it is the first consultant's responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission, or referral expires, at which time a new screening and referral must be obtained. A new approval/EPSDT screening must be provided anytime the diagnosis, plan of care, or treatment changes. The consultant must contact the PMP for a new referral/screening at that time.

If a child is admitted to the hospital as a result of an EPSDT screening, the days will not count against the yearly benefit limit. Facility fees for outpatient visits will not count against the yearly benefit limit if the visit is the result of an EPSDT screening and referral. Services rendered by speech and occupational therapists are covered **only** as the result of an EPSDT screening.

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.

A.4.1 Vision, Hearing, and Dental Referrals

If the EPSDT screening provider chooses to refer a recipient for vision, hearing, and/or dental services, the recipient must be referred to the appropriate provider for diagnosis and/or treatment. After the recipient's vision, hearing, and/or dental service is initiated, the consultant's portion of the EPSDT referral form must be completed by the consultant and the appropriate copy must be returned to the screening provider. Referral forms should be returned in 30 days, from the date of the appointment, or (if no appointment was made) from the date of the screening examination.

NOTE:
If the recipient is one year of age or older and is not under the care of a dentist, the recipient must be referred to a dentist for diagnosis and/or treatment. Follow-up on dental referrals is not required.

A referral form is completed by the screening provider when an abnormality or condition is noted during the child's screening that requires further diagnosis and/or treatment. The referring provider must document the condition(s) within the medical record (either in the medical history or physical exam portion). Medicaid has the right to recoup the screening service fees from the referring provider when a referral is made for a condition not documented in the medical record (in medical history or physical exam portion).

A.4.2 Referrals Resulting from a Diagnosis

If, as a result of a medical, vision, hearing, or dental screening, it is suspected or confirmed that the child has a physical or mental problem, the screening provider and Patient 1st PMP, if applicable, must refer the child without delay for further evaluation of the child's health status. Follow-up is required to assure that the child receives a complete diagnostic evaluation. Diagnostic services may include but are not limited to physical examination, developmental assessments, psychological and mental health evaluation, laboratory tests and any x-rays. Diagnosis may be provided at the same time or it may be provided at a second appointment. For services such as physical therapy, speech therapy, and occupational therapy 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 Pt. 1st/EPSDT referral form may be considered the physician's order as long as these guidelines are met. The physician's order/prescription date is considered "today's date" on the referral form.

The time limit for completing the referral form (Form 362) requires the form to be completed within 364 days of the date of the screening. If an abnormality or condition is noted during an EPSDT screening and an EPSDT referral form is not issued at the time (for example, sickle cell remission), an EPDST referral may be issued at a later date for the same diagnosis only (for example, sickle cell remission changes to sickle cell crisis). In this instance, the date utilized on the referral form will be the same as the date of the EPSDT screening where the abnormality/condition was noted. If another abnormality or condition occurs that was not diagnosed during an EPSDT screening, or if a condition has changed sufficiently so that further examination is medically necessary, an interperiodic screening should be performed (or periodic screening if it is due) to identify the problem.

EPSDT referrals are valid for **one year from the date of the EPSDT screening**. Therefore the maximum time an EPSDT referral is valid is 12 months from the date of the well child check-up (EPSDT screening). The EPSDT screening date must be current to be valid. The EPSDT screening date may not be backdated or future dated. The date of the EPSDT screening should be documented under "Type of Referral" on form 362, the Alabama Medicaid Agency Referral Form. The EPSDT screening date documented on the Referral Form is the date used to determine the length of time an **EPSDT referral is valid** (regardless of a Patient 1st referral). The "Length of Referral" is used to determine the amount of time the referral is valid from the referral date and is inclusive of all types of referrals (e.g., Patient 1st referral, EPSDT referral, Targeted Case Management, etc). Please refer to Appendix E, Medicaid Forms, for additional information.

Diagnosis and treatment services may be provided by the screening provider (self referral) or may be obtained by referral to any other practitioner or facility qualified to evaluate, diagnose, or treat the child's health problem.

NOTE:
The number of visits or months must be documented on the EPSDT referral form to be considered a valid referral.

A.4.3 Treatment

Treatment may include but is not limited to physicians' or dentists' services, optometrists' services, podiatrists' services, hospital services (inpatient and outpatient), clinic services, laboratory and X-ray services, prescribed drugs, eyeglasses, hearing aids, prostheses, physical therapy, rehabilitation services, psychological services, and other types of health care and mental health services.

If a condition requires a referral, it is the responsibility of the screening provider and Patient 1st PMP, if applicable, to:

- Document the abnormality discovered during the EPSDT screening in the record
- Determine what resources a child needs and to which provider he/she wishes to be referred (the recipient's freedom of choice of providers must be ensured)
- Make the appropriate referral in a timely manner

- Offer and provide assistance in scheduling the appointment
- Verify whether the child received the service. Referrals must be followed up within 30 days (excluding dental) from the date of the appointment with the consultant.

A.4.4 Completing the Referral Form

The Referral for Services Form 362 must be completed after a screening if further diagnosis and/or treatment are required for a child not assigned to a PMP. The referral form is completed when referring the recipient to other providers for services that were identified during the screening as medically necessary.

Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form.

Screening providers must include their 10-digit National Provider Identifier (NPI), name, and address for those recipients who do not participate in managed care (i.e., Patient 1st).

PMPs must include their 10-digit National Provider Identifier (NPI), name, and address for those recipients who participate in Patient 1st.

- The **screening provider** must document the time span in which the referral is valid. The maximum time span is 12 months from the date of the screening.
- The **consulting provider** must follow the appropriate billing instructions and guidelines for completion of the CMS 1500 claim form found in Chapter 5, Section 5.2.2 of the Alabama Medicaid Provider Manual.

NOTE:

Once benefit limitations have been exceeded, Medicaid will not pay for services without the EPSDT referral. This is important for patients with chronic conditions or a problem that will require numerous visits to treat. Providers should write the referral as soon as the condition is noted so that the regular benefits are not exhausted.

The referral form should follow the recipient for all services related to the condition noted on the form. If a child is screened with a particular condition noted and referred for further diagnosis, and another condition develops that is not noted on the referral form, the child must be re-screened in order to receive expanded benefits for the second condition noted. If not re-screened, the services rendered would count against the child's routine benefit limits.

NOTE:

If the screening provider refers a child to a consultant, it is the screening provider’s responsibility to follow up. However, if the managed care provider refers the child to a consultant, it is the managed care provider’s responsibility to follow up.

A.4.5 EPSDT Referrals for Patient 1st Recipients

Scenario: A child is referred by the PMP to be screened by a county health department and appears to have a foot deformity.

Procedure: The child **must** be sent to their assigned Primary Medical Provider (PMP) to obtain the PMP referral form. The PMP may choose to

- Provide the necessary treatment
- Refer the child to an orthopedic specialist
- Instruct the screening provider to complete the referral form

The PMP must complete the Alabama Medicaid Agency Referral Form (Form 362) if referring the child to a specialist. The name and address of the screening provider should be entered to reflect, in this scenario, the county health department. The screening NPI and signature will reflect the county health department number and the signature of the health department employee who performed the screening.

The referring/PMP number reflects the NPI of the PMP. The consulting provider must use the PMP's number as the referring physician on the claim form.

In this scenario, the specialist may suggest surgery, braces, and/or therapy. All services approved by and referred by the PMP would then be covered by an EPSDT screening referral.

NOTE:
The PMP must be contacted and approve any and all referrals made by the specialist.

A.4.6 EPSDT Referrals for Non-Patient 1st Recipients

Scenario: A child is screened by a county health department and appears to have a foot deformity.

Procedure: This child is referred to a pediatrician. The pediatrician may then refer the child to an orthopedic specialist. The specialist may suggest surgery, braces, and/or therapy.

All services in this scenario are covered by the original EPSDT screening referral, which must follow the child from visit to visit. Each provider treating the condition diagnosed during the screening, and documented in the referral, must include the referring provider's number on the claim form. Please refer to Chapter 5, Filing Claims, for instructions on including the referring NPI on the claim form.

A.4.7 Billing Instructions for Referred Services

For EPSDT Referred Services

If you file hard copy claims on the **UB-04**, you must complete the following fields:

- Block 2 – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT

If you file **electronically** on the UB-04 (837 Institutional) using HP *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**1**" to indicate EPSDT

If you file **electronically** on the CMS-1500 (837 Professional) using HP *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

For Patient 1st and EPSDT Referred Services

If you file claims on the **UB-04**, you must complete:

- Block 2 – Enter the referring PMP's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT and managed care

If you file electronically on the UB-04 (837 Institutional) using HP *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of referring PMP
- Block 17a – Enter the referring PMP's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**4**" to indicate EPSDT and managed care

If you file **electronically** on the CMS-1500 (837 Professional) using HP *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

NOTE:

Each line item on the CMS-1500 Claim Form must have an indicator in Block 24 or 24H if billing for a Referred Service.

For Example: If the first line is an office visit and the indicator in Block 24 Or 24H is a "4", All additional services for that Date Of Service must also have an indicator of "4" in Block 24 Or 24H or the claim will deny.

Coordinating Care

The Alabama Medicaid Agency establishes the service standards and requirements that the providers must meet.

Providers of medical screening services are responsible for overall care coordination for those recipients that are not enrolled in a managed care system. For those recipients who are enrolled in a Managed Care system, it is the managed care provider's responsibility for overall care coordination. These ongoing activities include scheduling, coordinating, follow-up, and monitoring necessary EPSDT screening and other health services.

Care coordination enhances EPSDT Program efficiency and effectiveness by assuring that needed services are provided in a timely and efficient manner and that duplicated and unnecessary services are avoided.

A.4.8 Consent Forms

Since EPSDT screenings are voluntary services, some parents of children may decline a screening. This does not preclude the child from receiving a screening at a later date or receiving medically necessary diagnosis, treatment or other health services separate from the screening, providing such services do not exceed normal benefit limitations.

A "Consent for Services" form must be signed at each visit by the responsible adult. The consent could be a permission form to treat or a signature reflecting the date the service is rendered (e.g., a sign-in sheet). The consent for services should be filed in the patient's permanent medical record. If a sign-in logbook is used, the provider will need to keep this record for a minimum of three years plus the current year. The responsible adult must be present at the time of the screening to give pertinent history and developmental status and to receive counseling as indicated. The absence of a responsible adult as defined above would invalidate the screening. When off-site screenings are performed, the parent may complete the history form prior to the screening in compliance with Off-Site Screening Protocol. Recipients 14 years of age or older may sign for themselves.

A.4.9 Medical Records

All screening providers must maintain complete records for three years plus the current year on all children who have received services or screened. Records of all EPSDT-eligible children must be made available to Medicaid upon request. Medicaid will monitor EPSDT services provided by screening physicians or agencies on a periodic basis. If Medicaid identifies claims paid where any three findings listed as critical components of the screening process are omitted, the claim may be adjusted.

Medical records must include the following documentation. The critical components of a well child check-up (comprehensive screening) are denoted with an asterisk.

- Consent signature
- * Family history of diseases and annual updates
- * Medical history and updates at each screening
- Mental health assessment
- * History of immunizations and administration as indicated
- * Age-appropriate developmental assessment
- * Age-appropriate anticipatory guidance
- * Nutritional assessment to include recorded results of hemoglobin/hematocrit and plotted height/weight
- * Documentation of sickle cell test results
- * Recorded results of hemoglobin/hematocrit
- *urine test for protein and sugar (Effective 10/01/2008, urine screening needs to be performed only if clinically indicated)
- * Lead testing/results (according to age)
- Tb skin test
- Height, weight, temperature, pulse, and blood pressure
- * Vision and hearing assessment/testing (Considered as two critical components)
- * Documentation of the unclothed physical examination
- * Dental referral/status for recipients 1 year of age and above
- * Failure to make appropriate referral, when required (i.e., medical, vision, hearing)
- * Referral follow-up on conditions related to medical, vision, or hearing problems

A.5 Off-site Screenings

Children are our state's most important assets and yet many of them arrive at school generally in poor health. The healthier a child, the greater his or her learning potential. The Alabama Medicaid Agency is committed to helping ensure that children are healthy and ready to learn. To that end, the Alabama Medicaid Agency has developed protocols for off-site EPSDT screenings. These services must be accessible to all children, not just Medicaid-eligible children.

NOTE:

EPSDT screening providers must also contact the recipient's primary medical provider (Patient 1st) to receive prior authorizations to perform the screening.

Off-site screenings are defined as screenings that are provided off-site from a medical facility, which is limited to hospitals, physician offices, Department of Public Health (DPH) clinics, and Federal/State certified clinics. Off-site screenings occur in schools, day care centers, head start centers, and housing projects.

An off-site EPSDT screening provider must develop and adhere to confidentiality policies set out by the respective agencies and should be submitted to the agency. Information pertinent to the child's performance may be shared. Information pertinent to infectious disease shall be released only by the County Health Officer. Sharing information with others outside the local agency may take place only if parental consent has been given.

Provider is defined as and will include only a county health department clinic, hospital, FQHC, IRHC, PBRHC, or a physician's office. A provider must be located within the county or within 15 miles of the county in which the off-site screenings occur. Medical personnel performing the physical examination are limited to physicians, certified registered nurse practitioners (CRNP), certified nurse midwives (CNM), physician assistants (PA), and registered nurses (RN) employed by the facilities listed above.

Clinic is defined as a certified medical facility, under the supervision of a physician that provides a full range of medical services on a regular basis. A clinic must be equipped to handle acute care situations and provide treatment and/or management of chronic diseases. Licensed medical personnel must perform medical services.

Medical facility is defined as a Federal/State certified clinic, hospital, physician's office, or a DPH clinic where diagnosis of health problems are rendered and treatment of diseases occur. The medical facility must have a permanent location, regularly scheduled hours of operation, and a published telephone number. Medical services and supplies must also be available for treatment of abnormal conditions identified at the time of an EPSDT screening.

Physician's office is defined as a place staffed by physician(s) and other medical professionals where medical activities, such as the practice of medicine, is conducted. This office is specifically designed and set up to provide medical diagnosis and treatment of medical conditions. This office is open and operating on a published, regularly scheduled basis with a published telephone number and regularly scheduled appointments.

A.5.1 Enrollment for Off-site providers

To be considered as an EPSDT screening provider for off-site screenings, potential providers must submit the following criteria:

- A letter documenting the ability to complete all components of a screening. The physical exam portion of the screening must be completed by an approved EPSDT screening provider: physician, nurse practitioner, physician assistant, or a registered nurse. All registered nurses, except BSNs, must complete a Medicaid-approved Pediatric Assessment course or show proof of having completed a similar program of study in their professional training that prepared them to perform pediatric health assessments.
- A primary care referral list of medical providers in the county to whom you will refer to services. The referral list must include pediatricians, family and/or general practice physicians, internal medicine physicians, vision and hearing providers, and dentists. All providers must agree to be on your referral list, therefore, you must submit their written agreement with your referral list. The list must be sufficient in number to allow recipients/parents a choice in the selection of a provider.
- Documentation to demonstrate that services will be offered to all children enrolled at an off-site location, not just Medicaid-eligible children. A copy of your fee schedule must be attached to your documentation and must include fees for non-Medicaid enrollees.
- Child abuse and confidentiality policies
- A signed Matrix of Responsibilities form between the off-site location authority (school superintendent, principal, day care director, etc.) and the screening provider. Only one screening provider will be approved per location.

NOTE:
Only RNs that are employed by a FQHC, RHC, Health Department, Physicians office, and hospital may perform off-site EPSDT screenings.

- A signed agreement/letter from a local physician to serve as Medical Director. This physician may be a pediatrician, family practice physician, general practice physician, or an internal medicine physician. Proof of 6 pediatric focused credits (CME) from the previous year must be included with the signed agreement. EXCEPTION: A board-certified pediatrician should submit a copy of current certification only. **The medical director is responsible for resolving problems that the nurses encounter and rendering care for medical emergencies.**
- A monthly schedule shall be maintained designating the dates, times, and the local agency in which you will be offering the EPSDT services. The monthly schedule should be readily available and retained in either the local agency/medical facility (i.e., the facility that has been approved as an off-site EPSDT screening provider) or the recipient's medical record. Failure to maintain schedules one week in advance of Off-site EPSDT screenings may result in termination and loss of revenue.

- A document, listing members of the Peer Review Coalition of community members to serve in an advisory capacity. The committee must have the opportunity to participate in policy development and program administration of the provider's off-site program and to advise the director about health and medical service needs within the community. The committee must be comprised of parents, school personnel, public health personnel and local physicians within the local community. Members must be familiar with the medical needs of low-income population groups and with the resources available in the community.
- Information packet materials, including letters, forms, and examples of anticipatory guidance information sheets to be used. These materials must be prior approved by Medicaid.
- A copy of the waiver certificate and/or CLIA number, issued by the Division of Health Care Facility, Bureau of Health Provider Standards for the State of Alabama Department of Public Health.
- A list of all physical locations at which EPSDT screenings will be provided. A separate NPI will be assigned to each off-site location and will be distinct from any other NPI. A separate application and contract is required for each off-site location.

A.5.2 Space for Screenings

The room in which screenings are done may vary according to the availability of space. Space to perform the screening assessment must include a well-lighted private room in close proximity to hot and cold running water, a bathroom, and a nearby waiting area.

A.5.3 Parent/Guardian Consent and Follow-up

Children under 14 years of age must have written consent from their parent/guardian before participating in the screening program. Children age 14 and above may consent for themselves. The parent/guardian should be encouraged to be present during the screening.

Once the health screening is complete, the parent/guardian must be informed of the results of the screening by mail or in a one-on-one meeting. The anticipatory guidance materials must be age appropriate and the material may be given to children 14 years of age and above. Documentation must reflect that anticipatory guidance materials were mailed to parent/guardian for recipients under 14 years of age.

NOTE:
The potential provider cannot begin well child check-ups (screenings) until approval has been authorized in writing and Medicaid has enrolled the provider for off-site screenings.

A.6 Vaccines for Children

In an effort to increase the immunization levels of Alabama's children by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program on October 1, 1994,

This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled and eligible, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations ("underinsured"), if they obtain those vaccines from a Federally Qualified Health Center or Rural Health Clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 400,000 of Alabama's children are Medicaid enrolled.

A.6.1 Fees

Medicaid has taken the past vaccine and administration fee costs and calculated an equivalent reimbursement fee of $8.00 per dose. When multiple doses are given on the same visit, Medicaid will reimburse for each dose. When doses are given in conjunction with an EPSDT screening visit, an administration fee of $8.00 per dose will also be paid. When doses are given in conjunction with an office visit, an administration fee of $8.00 per dose will also be paid. Providers are encouraged to utilize licensed available combination vaccines when indicated, rather than the individual components of the vaccine.

Providers should use the immunization(s) procedure code designated by the VFC Program when billing for the administration of an immunization. Please refer to section A.6.3 for the list of designated VFC procedure codes.

Medicaid VFC providers may give VFC vaccines to children who are Medicaid enrolled, non-Medicaid, uninsured, American Indian, or Alaskan Native. If a VFC vaccine is given to any of the above patients, with the exception of Medicaid enrolled, an administration fee not to exceed $14.26 for each vaccine administered may be charged. Underinsured patients must go to an FQHC, RHC, or county health department to receive VFC vaccines. An administration fee not to exceed $14.26 for each vaccine administered may be charged. No VFC-eligible patient should be denied immunizations because of an inability to pay the administration fee.

Physicians and health departments are not required to file recipient health insurance prior to filing Medicaid for preventive pediatric services, including administration fees for VFC. Exceptions to this rule require that all providers must file with a recipient's health plan when the plan is an HMO or other managed care plan. In addition, FQHCs and RHCs are required to file other insurance prior to filing Medicaid as are any providers receiving a lump sum payment for bundled services or a capitation payment from Medicaid.

A.6.2 Enrollment

The Department of Public Health is the lead agency in administering the VFC Program. Enrollment and vaccine order forms are available through the Immunization Division. Questions regarding enrollment should be directed to the VFC Coordinator at (800) 469-4599.

Participation in Medicaid is not required for VFC enrollment. Participation in the VFC Program is not required for Medicaid enrollment.

A.6.3 Vaccines for Children Billing Instructions

Providers must use an appropriate CPT-4 code on a CMS-1500 claim form or UB-04 claim form in order to receive reimbursement for the administration of each immunization given from VFC stock.

Added: or UB-04 claim form

When immunizations are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8.00 per injection will be paid for recipients 18 years or younger. The statewide fee-for-service rate will be paid for recipients 19 and 20 years old.

NOTE:

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

The following CPT-4 codes must be used when billing Medicaid for immunizations for any recipient under age 19:

CPT-4 Procedure Code	*Immunization*
90633	Hepatitis A, 2-dose pediatric formulation (12months-18years of age) – Eff. 2/1/06
90636	Hepatitis A & B, 3-dose adult formulation (18 years of age only) – Eff. 2/1/06
90645	Hemophilus influenza type b (Hibtiter)
90647	Hemophilus influenza type b (Pedvax)
90648	Hemophilus influenza type b (ActHib)(primary dose). Effective 08/19/09, Hibirix booster dose for ages 15 months – 4years. The ACIP recommends booster dose between 12 months and 4 years of age.
90649	Human Papilloma Virus (HPV) Vaccine, Types 6,11,16,18 (Quadrivalent), 3-dose schedule-Eff. 11/1/06 (9-18 years) Effective 10-02-09, approved for males ages 9-18.
90650	Human Papilloma Virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for IM use, approved for females ages 10-18. Eff. 10-1-09
90655	Influenza, preservative-free (6-35 months) – Eff. 1-1-05
90656	Influenza virus vaccine, split virus, preservative free, (3 years and older), for intramuscular use.
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90660	Influenza Virus Vaccine, Live, For Intranasal Use (LAIV) eff. 10/1/06 (2 years and older)
90669	Pneumococcal Conjugate vaccine 7 valent (Pnu 7)
90670	Pneumococcal Conjugate, 13 valent (PREVNAR 13) (0-5 years) (no diagnosis restrictions)

Added: (0-5 years) (no diagnosis restrictions)

Added: 90670

CPT-4 Procedure Code	***Immunization***
90670	Pneumococcal Conjugate, 13 valent (PREVNAR 13) eff. 06/01/13 (6-18 years) who are at high risk for invasive pneumococcal disease because of: • Anatomic or functional asplenia (sickle cell disease, other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction) • Immunocompromising conditions (HIV infection, chronic renal failure/nephrotic syndrome, congenital immunodeficiency, diseases associated with treatment with immunosuppressive drugs/radiation therapy, including malignant neoplasms, leukemias, lymphomas, and Hodgkin disease; or solid organ transplant) • Cochlear implant • Cerebrospinal fluid (CSF) leaks.
90680	Rotavirus Vaccine, Pentavalent, 3 dose schedule, live, for oral use (6-32 weeks of age only) eff. 2/3/06
90681	Rotarix is a new Rotavirus vaccine (RV1), and is a two-dose series, for 2 and 4 months of age- Effec. 06/25/2008
90696	Kinrix (DTaP-IPV) is indicated as a booster dose for children 4 through 6 years of age (prior to 7 years of age)- Effec. 06/26/2008
90698	Pentacel (DTaP-Hib-IPV-) is indicated as a primary series and first booster dose (doses 1-4) at 2, 4, 6 and 15-18 months of age – Effec. 06/26/2008
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP) (0yr-6yr)
90702	Diphtheria, Tetanus (DT) (0yr-7yr)
90707	Measles, Mumps, Rubella (MMR))
90710	Measles, Mumps, Rubella, and Varicella (MMRV) vaccine, Live, for subcutaneous use (1-12 years of age) – Eff. 9/6/05
90713	Poliomyelitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05 (7yr-999yr)
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05 (7yr-999yr)
90716	Varicella (Chicken pox) vaccine *(for selected recipients)*
90718	Tetanus and Diptheria (Td) (*for adult use*) (7yr-999yr)
90721	Diphtheria, Tetanus, Acellular Pertussis and *Hemophilus influenza type b,(DTaP-HIB) (1-5 yrs. of age)*
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Meningococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and *Hemophilus influenza b* (Hep B-Hib) (0-18 yrs of age)

A.6.4 ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us/ for more information.

A.6.5 Recommended Immunization Schedule

You may access the recommended immunization schedule at www.cdc.gov/nip.

The schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

A.6.6 Synagis

The drug Synagis must be prior authorized through Health Information Designs (HID) at 1-800-748-0130. The new form for prior authorization is available on our website at www.medicaid.alabama.gov under Programs: Pharmacy: Prior Authorizations/Override Criteria and Forms: Instruction Booklet for Form 369 and Form 351. The appropriate administration fee may be billed in addition to Synagis.

A.7 Required Screening Protocols

The following table lists medical, vision, hearing, and dental screening protocols for infants and children by recipient age. **Refer to the following page for adolescents.**

	Infancy						**Early Childhood**					**Middle Childhood**					
Age By	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	Mo	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Mo**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**	**Yr**
Medical Screening [1]	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Initial/Interval History	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Measurements																	
Height and Weight	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Head Circumference	X	X	X	X	X	X	X	X	X								
Body-mass index (BMI) [8] – If clinically indicated									X	X		X	X	X	X	X	X
Blood Pressure/Pulse										<----------Annually---------->							
Developmental Assessment	S	S	S	S	S	S	S	S	S	<----------Annually---------->							
Physical Exam/Assessment [2]	X	X	X	X	X	X	X	X	X	<----------Annually---------->							
Procedures																	
Immunization	X	X	X	X		<-------X------>						<----X---->					
Newborn Screening 9	X+----------X+																
Anemia Screening	X----------					X											
Urine screening[3] (Effective 10/01/2008 urine screens should be performed only when clinically indicated).																	
Lead Screening [4]					X+	**X**	X+	X+	**X**	X+		X+	X+	X+			
Nutritional Assessment	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X		S/X	<--------Annually-->				
Health Education [5]	X	X	X	X	X	X	X	X	X	X		X	<--------Annually-->				
Vision Screening [6]	S	S	S	S	S	S	S	S	S	O		O	O	O	O	O	O
Hearing Screening [6]	S	S	S	S	S	S	S	S	S	S		O	O	O	O	O	O
Dental Screening [7]						<----------Annually---------->											
TB Skin Test [8] (TST)	The decision to place a TST should be made after completing a risk assessment using A.3.5 and determining the tuberculosis prevalence in the community by contacting the local health officials.																

Key

X	Required at the visit for this age
X+	Perform blood level if unknown
S	Subjective by history and observation
O	Objective by standard testing methods
<----->	Annually
X-------X	One test must be administered during this time frame. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age.
<---X--->	Range in which a service may be provided, where X indicates the preferred age
1	If a child comes under care for the first time at any point of the schedule, or if any components are not accomplished at the recommended age, the schedule should be brought up to date at the earliest possible time.
2	The physical examination/assessment must include an oral/dental inspection.
3	Urine screening (dipstick) is done if clinically indicated and must be done at 5 years and 11-21 years of age. (Effective 10/01/2008 urine screening performed only when clinically indicated).
4	All children are considered at risk and must be screened for lead poisoning. A blood lead test is required at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. **X** indicated lead screening is required. X+ indicates a screening blood lead test also is required for any Medicaid-eligible child 36 to 72 months of age who has not previously been screened for lead poisoning.
5	Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 to 20, must receive more intensive health education that addresses physiological, emotional, substance usage and reproductive health issues at each screening visit.
6	These screenings must be performed annually. Patient should be rescreened within 30-45 days if he/she is uncooperative.
7	A child must be referred for an annual complete dental screening beginning at age one to age 21 unless the child is under care. Anticipatory guidance should begin with age one.
8	Please refer to Section A.3.6, Critical Components of Screenings, for detailed information.
9	PMP should verify initial newborn screening results collected by the birthing facility. If unable to verify initial results collect a bloodspot specimen and mark the filter form “First Test.” The BCL will accept specimens up to 12 months of age. A second newborn screening specimen is recommended at 2-6 weeks of age (4 weeks optimal) on all full term infants with a normal first test screen. If the first test specimen was collected after two weeks of age, a second test is not recommended.

Adolescent Screening Protocols

For adolescents 11-20 years of age the following are performed annually:

- History
- Height/Weight
- Blood Pressure/Pulse
- Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
- Developmental Assessment
- Physical Exam
- Urine Screening (Effective 10/01/2008 urine screening is no longer a requirement. Urine screens are done only if clinically indicated
- Nutritional Assessment
- Health Education
- Vision Screening
- Hearing Screening
- Dental Screening

An anemia screening should be performed once for adolescents 11-20 years of age.

A urine screening should be performed annually for adolescents 11-20 years of age.

Effective 10/01/2008 urine screens no longer a requirement of adolescent EPSDT screenings. Urine screens should only be done when clinically indicated.

Immunizations are performed for adolescents 11-16 years of age according to AICP guidelines. Refer to Section A.7.4, Recommended Immunization Schedule, for the recommended ages for vaccines.

Please refer to http://www.rehab.alabama.gov/ for the Early Intervention Child Find referral form and instructions.

B Electronic Media Claims (EMC) Guidelines

This appendix contains information about electronic submission of claims and the software that providers use to transmit claims to HP. It contains the following sections:

- General Information
- Provider Electronic Solutions
- Vendor Software
- Alabama Medicaid Interactive Website

Technical support is available through the HP Electronic Claims Submission Help Desk.

(800) 456-1242 (Nationwide Toll Free)
(334) 215-0111

B.1 General Information

All claims which do not require attachments or an Administrative Review override by Medicaid must be submitted electronically. Electronic Claim Submission (ECS) offers many benefits to all participants in the claims submission process. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.

Electronic claim submission reduces claims processing time from start to finish. Rather than mailing paper claims, providers use the Alabama Medicaid Interactive website to submit claims to a central location.

With ECS, electronic claims avoid the sorting and keying process. The claim data is immediately available to the system. However, it is not only at the start of the claims cycle that electronic submission can save providers time.

Providers who submit claims electronically can check their claims to ensure that the data has passed basic edits, or can determine claim data that prevents the claim from paying. Providers can determine how much payment they will receive from each submission, in a fraction of the time it took when submitting claims on paper.

ECS assists providers in receiving quick payment and reduces claims processing time. Also, electronic claims submission provides an audit trail of claims that have failed preliminary edits. Providers may receive information regarding certain problems on submitted claims within minutes. This allows the provider the opportunity to the make necessary corrections and resubmit the claim before the next scheduled check writing date.

To submit claims electronically, providers use software designed specifically for this purpose as well as the Alabama Medicaid Interactive web site. Providers may use software created by HP, called Provider Electronic Solutions software, or software developed by outside vendors. The following three sections provide general information about each electronic option.

B.2 Provider Electronic Solutions

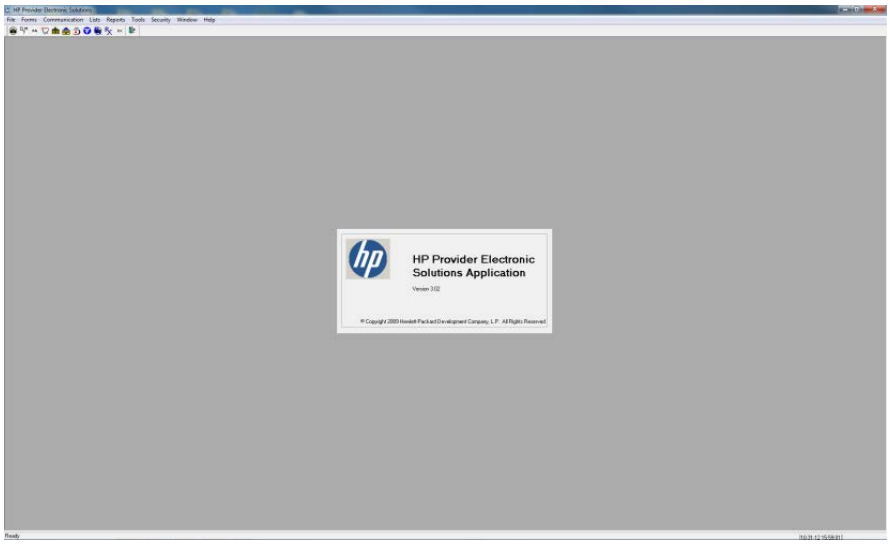
Provider Electronic Solutions software is data entry software used to verify eligibility and transmit claims in the proper format to the web so that they may be processed by the system.

Provider Electronic Solutions software is available free of charge to any provider. HP will mail the software to the provider at no cost, or the provider may download the software from the Internet.

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.10_Provider_Electronic_Solutions.aspx

Providers use the Provider Electronic Solutions software to submit the following batch transaction types:

- 270 Eligibility Request
- 276 Claim Status Request
- 278 Prior Authorization Request
- 837 Dental
- 837 Institutional Inpatient
- 837 Institutional Nursing Home
- 837 Institutional Outpatient
- 837 Professional
- NCPDP Pharmacy Eligibility
- NCPDP Pharmacy
- NCPDP Pharmacy Reversal



B.2.1 Verifying Eligibility

Providers have access to all available eligibility information on a recipient including but not limited to the following:

- Recipient name on file
- Full recipient number including the check digit (13th digit)
- Managed care status – Patient 1st or Maternity Care
- Aid category – indicating benefit limitations, for example, SOBRA
- Name and phone number of assigned Primary Medical Provider
- Benefit limits to date, for services such as physician visits, inpatient/outpatient visits, EPSDT screenings, and vision services
- Third party insurance information

NOTE:

The Provider Electronic Solutions software offers the feature of verifying recipient's eye care benefit limits. Select the eligibility icon and enter the requested information in all of the fields. When inquiring about a recipient's eligibility for eye care services, be sure to check the current year and previous year. For example, to determine if a recipient has met the benefit limit allowed for eye exams services, the provider needs to check the current and previous year service usage by entering the appropriate service year.

Providers have access to the following information about their submissions.

- **Communication Log** - displays information about successful or non-successful communication during transaction submissions
- **View Batch Response** - allows the user to view the response files downloaded from the web. For example claim responses 277 may be viewed after the submission of a 276 – Claim Status.
- **Download Electronic Remittance Advice (ERA)** - allows the user to download the 835 - Electronic Remittance Advice (ERA). The 835 file should be viewed in a text editor as the Provider Electronic Solutions software cannot display the Electronic Remittance Advice file.

B.2.2 Using Report and List Features: Managing your Data

Providers use the Lists feature to store frequently submitted values. These values can then be reused in later claims submissions, shortening data entry time. Provider Electronic Solutions software stores lists of data about the following topics:

- Attending/Operating Provider
- Prescriber
- Provider
- Recipient
- UPIN
- Admission Type
- Carrier
- Condition Code

- Diagnosis ICD-9
- Diagnosis ICD-10
- Modifier
- NDC
- Occurrence
- Patient Status
- Place of Service
- Policy Holder
- Procedure HCPCS
- Procedure ICD-9
- Procedure ICD-10
- Revenue
- Taxonomy
- Type of Bill

Providers can generate reports about these lists, as well as detail and summary reports about the claims they have submitted.

B.2.3 Archive and Connection Tools: Protecting your Data

Providers use the Get Upgrades option to upgrade their software from any downloaded update through the web. Options allow users to set up their modems, batch and interactive submitter IDs, carrier information (for example, phone number to dial), and to establish their retention settings (sets the number of files to keep before archiving).

The Archive tool allows users to create archives and restore archives. This feature is very useful for space conservation on the provider's computer system. The Database Recovery tool allows users to compact, repair, and unlock their databases. These tools are very useful in correcting database problems, allowing users to correct the problem without HP sending new software.

B.2.4 Additional Information about Provider Electronic Solutions

Provider Electronic Solutions software does not interface with accounting systems or other databases. This would require claims data to be keyed twice, once when submitting the claim using Provider Electronic Solutions software and again into the provider's database.

However, this software is perfect for providers who do not submit a large number of Medicaid claims, and for providers who want to save the vendor fee.

Provider Electronic Solutions software comes with full installation instructions, a user's guide, and full technical support.

For more information on obtaining Provider Electronic Solutions software, contact the HP Electronic Claims Submission Help Desk.

(800) 456-1242 (Nationwide Toll Free)
(334) 215-0111

B.3 Vendor Software

Providers may prefer to submit claims using vendor software. Providers are recommended to contact HP to determine if their vendor's software is approved for claims submission.

B.4 Alabama Medicaid Interactive Web Site

The Interactive Services web use of online user friendly forms, allows providers to inquire about recipient eligibility, claim status, prior authorization requests and household inquiries. A provider will also able to enter and submit claims, including online voids and adjustments.

The website is available free of charge to any provider. This site is available 24-hours a day, seven days a week, excluding time for scheduled maintenance.

The Alabama Medicaid Interactive web site address is https://www.medicaid.alabamaservices.org/ALPortal .For additional information regarding the features or sign-up procedures, refer to the Alabama Medicaid Interactive Web Site User Manual, found on the site's AL Links page under the Information menu.

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C

C Family Planning

Family planning services are services provided to prevent or delay pregnancy.

C.1 Eligible Individuals

Eligible individuals are those females of childbearing age 10 through 55 years of age and males of any age who may be sexually active and meet the criteria for Medicaid eligibility. Family planning services **do not require a referral** for recipients in Medicaid's managed care programs.

Reimbursement will be made only for eligible Medicaid recipients. Eligibility should be verified **prior to rendering** services to **ANY** Medicaid recipient.

SOBRA-eligible Medicaid women are covered for family planning services through the end of the month in which the 60th postpartum day falls.

Plan First

The Plan First program is an 1115 Research and Demonstration waiver approved by the Centers for Medicare and Medicaid Services that extends family planning coverage for women ages 19 through 55. Please refer to the section, Plan First, for additional information.

C.1.1 Authorization for Recipient Services

The recipient must have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary on the part of the recipient and without any form of duress or coercion applied to gain such acceptance. Recipients are required to give written consent prior to receiving family planning services. **A recipient consent for services must be obtained at each Family Planning visit. A sign-in logbook may be used after the initial consent form has been signed.**

Age of Consent

Family planning services are available to:

- Females, any age, after onset of menses. If age 14 or over, no parental or other consent is required.
- Males, any age. If age 14 or over, no parental or other consent is required.
- If a child is under the age of 14, whether they are sexually active or not, parental consent is required.

C.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

C.2.1 Family Planning Visits

The following services are covered services when provided by Family Planning providers.

Initial Visit (99205-FP)

The initial visit is the first time a recipient receives family planning services. An initial visit is limited to one per provider per recipient per lifetime.

The initial visit requires the establishment of medical records, an in-depth evaluation of an individual including a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted disease prevention counseling, and issuance of supplies or prescription. Counseling in the family planning setting is interactive and includes education. Counseling/education topics must be based on patient need and on protocol requirements.

PT+3 Teaching Method

All family planning counseling must utilize the **PT+3 teaching method**, after the provider has received training. The acronym, PT+3, means:

P = Personalize the PROBLEM,
T = "TAKLE" the problem
T = set a Therapeutic Tone,
A = Assess the knowledge level of the patient,
K = provide Knowledge
L = Listen for feedback,
E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

At all points during the counseling and education process, the patient must be given the information in such a way as to encourage and support the exercise of choice. In order to support informed choice, certain informational elements should be offered. Due to the constraint of time, the topics are listed in order of priority. Priority One includes those topics that MUST be DISCUSSED with the patient. Priority Two includes those topics that can be presented to the patient in a written document, with verbal follow-up. Priority Three includes those topics that can be presented in written format only, with follow-up occurring should the patient need/desire further clarification.

At all times, the PT+3 method of teaching/counseling should be used so that time is targeted toward individual patient need.

Priority One Topics:

1. Patient expressed needs or problems
2. Contraception:
    a. Listing of the various options
    b. How to use
    c. Side effect management
3. Prevention of STDs including HIV
4. Breast self-exam or testicular self-exam

Priority Two Topics

1. Explanation of any screening or lab testing done
2. Services offered
3. Telephone number of office or instructions about accessing emergency care
4. Folic Acid

Priority Three Topics

1. Need for Mammogram
2. Anatomy and physiology

Billable laboratory services **for the initial and annual visits include:**

- Hemoglobin or hematocrit,
- Urinalysis,
- PAP smear,
- STD/HIV test, and
- Pregnancy testing.

Since a family planning visit may be the only medical encounter a female has, **performing the listed laboratory tests is encouraged at the initial and annual visits.** Pregnancy testing is covered during any visit where clinical indication is present and evaluation is needed. Any laboratory procedure performed within the past 30 days with available results need not be repeated. A pap smear may be accepted if done within the past 6 months and is considered normal.

The **physical assessment** is another integral part of the initial family planning visit. The following services, at a minimum, **must** be provided during the initial visit:

- Height, blood pressure, and weight check
- Thyroid palpation
- Breast and axilla examination accompanied by instruction for self-breast examination
- Abdominal examination and liver palpation
- Auscultation of heart and lungs
- Pelvic evaluation to include bimanual and recto-vaginal examination with cervical visualization
- Examination of extremities for edema and varicosity
- Testicular, genital, and rectal examination for males.

Annual Visit (99214-FP)

The annual visit is the re-evaluation of an established patient requiring an update to medical records, interim history, complete physical examination, appropriate diagnostic laboratory tests and/or procedures, family planning counseling using PT+3 teaching method, and adjustment of contraceptive management as indicated. An annual visit is **limited to one per calendar year**.

The services listed below must be provided during the annual visit:

- Updating of entire history and screening, noting any changes
- Counseling and education, as necessary, using the PT+3 teaching method
- Complete physical assessment as outlined in the “Initial Visit” requirements
- Laboratory tests as outlined under “Initial Visit”
- Issuance of supplies or prescription.

Periodic Revisit (99213-FP)

The periodic revisit is a follow-up evaluation of an established patient with a new or existing family planning condition. Four periodic visits are available per calendar year. These visits are available for multiple reasons such as contraceptive changes, issuance of supplies, or contraceptive problems (e.g. breakthrough bleeding or the need for additional guidance). Providers may utilize the appropriate **V254** diagnosis code, “Surveillance of previously prescribed contraceptive methods,” for a visit related to a contraceptive problem.

The following services, at a minimum, must be provided during the revisit:

- Weight and blood pressure
- Interim history
- Symptom appraisal as needed

Documentation of any treatment/counseling including administration/issuance of contraceptive supplies.

NOTE:

Family Planning visits are not payable after sterilization.

Home Visit (99347-FP)

The home visit is a brief evaluation by a medical professional in the home of an established patient and is for the purpose of providing contraceptive counseling (using the PT+3 teaching method) and administration/**issuance of supplies** as indicated. The home visit is for postpartum women during the 60-day postpartum period and usually occurs within 7-14 days after delivery. A home visit is limited to one per 60-day postpartum period.

To qualify for reimbursement for the home visit:

- Medical professionals who are licensed to administer medications such as oral contraceptives or to give injections must provide the home visit.
- The home visit must include: brief medical histories: family, medical, contraceptive, and OB/GYN, blood pressure and weight check, contraceptive education and counseling using the PT+3 teaching method assuring that the patient:
  - understands how to use the method selected,
  - how to manage side effects/adverse reactions,
  - when/whom to contact in case of adverse reactions, and the importance of follow-up.
  - scheduling of a follow-up visit in the clinic if needed
  - issuance or prescription of contraceptive supplies as appropriate.

The patient must give her signed consent for this visit.

Extended Family Planning Counseling Visit (99212-FP)

The extended family planning counseling visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The extended family planning counseling visit is performed in conjunction with the 6-week postpartum visit in the office/clinic setting. The counseling services are those provided **above and beyond the routine contraceptive counseling that is included in the postpartum visit.** The purpose of this additional counseling time is to take full advantage of the window of opportunity that occurs just after delivery when the physical need for pregnancy delay is at a peak**.** Extended family planning counseling is limited to once during the 60-day post-partum period, and is not available for women who have undergone a sterilization procedure.

Services required:

- Contraceptive counseling and education
- STD/HIV risk screening and counseling
- Issuance of contraceptive supplies.

NOTE:

In the event of a premature delivery or miscarriage, the EDC, "Expected Date of Confinement", must be documented on the claim form in block 19 in order to be reimbursed for procedure code 99212-FP.

STD/HIV Risk Screening and (Pre-HIV test) Counseling (99401, Diagnosis Code V259)

STD/HIV screening, counseling, and testing is necessary to identify infected persons who will benefit from medical treatment and to support and encourage all persons to practice responsible sex. Patients who contract ANY type of STD are at greater risk of contracting HIV and those who are HIV+ and contract any type of STD have a much greater chance of transmitting HIV. The best way to prevent HIV is to prevent an STD. For this reason, emphasis is being placed on STD/HIV screening and counseling in lieu of HIV testing only. The HIV pre-test counseling code will be used even though this activity is performed in conjunction with STD risk counseling. Document on the form provided in the Attachment section.

Basic requirements of STD/HIV screening and counseling are:

1. Determine degree of risk
2. Intervene with confrontation and counseling
3. Test for STDs and HIV as clinically indicated
4. Document using the form provided
5. Screen for risk at the initial and annual visit or as clinically indicated.

Requirements Detailed:

- Determine degree of risk.
- Screen for STD/HIV risk using the screening tool provided. See Attachments for a reproducible copy.
- Intervene with confrontation and counseling.
    a. Risk Level I - No risk factors identified. Minimal counseling required.
    b. Risk Level II - At Risk – Due to exposure to blood or blood products only. limited counseling required.
    c. Risk Level III - One or more risk factors present: Prevention Counseling required using the PT+3 method.
- Test for STDs and HIV as indicated by screening results and clinical symptoms.
- Document using the form provided.
- Screen for risk at the initial and annual visit or as clinically indicated.

At a minimum, screening for STD/HIV risk is to be done at these visits, however screening and offering STD and HIV testing should be done as necessary or appropriate.

Please note that the pre-test counseling may be billed regardless of whether the counseling session results in the drawing of blood or of STD testing.

STD/HIV Post-Test Counseling (99402, Diagnosis Code V259)

Post-test counseling is performed to provide the patient with test results. When STD testing results in a positive finding, the patient should be called in and told of test results and treated immediately. A plan of notification of partners with treatment should be developed. Counseling should focus on immediate treatment and future prevention efforts.

Post-test counseling for HIV testing, if negative, should emphasize and reinforce the HIV prevention message imparted during the pre-test counseling session. If positive results are obtained, this counseling visit should focus on

- the meaning of the test result,
- assisting with the emotional consequences of learning the result,
- providing a referral for and stressing the importance of getting into medical care as soon as possible,
- developing a plan to prevent transmission of HIV,
- developing a plan for notification of partners, and
- justification, if needed, for a second post-test counseling visit.

Should a second post-test visit be necessary, requirements for this second session are the same as those above. Forms for documentation of HIV testing and post-test counseling are available in reproducible form in the Attachment section.

NOTE:

Counseling is limited to two counseling services per recipient each calendar year and must be performed in conjunction with a family planning visit. This means Medicaid will pay for a total of two counseling services. The recipient can have two services of 99401; or two services of 99402 or one service of 99401 and one service of 99402 in the same calendar year. Once two counseling services (99401 or 99402) are paid for the recipient for the year, Medicaid will not pay for additional counseling services for that calendar year.

C.2.2 Family Planning Protocols-Clinical

Visits		*INIT*	*AN*	*PER*	*EXT/C*	*HOME*
Consent For Services		*X*	*X*	*X*	*X*	*X*
History						
	Family	X	X			X
	Med/Surg/OB-GYN	X	X			X
	Contraceptive	X	X			X
	STD/HIV screening	X	X			X
	Interim		X	X		
Blood Pressure		**X**	**X**	**X**		**X**
Weight		**X**	**X**	**X**		**X**
Physical Exam						
	Skin/General appearance	X	X	CI		
	Eyes/ENT	X	X	CI		
	Head/Neck/Thyroid	X	X	CI		
	Nodes	X	X	CI		
	Heart/Lungs	X	X	CI		
	Breast/SBE	X	X	CI		
	Abdomen	X	X	CI		
	Extremities/Back	X	X	CI		
	External genitalia	X	X	CI		
	Glands	X	X	CI		
	Vagina	X	X	CI		
	Cervix	X	X	CI		
	Uterus size/shape	X	X	CI		
	Adnexa	X	X	CI		
	Recto-vaginal	X	X	CI		
	Rectum	X	X	CI		
Laboratory						
	HGB or HCT	CI	CI	CI		
	Urinalysis	CI	CI	CI		
	Pap smear	X	X			
	STD tests including HIV	CI	CI	CI		
	Pregnancy testing	CI	CI	CI		

C.2.3 Family Planning Protocols – Educational

		INIT	AN	Per	EXT/C	Home
Counseling Using PT + 3 Teaching Method						
Priority One	*Patient expressed needs or problems*	X	X	X	X	X
	Contraceptives: **** Listing of the various options* ****How to use* **** Side effect management*	CI	CI	CI	CI	CI
	Prevention of STDs including HIV	X	X	CI	CI	CI
	Breast self-exam or testicular self-exam	X	X	X	X	X
Priority Two	*Explanation of any screening or lab testing done*	X	X	X	X	X
	Services offered	X	X			
	Telephone number of office or instructions regarding the accessing of emergency care	X	X	X	X	X
	Folic Acid	X	X			
Priority Three	*Need for Mammogram*	X	X			
Optional	Anatomy and physiology	CI	CI	CI	CI	CI

***Topic priority explanations: Priority One** includes those topics that MUST be discussed with the patient. All patient concerns fall in this area. **Priority Two** includes those topics that can be presented to the patient in a written document, with verbal follow-up. **Priority Three** includes those topics that can be presented in written format only, with verbal clarification done if needed or desired by the patient. At all times, if the patient wants to discuss a topic, the opportunity should be provided.

C.3 Sterilization

Counseling services involving complete information regarding male/female sterilization procedures shall be provided for the individual or couple requesting such services. These counseling services may be provided during any contraceptive visit to the office/clinic. Counseling and education should use the PT+ 3 teaching method. Full information concerning alternative methods of contraception will be discussed with the recipient.

NOTE:

The recipient is to be made aware that sterilization is considered permanent and irreversible and Medicaid does not cover the reversal of a voluntary sterilization. A "Consent to Sterilization" is a **required form**. The sterilization consent form is included with a sterilization booklet given to the recipient.

Counseling related to sterilization **must** include:

- Assessment of base knowledge level of the reproductive process/sterilization procedure.
- Instruction as needed.
- Listing and discussion of all reversible contraceptive methods.
- Information stressing that the sterilization procedure is considered irreversible.
- Complete explanation of the sterilization procedures using charts or body models.
- Complete information concerning possible complications and failure rates.
- Information regarding the relative merits of male versus female sterilization given to both partners, if possible.
- Information explaining that sterilization does not interfere with sexual function or pleasure.

The counselor shall in no way coerce or “talk the patient into being” sterilized.

C.3.1 Contraindications to Sterilization

The following conditions shall be considered contraindications for voluntary sterilization:

- The recipient has physical, mental, or emotional conditions that could be improved by other treatment.
- The recipient is mentally incompetent or institutionalized, regardless of age.
- The recipient is suffering from temporary economic difficulties that may improve.
- The recipient or couple feels that they are not yet ready to assume the responsibilities of parenthood.
- The recipient expresses possible wish to reverse the procedure in case of a change of circumstances.

NOTE:

If sterilization is not desired, alternate methods of contraception must be discussed.

C.3.2 General Rules

Surgical procedures for male and female recipients as a method of birth control are covered services under the rules and regulations as stated in the *Alabama Medicaid Agency Administrative Code,* Chapter 14, Rule No. 560-X-14-.04, and as set forth below.

a. The recipient must be eligible for Medicaid at the time the procedure is performed.
b. The recipient is at least 21 years old at the time informed consent is obtained.
c. The recipient is mentally competent.
d. The recipient has voluntarily given informed consent in accordance with all requirements.
e. At least 30 days, but not more than 180 days, have passed between the date of signed informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.
f. A recipient may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since he/she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days prior to EDC (expected date of delivery). If the recipient decides to be sterilized, the provider must be responsible for referring the recipient to the proper medical source and for ensuring that the recipient is accepted by that resource. In addition, the provider shall:
g. Inform the recipient that, in accordance with federal regulations, a 30-day waiting period is required between the time the consent form is signed and the procedure is performed.
h. Provide information and instructions concerning the need for follow-up, particularly for male recipients.
i. Provide appropriate post-operative semen analysis for vasectomy recipients.

NOTE:

Payment is not available for the sterilization of a mentally incompetent or institutionalized individual. Federal regulations prohibit Medicaid coverage of sterilization for anyone less than 21 years of age.

The provider must submit a copy of the recipient's signed sterilization consent form to HP. HP will NOT pay any claims to ANY provider until a correctly completed appropriate form is on file at HP.

All blanks on the consent form **must be** appropriately **completed** before Medicaid pays the provider for the sterilization procedure. The only exception is the "Race and Ethnicity," and the "Title of the person obtaining consent" designation which is optional.

NOTE:

When the claim for the sterilization procedure is submitted to HP, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 21 days, for the approved consent form. After the 21st day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

The sterilization consent forms shall be completed as follows.

a. The counselor must thoroughly explain the sterilization procedure to the recipient:
b. The "Consent to Sterilization" must be signed by the person to be sterilized at least 30 days prior to the procedure date. The birth date must indicate the person to be at least 21 years of age on the date the signature was obtained.
c. The person obtaining consent (counselor) and the title for that person (e.g., M.D., D.O., R.N., L.P.N., C.R.N.P., C.N.M.W.), if applicable, must be indicated on the consent form.
d. The counselor's original signature with date, as well as the recipient's signature with date, shall reflect that at least 30 days, but not more than 180 days, have passed prior to the procedure being performed. The counselor signs and dates the consent form after the recipient signs the consent form and prior to the procedure. The counselor may sign the consent form on the same date as the recipient if the counselor signs after the recipient.
e. If no interpreter is used, this section of the form must be marked as "Not Applicable" (N/A). If the "Interpreter's Statement" is signed and dated, please complete the "in_____ language" line also. The recipient and interpreter must sign and date the consent form on the same date.

f. Procedure recorded in the "Physician's Statement": It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure. However, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form. Example: "Bilateral tubal ligation" listed in the recipient's section and "postpartum tubal ligation" listed under the physician's section is acceptable.

NOTE:

The physician's statement must be signed or initialed by an individual clearly identified as a physician. The signature or initials are not acceptable if they are rubber stamped, unless the physician has initialed the stamp. The physician must date the certification on the same date he or she signs it.

g. Each copy of the consent form (Form 193) is used in the correct manner. Upon completion, the forms should be dispensed according to the following procedure:

    a. Original – Patient

    b. Copy 2 – HP

    c. Copy 3 - Patient's permanent record

C.3.3 Referrals

Family planning providers shall be responsible for referring the recipient to the proper resource, and for ensuring that the recipient is accepted by the resource to which they are referred, in the following circumstances:

a. Medical/GYN problems indicated by history, physical examination, or laboratory and clinical tests, including the removal of Norplant capsules

b. Pregnancy related services.

C.3.4 Family Planning Drugs

Medically approved pharmaceutical supplies and devices, such as oral contraceptive pills, diaphragms, intrauterine devices, injections and implants are covered if provided for family planning purposes.

C.4 Plan First

Plan First operates under an 1115 Research and Demonstration waiver granted by the Centers for Medicare and Medicaid Services (CMS). The Alabama Medicaid Agency initiated this program to extend family planning and birth control services to an expanded eligibility group in Alabama who qualify for prenatal care through Medicaid's SOBRA program.

Under Plan First, eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera shot, vaginal ring and contraceptive patch doctor/clinic visits (for family planning only), and tubal ligations. Plan First does not cover any other medical services, and women who have been previously sterilized are not eligible for participation in this program.

NOTE:

Pain medication prescribed after a tubal ligation **is not** covered for a Plan First recipient.

NOTE:

If for medical reasons, a **Plan First recipient** requires an **inpatient stay** for sterilization, **prior approval** must be requested by the physician and approved by Medicaid prior to performing the sterilization. Please contact the Plan First Program Manager at (334) 353-5263 for prior approval of an inpatient stay.

C.5 Eligible Individuals

Eligible individuals are females of childbearing age between 19 through 55 years of age who meet the eligibility criteria described below. These women are identified on the Eligibility Master File with an aid category of 50.

As always, providers are responsible for verifying eligibility and coverage via PES or AVRS systems.

Eligible recipients fall into three categories; however, there is no difference in benefits. The income limit for each of these groups must not exceed 133% of the federal poverty level. The three groups are described below:

Group 1

Women 19 through 55 years of age who have SOBRA-eligible children (poverty level), who become eligible for family planning without a separate eligibility determination. They must answer yes to the Plan First question on the application. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 2

SOBRA poverty level pregnant women 19 through 55 years of age are automatically eligible for family planning services after 60 days postpartum without a separate eligibility determination if they meet all eligibility criteria. Income is verified at initial application and re-verified at recertification of their children. Eligibility is redetermined every 12 months.

Group 3

Other women age 19 through 55 who are not pregnant, postpartum or who are not applying for a child must apply using a simplified shortened application. An eligibility determination will be completed using poverty level eligibility rules and standards. Client declaration of income will be accepted unless there is a discrepancy. Client declaration of income will be accepted. The agency will process the information through data matches with state and federal agencies. If a discrepancy exists between the client's declaration and the income reported through data matches, the client will be required to provide documentation and resolve the discrepancy. Eligibility is redetermined every 12 months.

C.6 Plan First Provider Enrollment

Participation in Plan First is open to any provider who wishes to be Medicaid enrolled and executes a Plan First agreement. Only those Plan First enrolled providers are able to service Plan First eligibles. Providers can be clinics, private physicians, nurse midwives, nurse practitioners, or physician assistants. Providers are bound by the requirements in the Appendix C of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology, 1996; and the approved 1115 Research and Demonstration Waiver.

In addition to enrolling as a Medicaid provider through HP, the provider must complete a Plan First agreement.

Clinics and clinic-based providers (Health Departments, FQHCs, and RHCs) are enrolled as one group. Individual providers within these groups are not required to individually enroll. Plan First recipients have the option of using any provider within these groups.

A provider who contracts with Alabama Medicaid as a Plan First provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for Plan First related claims. A specialty of 700 is added to the provider file for those enrolling in Plan First. In order for claims to process for Plan First recipients, this specialty code must be present on the provider file.

Providers that perform only tubal ligations do not have to enroll as a Plan First provider. This includes surgeons and anesthesiologists as well as outpatient surgery centers.

If you have further questions regarding this program or if you wish to enroll, please call the Plan First Program Manager at (334) 353-5263. Recipients may call the Plan First hotline toll-free at 1 (888) 737-2083 for more information.

C.6.1 Network List

The Alabama Medicaid Agency maintains a listing of all providers who have enrolled to provide services to Plan First eligibles. The list contains the provider's address and phone number and is sorted by the provider's county of practice. The list is made available to all Plan First care coordinators and staff of the Plan First toll free hotline, and will also be available to any other party who may be assisting women in locating a Plan First provider. The list is available online at the Alabama Medicaid web site (www.medicaid.alabama.gov) as well as in printed form.

Confidentiality

Providers agree that any information obtained through this program is confidential and will not be disclosed directly or indirectly except for purposes directly connected with the conduct of this program. The informed, written consent of the individual must be obtained for any disclosure.

Availability of Records

The provider shall make available for review and audit by authorized representatives of the Alabama Medicaid Agency at all reasonable times, the medical records pertaining to the services rendered to program recipients.

C.7 Plan First Benefits and Limitations

Services covered are the same as current Medicaid family planning services unless otherwise noted. See Section C.2 for a listing of these. Please note; however, that **Plan First is for women only ages 19 through 55** services for male family planners are not a part of the Plan First program.

Oral Contraceptives, Contraceptive Patch and Vaginal Ring

Effective 11/1/2009, women on Plan First 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 the pharmacy such as depo and diaphragms. In order to fill a prescription at a community/outpatient pharmacy, the Plan First recipient must have received the prescription from a private provider. A 30-day supply is the maximum that may be dispensed at one time.

NOTE:
Plan First recipients seeing providers at a Federally Qualified Health Center (FQHC) or the health department will continue to receive the oral contraceptives, contraceptive patch or vaginal ring from the FQHC or health department provider. A 12-month supply of contraceptives may be dispensed at one time.

Providers with questions may contact the Plan First Program Manager at (334) 353-5263.

C.7.1 Care Coordination

Medicaid will reimburse for care coordination services provided to a Plan First recipient. Care coordination services are designed to provide special assistance to those women who are at high risk for an unintended pregnancy and allow for enhanced contraceptive education, encouragement to continue with pregnancy spacing plans and assistance with the mitigation or removal of barriers to successful pregnancy planning. These services must be provided by licensed social workers or registered nurses associated with the Department of Public Health. Services are available to all Plan First recipients, regardless of the service provider. Should care coordination services be needed, a referral can be made by calling the local health department and asking for the Plan First Care Coordinator.

As mentioned above, the goal of care coordination is to form a partnership with the patient to address impediments to successful family planning. The bio-psychosocial model of care coordination is used to achieve this goal and includes:

- A bio-psychosocial assessment and development of case plan for all patients who accept care coordination.
- Counseling regarding sexuality, family planning, HIV/AIDS, STDs, and psychosocial issues identified in the assessment, such as substance abuse or domestic violence.
- Referrals and follow up to ensure appointments are kept, including subsequent family planning visits.
- Answers to general questions about family planning.
- Low-literacy family planning education based on the PT+3 model.

- Consultation with providers regarding problems with the selected family planning method.

The care coordinator will work diligently with family planning providers to ensure that patients receive care coordination services in a timely manner. All Plan First patients are eligible to receive an initial risk assessment to determine if and what type of care coordination services is needed.

C.7.2 Patient Choice/Consent for Service

As with any family planning visit, the recipient must have freedom of choice in deciding to receive or reject family planning services. Acceptance of any family planning service must be voluntary without any form of duress or coercion applied to gain such acceptance. **Recipients are required to give written consent prior to receiving family planning services.**

C.8 Cost Sharing (Co-payment)

Medicaid recipients and Plan First beneficiaries are exempt from co-payment requirements for family planning services.

There are to be no co-payments on prescription drugs/supplies that are designated as family planning.

Plan First Claims Information

Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Claims for family planning services - See sections C.10, Completing the Claim form and C.10.2 and C.10.4 for diagnosis and procedure codes. Service requirements per visit are detailed in Section C.2.2, Family Planning Protocol - Clinical.

Non-enrolled providers who are billing for a tubal ligation or a tubal ligation with a family planning visit can file an electronic or paper claim to HP in order to receive reimbursement. The approved Plan First tubal codes are 58600, 58615, 58670, and 58671. The Plan First family planning visit codes are 99205-FP (initial), 99214-FP (annual), or 99213-FP (periodic). In addition to these codes, the diagnosis code V25.9 must be used as well **as a secondary modifier of 56**.

If the sterilization is **not** performed, the non-enrolled provider must use the V25.9 diagnosis code and a secondary modifier of 56 with procedure code 99205-FP, 99214-FP or 99213-FP.

For information about Third Party Liability, please refer to Section 3.3.6, Third Party Liability.

Quality Assurance Overview

As with any waiver, there is a requirement for Quality Assurance monitoring and complaint/grievance resolution.

The Waiver has four major goals:

- To assure accessibility of family planning services to eligible clients,
- To assure that client assessments include the assessment and care plan appropriate for the risk level,

- To assure that the family planning encounters provided through enrolled providers follows the guidelines in the Appendix C, Plan First, of the Alabama Medicaid Provider Manual; The American College of Obstetrics and Gynecology, 1996; and
- To ensure that an effective complaint and grievance system is in place for both providers and recipients.

The Waiver has provisions for UAB to assist in providing outcome and summary reports to support effectiveness of the Program. This will enable comparisons between different sectors of populations and historical data.

Through referral from a Plan First Provider, the Waiver has approved Care Coordinators to assist patients who are assessed to be at high risk of an unintended pregnancy. The Care Coordinators will make and follow a plan to aid the high-risk patients in avoiding unintended pregnancies through improved compliance and informed decisions about Family Planning services.

The Alabama Medicaid Agency is responsible for Quality Assurance, Complaint and Grievance Resolution, and Utilization Monitoring. In order to accomplish these Waiver requirements, the Agency will implement several monitoring functions as outlined below:

- Utilization reports from claims data to monitor trends and utilization,
- Monitor Care Coordinator activity via summary reports
- Review Summary Reports, UAB
- Coordinate complaints and grievances to acceptable resolution.

C.9 Services Other Than Family Planning

Services **required** to manage or treat medical conditions/diseases whether or not such procedures are also related to preventing or delaying pregnancy are **not** eligible as family planning. Many procedures that are done for “medical” reasons also have family planning implications.

- Sterilization by hysterectomy is not a family planning covered service.
- Abortions are not covered as a family planning service. Refer to Chapter 28, Physician's Program, for details about abortions.
- Hospital charges incurred when a recipient enters the hospital for sterilization purposes, but then opts out of the procedure cannot be reimbursed as a family planning service.
- Removal of an IUD due to a uterine or pelvic infection is not considered a family planning service, and is not reimbursable as such.
- Colposcopy and biopsy of cervix/vagina performed to identify and treat medical conditions are not considered family planning services.
- Diagnostic or screening mammograms are not considered family planning services.
- Medical complications requiring treatment (for example, perforated bowel) caused by or following a family planning procedure are not a covered family planning service.
- Any procedure or service provided to a woman who is known to be pregnant is not considered a family planning service.
- Removal of contraceptive implants due to medical complications are not family planning services.

C.10 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

- Providers who bill Medicaid claims electronically receive the following benefits:
- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When filing a claim on paper, a CMS-1500 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

C.10.1 Time Limit for Filing Claims

Medicaid requires all claims for family planning to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

C.10.2 Diagnosis Codes

V2501	Prescription of Oral Contraceptives
V2502	Initiation of other contraceptive measures – fitting of diaphragm, prescriptions of foams, creams, or other agents
V2504	Counseling and instructions in natural family planning
V2509	Other – Family planning advice
V2511	Encounter for insertion of intrauterine contraceptive device
V2512	Encounter for removal of intrauterine contraceptive device
V2513	Encounter for removal and reinsertion of intrauterine contraceptive device
	Encounter for replacement of intrauterine contraceptive device
V252	Sterilization- Admission for interruption of fallopian tubes or vas deferens
V2540	Contraceptive surveillance, unspecified
V2541	Contraceptive Pill
V2542	Intrauterine contraceptive device – Checking, reinsertion, or removal of intrauterine device
V2543	Implantable subdermal contraceptive
V2549	Other contraceptive method
V255	Insertion of implantable subdermal contraceptive (Norplant)
V258	Other specified contraceptive - management post vasectomy sperm count
V259	Unspecified contraceptive management
V615	Multiparity
V7241	Pregnancy examination or test, negative result

Added: 2504, Counseling and instructions in natural family planning

NOTE:

All claims filed for Plan First recipients must utilize one of the family planning diagnosis codes noted above. This includes claims filed for lab services. Diagnosis codes that are used and not listed above will cause the claim for a Plan First recipient to deny.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4 or 5 digits). Do not use decimal points in the diagnosis code field.

C.10.3 Family Planning Indicator References

Providers must complete the Family Planning Indicator, as applicable. “Y or “N” are the only valid indicators, when filing electronic claims.

C.10.4 Procedure Codes and Modifiers

The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Collection of laboratory specimens may be billed only when sending specimens to another site for analysis if the other site is not owned, operated, or financially associated with the site in which the specimen was collected.

The collection fee may not be billed if the lab work is done at the same site where the specimen was collected or in a lab owned, operated, or financially associated with the site in which the specimen was collected.

Providers will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories.

Providers may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Providers who send specimens to independent laboratories for analysis may bill a collection fee. This fee shall not be paid to any provider who has not actually extracted the specimen from the patient.

NOTE:

Providers should use procedure code 36415-90 for routine venipuncture collection, 36416-90 for collection of capillary blood specimen (eg, finger, heel, ear stick) and Q0091-90 for collection of Pap smear specimen.

NOTE:

Family planning visits do not count against the recipient's office visits when the procedure codes listed below and the appropriate family planning indicator are used.

Code	Procedure Description
99420	Low Risk assessment; use with modifier 22 for high-risk assessment*. For Plan First patients only – to be billed only by health departments.*
99403	Care coordination*. For Plan first patients only – to be billed by health departments only.*
99402	STD/HIV Post-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. See note box below. (Must use diagnosis code V259)
99401	STD/HIV Risk Screening and HIV Pre-test Counseling (Must be billed in conjunction with a family planning visit) – Limited to two per recipient per calendar year. See note box below. (Must use diagnosis code V259)
88305	Level IV Surgical Pathology, gross and microscopic examination
88304	Level III Surgical Pathology, gross and microscopic examination
88302	Surgical pathology, gross and microscopic examination
88300	Level I Surgical Pathology, gross examination only
89300	Semen analysis; presence and/or motility of sperm *(not applicable for Plan First)*
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening, under physician supervision.
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision.
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal

Code	Procedure Description
88162	Cytopathology, any other source
88161	Cytopathology, any other source
88160	Cytopathology, smears, any other source
88155	Cytopathology, slides, cervical or vaginal
88154	Cytopathology, slides, computer assisted
88153	Cytopathology, slides, manual screening & rescreening under physician supervision (use in conjunction with 88142-88154, 88164-88167)
88152	Cytopathology, slides, cervical or vaginal
88150	Cytopathology, manual screening under physician supervision
88148	Cytopathology, screening by automated system with manual rescreening
88147	Cytopathology smears, screening by automated system under physician supervision
88143	Cytopathology, manual screening & rescreening under physician supervision
88142	Cytopathology, cervical or vaginal, automated thin layer preparation
88141	Cytopathology, cervical or vaginal; requiring interpretation by physician (use in conjunction with 88142-88154, 88164-88167)
88108	Cytopathology, concentration technique, smears and interpretation
87850	Neisseria gonorrhea
87798	Infectious agent detection by nucleic acid (DNA or RNA), not otherwise specified; amplified probe technique, each organism
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, direct probe technique
87660	Trichomonas vaginalis, direct probe technique
87622	Papillomavirus, human, quantification
87621	Papillomavirus, human, amplified probe technique
87620	Papillomavirus, human, direct probe technique
87592	Neisseria gonorrhea, quantification
87591	Neisseria gonorrhea, amplified probe technique
87590	Neisseria gonorrhea, direct probe technique
87539	HIV-2, quantification
87538	HIV-2, amplified probe technique
87537	HIV-2, direct probe technique
87536	HIV-1, quantification
87535	HIV-1, amplified probe technique
87534	HIV-1, direct probe technique
87533	Herpes virus-6, quantification
87532	Herpes virus-6, amplified probe technique
87531	Herpes virus-6, direct probe technique
87530	Herpes simplex virus, quantification
87529	Herpes simplex virus, amplified probe technique
87528	Herpes simplex virus, direct probe technique
87512	Gardnerella vaginalis, quantification
87511	Gardnerella vaginalis, amplified probe technique
87510	Gardnerella vaginalis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Amplified probe technique.
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia Trachomatis. Direct probe technique.
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique
87389	Infectious Agent Antigen
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87209	Smear, primary source with interpretation; complex special stain (eg, trichrome, iron hemotoxylin) for ova and parasites
87207	Smear, primary source, with interpretation, special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
87206	Smear, primary source, with interpretation, fluorescent and/or acid fast stain for bacteria, fungi,

Added: 87798

Code	Procedure Description
	or cell types
87205	Smear, primary source, with interpretation; routine stain for bacteria, fungi, or cell types
87177	Smear, primary source, with interpretation, wet and dry mount for ova and parasites, concentration and identification
87164	Dark field examination, any source; includes specimen collection
87110	Culture, chlamydia
87081	Culture, bacterial, screening only, for single organisms
86780	Antibody; Treponema Pallidum
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86689	HTLV or HIV antibody
86593	Syphilis
86592	Syphilis
85032	Manual cell count (erythrocyte, leukocyte or platelet) each
85027	Blood count; RBC only
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85018	Blood count; hemoglobin
85014	Blood count; other than spun hematocrit
85013	Blood count; spun microhematocrit
85009	Blood count; differential WBC count, buffy coat
85008	Blood count; manual blood smear examination without differential parameters
85007	Blood count; manual differential WBC count (includes RBC morphology and platelet estimation)
84703	HCG qualitative
84702	HCG quantitative
81025	Urine pregnancy test
81020	Urinalysis; two or three glass test
81015	Urinalysis microscopic only
81007	Urinalysis; bacteriuria screen, by non-culture technique, commercial kit
81005	Urinalysis; qualitative or semiquantitative, except immunoassays
81003	Urinalysis; automated without microscopy
81002	Urinalysis; non-automated without microscopy
81001	Urinalysis; automated with microscopy
81000	Urinalysis by dip stick or tablet reagent
76830	Transvaginal Ultrasound Non-OB
76857	Ultrasound, Pelvic (Nonobstetric), real time with image documentation; limited or follow-up (EG, for follicles) (This procedure is to be used for locating missing IUDs Only)
74740	Hysterosalpingography, radiological supervision and interpretation
73060	X-ray of Humerus-Purpose Location of Implanon Capsules
58671	Tubal ligation by laparoscopic surgery
58670	Tubal ligation by laparoscopic surgery
58615	Tubal ligation by suprapubic approach
58611	Tubal ligation done in conjunction with a c-section (*Not applicable for Plan first)*
58605	Tubal ligation by abdominal approach (postpartum) (*Not applicable for Plan first)*
58600	Tubal ligation by abdominal incision
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants (by Prior Approval only; **See note box below procedures)
A4264	Intratubal occlusion device (by Prior Approval only; **See note box below procedures)
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58301	IUD removal
58300	IUD insertion
57170	Diaphragm – fitting with instructions
55450	Vasectomy (*Not applicable for Plan first)*

Added: 76857

Code	Procedure Description
55250	Vasectomy (*Not applicable for Plan first)*
11980	Subcutaneous hormone pellet implantation(implantation of estradiol and/or testosterone beneath the skin)
11976	Removal, implantable contraceptive capsule (Implanon, Nexplanon)
11981	Insertion, non-biodegradable drug delivery implant (Implanon, Nexplanon)
00851	Anesthesia Intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection.
J1056	Lunelle
J1050-FP	Depro-Provera-no less than 104 mg and no more than 150 mg per injection once every 70 days
J3490	Depo – Subq Provera 104 – Limited to one injection *every 70 days*
J7302	Mirena IUD (limited to one every 5 calendar years)) Exceptions are in NOTE box below
J7304	Ortho Evra Patch (To be used for billing by Plan First Private Providers) TPL exempt applicable until current office supplies exhausted
J7304-FP	Ortho Evra Patch (For Health Department Billing Only) TPL exempt
J7304-SE	Ortho Evra Patch (For FQHCs, PRHCs, IRHCs Billing only) applicable until current office supplies exhausted
J7303	Vaginal Ring (This code is Not applicable for Plan First billing)
J7303-FP	Vaginal Ring (For Health Department billing only and is covered for Plan First)
99205-FP	Initial visit
99214-FP	Annual visit
99213-FP	Periodic visit
99347-FP	Home visit – Limited to one per 60 day post-partum period. (Not applicable for Plan First)
S4993-FP	Birth control pills (For Health Department billing only)
96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
99212-FP	Extended contraceptive counseling visit (May be billed alone or in conjunction with the postpartum visit – Limited to one service during the 60 day postpartum period.) (Not applicable for Plan First.)
S4993	Birth control pills (To be used for billing by Plan First Private Providers) applicable until current office supplies exhausted (Refer to ALERT dated 8/21/2006).
S4993-SE	Birth Control Pills (For FQHCs, PRHCs, IRHCs Billing only) applicable until current office supplies exhausted
J7307	Etonogestrel (contraceptive) implant system, including implants and supplies also known as Implanon Effective 1/1/2008, J7307 replaces S0180
J7300	Mechanical (Paragard) IUD
S4989	Hormonal (Progestasert) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
36415-90	Routine venipuncture for collection
36416-90	Collection of capillary blood specimen (eg, finger, heel, ear stick)

NOTE:

The Essure method of sterilization is restricted to Prior Approval and also requires a sterilization consent form. The limitations are as follows:

This procedure must be performed in an outpatient setting and the patient must meet one of the following criteria:

Morbid obesity (BMI of 45 or greater); or

Abdominal mesh that mechanically interfaces with laparoscopic tubal ligation sterilization procedures; or

Permanent colostomy with documented adhesions; or

Multiple abdominal/pelvic surgeries with documented severe adhesions; or

Artificial heart valve requiring continuous anticoagulation; or

Other severe medical problems that would be a contraindication to laparoscopic tubal ligation procedures based on medical documentation submitted.

Effective January 1, 2010, Medical providers will use two procedures to bill for the Essure. A4264 will be used for reimbursement of the device and 58565 will be used for reimbursement of the procedure. The outpatient facility will **only** bill 58565 for the surgical procedure.

NOTE:

Once a sterilization claim is processed for a Plan First recipient, the Medicaid eligibility is ended. Therefore, a claim for the Essure related follow-up procedures (58340 and 74740) would deny due to no eligibility. The performing provider should submit the claims for procedures 58340 and 74740 for administrative review to:

Alabama Medicaid Agency

Plan First Program Manager

501 Dexter Avenue

Montgomery, AL 36103

The claims will be researched and a lump sum payment will be made to the provider if there is a paid claim on file for the Essure procedure.

NOTE:

Effective 1/1/2010, the Mirena IUD was restricted to 1 every 5 years. Medicaid recipients **must meet** the following criteria to receive the Mirena IUD within the 5 year limit:

1. Recipient develops high blood pressure or any other medical condition that would allow for a progestin only method.

2. Any nulliparous woman who has a spontaneous expulsion within 6 months of placement.

3. Mirena IUD is removed to allow a pregnancy. Once delivered, recipient is eligible for another Mirena IUD.

In order to receive reimbursement, providers will need to submit a clean claim and medical records documenting the above mentioned criteria to the:

Plan First Program Manager
Alabama Medicaid Agency
Medical Services Division
P.O. Box 5624
Montgomery, AL 36103-5624

NOTE:

Effective January 1, 2012, intrauterine devices (IUDs) and implantable contraceptive 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®, Paragard®, and Implanon®.

NOTE:

Effective 5/1/2012, Federally Qualified Health Centers and Rural Health Centers may submit claims for Mirena®, Paragard®, and Implanon® fee-for-service outside the encounter rate. FQHC and RHCs may submit a separate medical claim using the following procedure codes:

Mirena® - J7302

Paragard® - J7300

Implanon® – J3707

C.11 Attachments

- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form
- Plan First Patient Contraceptive Order Form

These handouts are available through the Communications Division (334-353-4099)

- How to do a Breast Self-Exam (Handout)
- Folic Acid for Women for healthy babies (Handout)
- Birth Control Method Sheets (Handout)
- STD/HIV Screening and Documentation Forms
- Sterilization Consent Form

NOTE:
Please go to the Alabama Medicaid Agency web site to access the Alabama Medicaid Product Catalog for any forms that you may need to order. The web address is www.medicaid.alabama.gov.

Patient Name_____ Sex: M F Today's Date _____

STD/HIV Risk Screening and Intervention Tool

Questions/Risk Factors	YES	NO
1. Have you had a blood transfusion or received any blood products prior to 1985? ***Blood exposure?***		
2. Have you ever had a job that exposed you to blood or other body fluids? Like a nursing Home or a day care or hospital? Doctor's office? Funeral Home? ***Occupational exposure?***		
3. Your medical history tells me that you (do or do not have) the free bleeding disease called Hemophilia. Is that correct? ***Has Hemophilia?***		
4. Has the use of alcohol or any other drug ever caused you to do things sexually that you Normally would not do? ***Risky use of alcohol or non-IV drugs****?*		
5. Have you **ever** put drugs of any type into your veins? ***Ever an IV drug user?***		
6. Have you ever had any type of infection of the sex organs*?* ***History of STDs?***		
7. Think about the first time you had sex. (Since your last HIV test?) Have you had sex With more than one partner since then? What about your current partner? ***Multiple Sex Partners***?		
8. Some women and some men use sex to get things they need. Have you ever had to do this?		
9. Have you ever been hit, kicked, slapped, pushed or shoved by your partner? ***History of Abuse?***		
10. Some women/men prefer sex with men, some with women and some with both. What type of partner do you prefer? **Circle One: Man Woman Both**		
11. **<u>As far as you know</u>,** have you ever had sex with someone who		
a. was a free bleeder or Hemophiliac?		
b. had HIV or AIDS or an STD?		
c. was a man who had sex with men?		
d. used IV drugs or put drugs into their veins?		
e. was a prostitute - either male or female?		
NOTE: For screening after a previous negative HIV test, ask, "Since your last HIV test ..."		

Documentation instructions and explanations:

1. **Yes or No.** Blood transfusion prior to 1985 places the person at risk for HIV/AIDS.
2. **Yes or No**. Any profession that exposes the patient to body fluids creates a risk for HIV/AIDS.
3. **Yes or No**. Yes, if the patient has Hemophilia; No, if does not have the disease. Hemophilia itself does not create risk for HIV, but the use of blood and blood products by the patient does create risk for HIV/AIDS.
4. **Yes or No.** Use of alcohol or non-IV drugs in a setting/manner that results in sexual risk taking places a person at risk for both STDs and HIV.
5. **Yes or No.** IV drug use is a risk factor for HIV specifically.
6. **Yes or No**. A history of any STD places the patient at risk for another STD including HIV/AIDS.
7. **Yes or No.** Having more than one partner places a patient at risk for both STDs and HIV, unless the partners were prior to 1978.
8. **Yes or No**. Exchanging sex for anything places a person at risk for both HIV and STDs.
9. **Yes or No.** Any type of abuse or coerciveness that the patient has experienced places the patient at risk for both HIV and STDs
10. **Circle** the appropriate choice. Male homosexuality and/or male bisexuality are risk factors for HIV/AIDS.
11. **a-e. Yes or No.** Any Yes answer is considered a risk factor for both STDs and HIV/AIDS.

Intervention Documentation: Circle the intervention taken

Level I: - No risk factors identified – No counseling required. Offer "STDs – Don't…" Handout – because "sometimes we change". HIV testing w/counseling is optional – at patient request.

Level II: Risks are related to blood products exposure ONLY – Recommend HIV test. Inform of need for and explain universal precautions. Use "STDs – Don't… " handout.

Level III: Any other risk factor present - significant risk exists. Recommend strongly the HIV test. Test for other STDs as CI. Provide prevention counseling about need for change in (specifically identified) habits and importance of protected sex. Use "STDs – Don't…" handout. Provide skill training in use of condom and in negotiation skills.

Remember: All patients should be given information the handout, "Facts about HIV and HIV testing."

Form 189 Alabama Medicaid Agency

Documentation of HIV testing:

❑ ***HIV Testing Done*** ❑ ***NO HIV Test drawn***

IF Patient declined, why? Circle One

* I am not at risk,
* Do not want to know,
* Other

Follow-up Notes:

Signature/title of counselor _____ **Date** _____

HIV Post Test Counseling

HIV Test Results: Date _____

❑ **HIV positive**

- ○ Test results explained
- ○ Provided emotional assistance related to test result
- ○ Explained need to notify partners/contacts
- ○ Offered options for partner notification
- ○ Stressed need for transmission prevention
- ○ Explained need for early medical evaluation & treatment

❑ **HIV Negative**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

❑ **Indeterminate**

- ○ Test results explained
- ○ Counseled re need for safe sex practices
- ○ Scheduled for retest on _____

Referrals made:

- ❑ Mental Health_____
- ❑ Partner notification services _____
- ❑ Other Health Care Provider_____
- ❑ Social Services_____
- ❑ Retesting
- ❑ Other_____

Retest Results (Date) _____

Positive Negative Indeterminate

Follow-up Notes:

Additional Post- test counseling

Reason:

Points covered:

Signature/title of counselor _____ **Date** _____

Form 189 Alabama Medicaid Agency

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (Doctor/Clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Month/Day/Year) _____. I, _____, hereby consent of my own free will to be sterilized by (Doctor) _____, by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to: Representative of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) _____ (Date) _____

(Typed/Printed Name) _____

Recipient's Medicaid Number) _____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

_____ American Indian or Alaska Native
_____ Hispanic
_____ Asian or Pacific Islander
_____ Black (not of Hispanic origin)
_____ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized) I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ Language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) _____ (Date) _____

Original – Patient
Copy 2 – HP
Copy 3 – Patient's Permanent Record

STATEMENT OF PERSON OBTAINING CONSENT

Before (Patient's Name) _____ signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Signature) _____ (Date) _____

(Title of Person Obtaining Consent) _____

(Typed/Printed Name) _____

(Facility) _____

(Address) _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (Patient's Name) _____ on (Date) _____, I explained to him/her the nature of the sterilization operation (Specify Type of Operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(1) _____ Premature delivery:
Individual's expected date of delivery: _____

(2) _____ Emergency abdominal surgery:
(Describe circumstances using an attachment)

(Signature) _____ (Date) _____

(Typed/Printed Name of Physician) _____

(NPI Number) _____

Alabama Medicaid Agency

Form 193 (Revised 2-30-2010)

Checklist for Consent Form Completion

Sterilization Claim & Primary Surgeon's Responsibility

It is the responsibility of the performing surgeon to submit a copy of the sterilization consent form to HP. Providers other than performing surgeon should not submit a copy of consent form to HP. Receipt of multiple consent forms slows down the consent from review process and payment of claims. Therefore, please do not forward copies of completed consent forms to other providers for submission to HP.

When the claim for the sterilization procedure is submitted to HP, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. The Saturday after the claim is keyed into the system, it will check to see if the consent form has been entered. It will check the system each Saturday, up to 21 days, for the approved consent form. After the 21st day, the claim will deny for no consent form on file. If the approved consent form is found in the system during the 21 days, it will process the claim on the Saturday it finds the form.

Sterilization Consent Form

Clarification of the completion of the sterilization consent form reflecting CMS regulations and Alabama Medicaid policy (refer to the current Appendix C of the Alabama Medicaid Provider Manual and 42CFR50 Revised October 1, 2001):

a) All blanks on the consent form must be appropriately completed before the State may pay the provider for sterilization procedure. The only exception is the Race, Ethnicity, and Title of person obtaining consent, which is optional.

b) The "Consent to Sterilization" must be signed by the person to be sterilized at least thirty days prior to the procedure date. The birth date must indicate the person to be at least twenty-one (21) years of age on the date the signature was obtained.

c) The interpreter, if one is used, must sign and date the consent the same day the recipient signs. In instances where the interpreter signs any date other than the date recorded by the recipient, the claim will be denied. If no interpreter is used, this section of the form must be marked as "not applicable" (N/A). If the Interpreter's Statement is signed and dated, please complete the "form of language" line also.

d) When it is not known in advance which specific physician will perform the procedure, it is acceptable to list a generic description of the physician, i.e. "staff physician, on-call physician, OB/GYN physician". When using a generic description and not a specific physician's name, the patient is to be informed that the physician on call or on duty will perform the procedure. The name of the provider facility (hospital, surgical center, etc.) or provider physician's group must also be entered in the same blank containing the generic physician description when the generic physician description is used. The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery and signs the "Physician's Statement".

e) Signature of person obtaining consent: The individual obtaining consent must sign after the recipient (may sign the same day as the recipient, as long as the recipient signs first) but prior to the procedure in order to properly document informed consent. In instances where the person obtaining consent does not sign prior to the procedure date, (date-wise – not time) the claim will be denied. In other words, denial will occur if the date of the signature of the person obtaining consent and the procedure date is the same or any date after the procedure date.

f) Procedure recorded in physician's statement: It is necessary for the recipient (by signature) to give consent in understanding their rights relative to the sterilization. Both sections of the form should indicate the same type of procedure; however, it is not necessary that the wording of the procedure/manner in which the sterilization is performed be identical under both sections of the form.

Most frequent causes of claims having to be returned for correction:	**Reasons consent forms and associated claims will be denied:**
1. Patient's date of birth not the same on the claim and consent form.	1. Missing recipient signature
2. Expected date of delivery not provided when the sterilization procedure is performed less than the required 30-day waiting period.	2. Missing or invalid date of recipient signature, including less than 30 days prior to procedure
3. Expected date of delivery is recorded but indicator for premature delivery or emergency surgery is not checked.	3. Recipient under age 21 on date consent form was signed
4. All blanks not appropriately completed.	4. Missing signature of person obtaining consent
5. Physician's stamp signature not initialed by physician.	5. Missing or invalid date of person obtaining consent, including date of procedure, or any later date
6. Date of sterilization not the same on the claim and on the consent form	6. Missing interpreter signature (if one was used)
7. Legibility of dates and signatures.	7. Missing or invalid date of interpreter, including any date other than the date the recipient signed (if one was used)
8. Facility name not on the consent form.	

*** As a reminder if these guidelines are not followed, HP will deny the consent form. ***

D Reserved for Future Use

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E Medicaid Forms

This section contains examples of various Alabama Medicaid forms used in documenting medical necessity and claims processing.

The following forms may be obtained by contacting the following:

Form Name	*Contact*	*Phone*
Certification and Documentation of Abortion	Communications	(334) 353-5203
Check Refund Form	HP Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	HP Provider Assistance Center	(800) 688-7989
Hysterectomy Consent Form	Communications	(334) 353-5203
Patient Status Notification (Form 199)	HP Provider Assistance Center	(800) 688-7989
Prior Authorization Form	HP Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Communications	(334) 353-5203
Family Planning Services Consent Form	Communications	(334) 353-5203
Prior Authorization Request	Clinical Services and Support	(334) 242-5050
Prior Authorization Change Request	Clinical Services and Support	(334) 242-5149
Early Refill DUR Override	Clinical Services and Support	(334) 242-5050
Growth Hormone For AIDS Wasting	Clinical Services and Support	(334) 242-5050
Growth Hormone For Children	Clinical Services and Support	(334) 242-5050
Adult Growth Hormone	Clinical Services and Support	(334) 242-5050
Maximum Unit Override	Clinical Services and Support	(334) 242-5050
Miscellaneous Medicaid Pharmacy PA Request Form	Clinical Services and Support	(334) 242-5050
EPSDT Child Health Medical Record	Communications	(334) 353-5203
Alabama Medicaid Agency Referral Form	Communications	(334) 353-5203
Residential Treatment Facility Model Attestation Letter	Institutional Services Unit	(334) 353-4945
Certification of Need for Services: Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-4945
Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-4945
Patient 1st Recipient Dismissal Form	Patient 1st Program	(334) 353-5907
Patient 1st Medical Exemption Request Form	Patient 1st Program	(334) 353-5907
Patient 1st Complaint/Grievance Form	Patient 1st Program	(334) 353-5907
Patient 1st Override Request Form	Patient 1st Program	(334) 353-5907
Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5562
Request for National Correct Coding Initiative (NCCI) Administrative Review	System Support Unit	(334) 353-1747
Request for NCCI Redetermination Review	HP Provider Assistance Center	(800) 688-7989
Medicaid Other Insurance Attachment Form	HP Provider Assistance Center	(800) 688-7989

Deleted: ~~Pharmacy Management~~

Added: Clinical Services and Support

Added: Prior Authorization Change Request

E.1 Certification and Documentation of Abortion

ALABAMA MEDICAID AGENCY

Certification and Documentation

For Abortion

I,_____, certify that the woman,

_____, suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Name of Patient	*Patient's Medicaid Number*		
Patient's Street Address	*City*	*State*	*Zip*
Printed Name of Physician	*Physician's NPI #*		
Signature of Physician	*Date Physician Signed*		
Date of Surgery			

INSTRUCTIONS: The physician must send this form with the medical records and claim to:

HP
P.O. Box 244034
Montgomery, AL 36124-4034

PHY-96-2 (Revised 2/10/2010) Alabama Medicaid Agency

Formerly MSA-PP-81-1

E.2 Check Refund Form

Check Refund Form (REF-02)

Mail To: HP
Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Provider Name _____ NPI Number _____

Check Number _____ Check Date _____ Check Amount _____

Information needed on each claim being refunded	Claim 1	Claim 2	Claim 3
13-digit Claim Number (from EOP)			
Recipient's ID Number (from EOP)			
Recipient's name (Last, First)			
Date(s) of service on claims			
Date of Medicaid payment			
Date(s) of service being refunded			
Service being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made
2. DUP: A payment was made by Alabama Medicaid more than once for the same service(s)
3. INS: A payment was received by a third party source other than Medicare
4. MC ADJ: An over application of deductible or coinsurance by Medicare has occurred
5. PNO: A payment was made on a recipient who is not a client in your office
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

2-11-08

E.3 Alabama Prior Review and Authorization Dental Request

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Section I – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone ( ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

Section II

Medicaid Recipient Identification Number _____
(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number ( ) _____

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one)				
11 = DENTAL OFFICE				
22 = OUTPATIENT HOSPITAL				
21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

2. Detailed description of condition or reason for the treatment:

_____

_____

_____

_____

3. Brief Dental/Medical History:_____

_____

_____

_____

_____

When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential."
Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____
FORWARD TO: HP, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343
Revised 2/10/10

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.4 Hysterectomy Consent Form

ATTACHMENT I

ALABAMA MEDICAID AGENCY HYSTERECTOMY CONSENT FORM

See the back of this form for completion instructions

PART I. **PHYSICIAN**

Certification by Physician Regarding Hysterectomy

I hereby certify that I have advised _____ Medicaid Number _____ to
Typed or Printed Name of Patient
undergo a hysterectomy because of the diagnosis of _____, _____.
diagnosis code
Further, I have explained orally and in writing to this patient and/or her representative (_____) that she will be
Name of Representative, if any
permanently incapable of reproducing as a result of this operation which is medically necessary. This explanation was given before the operation was performed.

_____ _____
Typed or Printed Name of Physician NPI #

_____ _____
Signature of Physician *Date of Signature*

PART II. **PATIENT**

Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information

I, _____ and/or _____ hereby acknowledge that
Name of Patient *Date of Birth* *Name of Representative, if any*

I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation. This oral and written explanation that the hysterectomy would make me sterile was given to me before the operation.

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Representative, if any *Date*

PART III. **PHYSICIAN**

Date of Surgery _____

PART IV. **UNUSUAL CIRCUMSTANCES**

Recipient Name: _____ Recipient ID: _____

I _____ certify
Printed name of physician

☐ patient was already sterile when the hysterectomy was performed. Cause of sterility _____. Medical records are attached.

☐ hysterectomy was performed under a life threatening situation. Medical records are attached.

☐ hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.

Before the operation was performed, I informed the recipient that she would be permanently incapable of reproducing as a result of this operation. ☐ Yes ☐ No

Signature: _____ Date: _____

PART V. **STATE REVIEW DECISION**

Signature of Reviewer: _____ Date of Review: _____ ☐ Pay ☐ Deny

Reason for denial: _____

PHY-81243 *(Revised 2-10-2010)* *Alabama Medicaid Agency*

PART I.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- Record the diagnosis requiring hysterectomy
- Record the diagnosis code
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Type or print the name of the physician who will perform the hysterectomy
- Record the NPI Number of the physician who will perform the hysterectomy
- Physician must sign and record the date of signature. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART II.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient and the patient's date of birth including the day/month/year
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Patient must sign and record the date of signature unless a representative is being used to complete the form. Date must be the date of surgery or a prior date. If any date after surgery is recorded, the form will be denied.
- Representative must sign and record the date of signature, if the recipient is unable to sign the consent form. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART III.

This section is required for all hysterectomies.

- Record the date of surgery once the surgery has been performed

PART IV

This section is for use when a hysterectomy was performed on a patient who was already sterile, under a life-threatening emergency in which prior acknowledgement was not possible or during a period of retroactive Medicaid eligibility. Medical records must be submitted for any hysterectomy recorded under this section. In lieu of this form, a properly executed informed consent and medical records may be submitted for these three circumstances.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- The physician who performed the surgery must record their name
- Check the appropriate box to indicate the specific unusual circumstance
- Check the appropriate box regarding whether or not the patient was informed she would be permanently incapable of reproducing as a result of the operation.
- Attach medical records including Medical History; Operative Records; Discharge Summary and a Hospital Consent Form for the Hysterectomy.

PART V

The reviewer at the State completes this section whenever unusual circumstances are identified. HP will send a copy of the consent form containing the State paym ent decision to the surgeon following State review.

E.5 Patient Status Notification (Form 199)

MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred, or expires)

TO: Alabama Medicaid Agency
P.O. Box 5624–36103
501 Dexter Avenue
Montgomery, Alabama 36104

Date _____

FROM: _____ NPI Number _____
(Name of Facility)

_____ Telephone Number _____
(Address of Facility)

CURRENT PATIENT STATUS

Patient's First Name M.I. Patient's Last Name

_____/_____/_____ Birthdate _____

Patient's Social Security No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Female ☐

Patient's Medicaid No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Male ☐

Date Admitted _____/_____
(Medicare Admission) (Medicaid Admission)

Number of Medicare Days this Admission: _____

For Medicaid Use Only:
Over 60–days late _____
Medicare Denial: _____

☐ New Admission ☐ Hospital ☐ Mental Institutuion

☐ Re–Admission From: ☐ Home

☐ Transferred Admission ☐ Other Nursing Home _____

Reference Information: _____
Name of Sponsor

_____
Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled

☐ Convalescent Care ☐ Post Extended Care Days ☐ Swing Bed Approved By _____

☐ Dual Diagnosis ☐ Mental Retardation Date Approved: _____

PATIENT DISCHARGE STATUS

Discharged to: _____ Date _____

Death (Date) _____ _____

Signed _____

Title _____

Distribution:
White: Alabama Medicaid Agency
Canary: Office of Determination for Medicaid Eligibility - check one: ☐ SSI ☐ D.O.
Pink: Nursing Home File Copy

_____
District Office

Form 199 (Formerly XIX-LTC-4)
Revised 2-13-08

THIS FORM MUST BE SUBMITTED TO MEDICAID WITHIN 60 DAYS OF MEDICAID ADMISSION DATE

Physician's current orders:
(a copy of orders may be attached)

PLEASE EXPLAIN REASON FOR HOSPITAL STAY OR POST EXTENDED CARE. (must be signed by an RN)

RN Signature

FOR POST EXTENDED HOSPITAL CARE ONLY:
(Please list nursing homes and dates they were contacted for placement. This form must be documented every 15 days.)

Nursing Home	Date Contacted

I CERTIFY THAT THIS RECIPIENT NEEDS NURSING HOME CARE
(Physician must sign and date)

Physician's Signature **Date**

E.6 Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ☐

Requesting Provider NPI # _____

Phone with Area Code _____

Name _____

Recipient Medicaid # _____

Name _____

Address _____

City/State/Zip _____

EPSDT Screening Date _____ DOB _____

Prescription Date CCYYMMDD _____

Rendering Provider NPI # _____

Phone with Area Code _____

Fax with Area Code _____

Name _____

Address _____

City/State/Zip _____

Ambulance Transport Code _____

Ambulance Transport Reason Code _____

DME Equipment: _____ New _____ Used

First Diagnosis _____.____ Second Diagnosis _____.____

Assignment/Service Code ____ Patient Condition ____ Prognosis Code ____

(01)	Medical Care	(44)	Home Health Visits	(AD)	Occupational Therapy
(02)	Surgical	(54)	LTC Waiver	(AE)	Physical Therapy
(12)	DME-Purchase	(56)	Medically-Related Transportation		
(18)	DME-Rental	(69)	Maternity	(A4)	Psychiatric*
(35)	Dental Care	(72)	Inhalation Therapy	(AF)	Speech Therapy
(40)	Oral Surgery	(74)	Private Duty Nursing	(AL)	Vision-Optometry
(42)	Home Health Care	(75)	Prosthetic Device	(CQ)	Case Management

Line Item	DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____

_____

_____

_____

_____

_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider _____ Date _____

FORWARD TO: HP, P.O. Box 244032 Montgomery, Alabama 36124-4032

Form 342
Revised 12-2011

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.7 Sterilization Consent Form

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (Doctor/Clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Month/Day/Year) _____. I, _____, hereby consent of my own free will to be sterilized by (Doctor) _____, by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to: Representative of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) _____ (Date) _____

(Typed/Printed Name) _____

Recipient's Medicaid Number) _____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

_____ American Indian or Alaska Native
_____ Hispanic
_____ Asian or Pacific Islander
_____ Black (not of Hispanic origin)
_____ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized) I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ Language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) _____ (Date) _____

Original – Patient
Copy 2 – HP
Copy 3 – Patient's Permanent Record

STATEMENT OF PERSON OBTAINING CONSENT

Before (Patient's Name) _____ signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Signature) _____ (Date) _____

(Title of Person Obtaining Consent) _____

(Typed/Printed Name) _____

(Facility) _____

(Address) _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (Patient's Name) _____ on (Date) _____, I explained to him/her the nature of the sterilization operation (Specify Type of Operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(1) _____ Premature delivery: Individual's expected date of delivery: _____

(2) _____ Emergency abdominal surgery: (Describe circumstances using an attachment)

(Signature) _____ (Date) _____

(Typed/Printed Name of Physician) _____

(NPI Number) _____

Alabama Medicaid Agency

Form 193 (Revised 2-30-2010)

E.8 Family Planning Services Consent Form

Name: _____
Medicaid Number: _____
Date of Birth: _____

I give my permission to _____ to provide family planning services to me. I understand that I will be given a physical exam that will include a pelvic (female) exam, Pap smear, tests for sexually transmitted diseases (STDs), tests of my blood and urine and any other tests that I might need. I have been told that birth control methods that I can pick from may include oral contraceptives (pills), Depo-Provera shots, intrauterine devices (IUDs), Norplant implant, diaphragms, foams, jellies, condoms, natural family planning or sterilization.

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
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Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Form 138 (Formerly MED-FP9106)
Revised 2/99

E.9 Prior Authorization Request Form

NOTE:
Prior Authorization Form 369 may be downloaded from the Medicaid website at www.medicaid.alabama.gov .

E.10 Prior Authorization Change Request Form

Added: Prior Authorization Change Request Form

Alabama Medicaid Agency
Prior Authorization (PA) Change Request

Supplier Information	
Contact Name	
NPI	
Phone Number	

Recipient Information	
Recipient Name	
Medicaid ID	

Prior Authorization Number	

Reason for Change *Please use this section to denote what field(s) on the PA request require a change.* *Complete all applicable fields below.* *Examples: Add/Change Modifier: Add "RR" to "E1088"* *Correct Date(s) of Service: Change requested effective date from 08/01/2010 to 10/01/2010*	
Add/Change Modifier	
Correct Number of Service(s)	
Correct Place of Service	
Correct Diagnosis Code(s)	
Correct Date(s) of Service	
Correct NPI	
Other (Please Explain)	

Comments

NOTE: The Alabama Medicaid Agency cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs or for procedure code changes. Please fax completed form to the Alabama Medicaid Agency at (334) 353-9352 or (334) 353-4909. Allow at least 3 business days to process request.

Form 471
Revised: 12/8/11

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.11 Early Refill DUR Override Request Form

NOTE:
The Pharmacy Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.12 Growth Hormone for AIDS Wasting

NOTE:
PA Form- Growth Hormone-AIDS Wasting, may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.13 Growth Hormone for Children Request Form

NOTE:
PA Form – Growth Hormone- Child may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.14 Adult Growth Hormone Request Form

NOTE:
PA Form – Growth Hormone – Adult may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.15 Maximum Unit Override

NOTE:
The Pharmacy Override Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.16 Miscellaneous Medicaid Pharmacy PA Request Form

NOTE:
The PA Form for Miscellaneous Drugs may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

E.17 EPSDT Child Health Medical Record (4 pages)

EPSDT CHILD HEALTH MEDICAL RECORD

Name_____ Medicaid Number _____
Last First Middle

Sex Race
__M ___White ____Black ____Am. Indian Birth Date _____
__F ___Latino ____Asian ____Other

I give permission for the child whose name is on this record to receive services in the _____
I understand that he/she will receive tests, immunizations, and exams. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____

FAMILY HISTORY
(Code Member Having Disease)
(F-Father, M-Mother, S-Sibling, GP-Grandparent,O-Other)
If Negative, place an N in the blank

____ heart disease ____ high blood pressure ____ tuberculosis ____ cancer
____ stroke ____ blood problem/disease ____ birth defects ____ stroke
____ asthma ____ nerve/mental problem ____ mental retardation ____ diabetes
____ alcohol/drug abuse ____ foster care ____ Other

Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____

MEDICAL HISTORY

HISTORY	0-Neg +-Pos	DETAIL POSITIVES	HISTORY	0-Neg +-Pos	DETAIL POSITIVES
Childhood Diseases			Frequent Colds		
Diabetes Mellitus			Tonsilitis		
Epilepsy			Bronchitis		
Thyroid Dysfunction			Ear Infection		
Mental I Illness			Pneumonia		
Rheumatic Fever			Convulsions		
Heart Disease			Headache		
Hepatitis			Drug Sensitivity		
Blood Dyscrasia			Allergies		
Anemia			Medications		
Eczema			Operation, Accident		
Tuberculosis			Drug Abuse		
Asthma			Chronic Problems		

Hospitilizations (year & reason)_____

Updates (each screening)_____

Form 172
Revised 1/1/97

Alabama Medicaid Agency

Page 2

DEVELOPMENTAL ASSESSMENT

DATE	NORMAL	ABNORMAL (detail)	DATE	NORMAL	ABNORMAL (detail)

ANTICIPATORY GUIDANCE

(Should be done at each screening and documented with a date)

2 Weeks to 3 Months_____
Dates completed

_____Nutrition
_____Safety
_____Spitting up, hiccoughs, sneezing, etc.
_____Immunizations
_____Need for affection
_____Skin & scalp care, bathing frequency
_____Teach how to use the thermometer and when to call the doctor

4 to 6 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Teething & drooling/dental hygiene
_____Fear of strangers
_____Lead poisoning
_____

7 to 12 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Night crying
_____Separation anxiety
_____Need for affection
_____Discipline
_____Lead poisoning
_____

13 to 18 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygeine
_____Temper tantrums
_____Obedience
_____Speech development
_____Lead poisoning
_____Toilet training counseling begins

19 to 24 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Need for peer relationships
_____Sharing
_____Toilet training should be in progress
_____Dental hygeine
_____Need for affection and patience
_____Lead poisoning

3 to 5 Years_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Assertion of independence
_____Need for attention
_____Manners
_____Lead poisoning
_____Alcohol & drugs

6 to 13 Years_____
Dates completed

_____Nutrition
_____Safety (auto passenger safety)
_____Dental care
_____School readiness
_____Onset of sexual awareness
_____Peer relationships (male & female)
_____Parent-child relationships
_____Prepubertal body changes (menst.)
_____Alcohol, drugs and smoking
_____Contraceptive information if sexually active
_____
_____
_____

14 to 21 Years_____
Dates completed

_____Nutrition/dental
_____Safety (automobile)
_____Understanding body anatomy
_____Male-female relationships
_____Contraceptive information
_____Obedience and discipline
_____Parent-child relationships
_____Alcohol, drugs and smoking
_____Occupational guidance
_____Substance abuse
_____
_____
_____

NUTRITIONAL ASSESSMENT

DATE	ADEQUATE	INADEQUATE (detail)	DATE	ADEQUATE	INADEQUATE (detail)

Form 172 Revised 1/1/97
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Alabama Medicaid Agency

Page 3

LABORATORY TESTING

	Hematocrit Hemoglobin	Urine Sugar/Albumin	Lead	Sickle Cell Screen	Other
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					

Date	PROGRESS NOTES	SIGNATURE

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PHYSICAL ASSESSMENT

(UC=Under the care)

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ *UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

PHYSICAL ASSESSMENT

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

Form 172 Revised 1/1/97
Page 4 of 4

Alabama Medicaid Agency

E.18 Alabama Medicaid Agency Referral Form

ALABAMA MEDICAID REFERRAL FORM

Today's Date _____

PHI-CONFIDENTIAL

Date Referral Begins _____

Important NPI Information
See Instructions

MEDICAID RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

PRIMARY PHYSICIAN (PMP)	SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)
Name	Name
Address	Address
Telephone # with Area Code _____	Telephone # with Area Code _____
Fax # with Area Code _____	Fax # with Area Code _____
Email _____	Email _____
Provider NPI # _____	**Provider NPI #** _____
Signature _____	Signature _____

TYPE OF REFERRAL

❑ Patient 1st ❑ EPSDT Screening Date _____ ❑ Case Management/Care Coordination	❑ Lock-in ❑ Patient 1st/EPSDT Screening Date _____ ❑ Other

LENGTH OF REFERRAL

Referral Valid for _____ month(s) or _____ visit(s) from date referral begins.

REFERRAL VALID FOR

❑ Evaluation Only ❑ Evaluation and Treatment ❑ Referral by consultant to other provider for identified condition (cascading referral) ❑ Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral)	❑ Treatment Only ❑ Hospital Care (Outpatient) ❑ Performance of Interperiodic Screening (if necessary)

Reason for Referral By Primary Physician (PMP)	**Other Conditions/Diagnoses Identified by Primary Physician (PMP)**

CONSULTANT INFORMATION

Consultant Name	
Address	Consultant Telephone # with Area Code

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).

Findings should be submitted to primary physician (PMP) by

❑ Mail ❑ E-mail ❑ Fax ❑ In addition, please telephone

Form 362
Rev. 1-30-08

Alabama Medicaid Agency
www.medicaid.alabama.gov

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. **Must be signed by Primary Physician (PMP) or designee**
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:**	Referrals effective February 23, 2008 or later MUST indicate the NPI number..

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 that **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.

*"The Alabama Medicaid Provider Manual" is available on the Alabama Medicaid website

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.

Form 362
Rev.1-30-08

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.19 Residential Treatment Facility Model Attestation Letter

Residential Treatment Facility
Model Attestation Letter

(RTF LETTERHEAD)
NAME OF THE RTF
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER
NPI NUMBER (IF APPLICABLE)

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the (NAME OF FACILITY) hereby complies with all of the requirements set forth in the interim final rule governing use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), the Alabama Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 42 CFR, Section 431.610, have the right to validate that (NAME OF FACILITY) is in compliance with the requirements set forth in the Psych Under 21 rule, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the Alabama Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the Alabama Medicaid Agency if it is my belief that (NAME OF FACILITY) is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature,

Printed Name
Title
Date

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Revised 2/11/08
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.20 Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 who are admitted to an Alabama residential treatment facility (RTF) on an emergency basis or for individuals who become eligible for Medicaid after admission to the RTF. The interdisciplinary team shall complete and sign this form within 14 days of the emergency admission. This form shall be completed on or before the date of the application for Medicaid coverage for individuals who become eligible after admission. This form shall be filed in the recipient's medical record upon completion to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Admission Date**

INTERDISCIPLINARY TEAM CERTIFICATION:

1. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
2. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
3. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician Team Member **Signature** **Date**

Printed Name of Other Team Member **Signature** **Date**

Printed Name of Other Team Member **Signature** **Date**

Form 371 ***Revised 10/01/01***

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.21 Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility

Certification of Need for Services:
Non-Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Planned Admission Date**

PHYSICIAN CERTIFICATION:

1. **I am not employed or reimbursed by the facility.**
2. **I have competence in diagnosis and treatment of mental illness.**
3. **I have knowledge of the patient's situation.**
4. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
5. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
6. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician **Physician Signature** **Phone Number** **Date**

Physician Address **NPI Number**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Form 370 *Revised 10/01/01*
This form can be downloaded from the Alabama Medicaid Agency web site: www.medicaid.alabama.gov.

E.22 Patient 1st Recipient Dismissal Form

Patient 1st Recipient Dismissal Form

Recipient Information

Recipient Name _____ DOB _____

Medicaid Number _____ Gender Male _____ Female _____

Address _____ Telephone # _____

City: _____ State: _____ Zip: _____

PMP

PMP Name _____ PMP NPI _____

Reason for Dismissal

❑Recipient Behavior ❑Non Compliance w/treatment ❑Other: _____

To assist you and the recipient in the dismissal process, please list the name and telephone number of any referral for this recipient within the last 30 days or send copy of the referral.

Referred To	Diagnosis	Date	Length of Referral

After care management, would you accept this recipient back in your practice? Yes❑ NO❑

For Medicaid Office Use Only:

Refer to Care Coordinator: ❑ Refer to Lock-in Program: ❑

A Primary Medical Provider may request removal of a recipient from his panel due to good cause. All requests for patients to be removed from a PMP's panel should be submitted on this form and provide the enrollee 30 days written notice. The request should contain documentation as to why the PMP does not wish to serve as the recipient's PMP.*

***IAW: ALABAMA MEDICAID BILLING MANUAL CHAPTER 39**

Fax number: (334) 353-3856
FORM 450
Revised 10/13/2011

www.medicaid.alabama.gov

E.23 Patient 1st Medical Exemption Request Form

Patient 1st Medical Exemption Request

The Patient 1st Program is based on the premise that patient care is best served by a medical home where a Primary Medical Provider (PMP) may coordinate care. The purpose of this form is for the provider to list the reasons why a patient would not benefit from this system of care.

_____	_____	_____
Recipient Name	Recipient Medicaid Number	Date of Birth

Attention Physician: This section is to be completed only by the physician. Please check all blocks that apply regarding the patient's medical condition, and mail to the address below. (**Note:** At least one block should be checked, and the physician information requested below completed.

☐ **Terminal Illness** (**Note:** The enrollee has a six month or less life expectancy and/or is currently a hospice patient.)

☐ **Impaired Mental Condition** which makes it impossible for the adult enrollee to understand and participate in Patient 1st. (**Note:** This statement is not a determination of the patient's legal mental competence.

☐ Currently undergoing **Chemotherapy** or **Radiation treatments.** (**Note:** Exemption for this is temporary and will end with the completion of the therapy).

☐ **Diagnosis/Other information**: (Specify reasons why this recipient would not benefit from having a medical home with a local PMP who would coordinate his/her care.)

_____

_____

_____

_____Print
Physician's Name NPI Number Telephone Number

_____Return
Mailing Address City State Zip

_____Physician's Signature Date

If you have questions about this form, contact Patient 1st at (334) 353-5907. If you would like to apply to become a Patient 1st provider, call 1-800-688-7989. Send this completed and signed form via Fax to (334)353-3856 or mail to:

Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Form 392
Revised 6/15/09

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.24 PATIENT 1st Complaint/Grievance Form

PATIENT 1st COMPLAINT/GRIEVANCE FORM

**Note: for reporting complaints regarding Patient 1st Providers Only*

Mail the completed, ***signed*** form to: Alabama Medicaid Agency
Quality Improvement Initiatives Unit
501 Dexter Avenue
Montgomery, AL 36103

Name of Person Completing this Form: _____
(May be the recipient, designated friend/family member, medical provider, hospital, community member, etc.)

Date Form Completed: _____ Relationship to Recipient: _____

Recipient Name: _____ DOB: _____

Recipient Medicaid Number: _____ County of Residence: _____

Address: _____

Telephone Number:_____

Name of Doctor: _____ Practice: _____

Please describe your complaint in detail including dates/names: (please attach any additional documentation)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Over (See Consent Statement and Signature)

Form 393
Revised 2/15/08

Page 1 of 2

Alabama Medicaid Agency
www.medicaid.alabama.gov

PATIENT 1ST COMPLAINT/GRIEVANCE FORM

Patient 1st staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. If you want us to use your name when investigating your complaint, sign your name in Section 1. If you do NOT want us to use your name when investigating your complaint, sign your name in Section 2. **PLEASE DO NOT SIGN BOTH STATEMENTS.**

1. If you agree to allow us to use your name in investigating this complaint, please sign the following:

I give the Patient 1st staff permission to use my name when sharing my complaint with the Primary Medical Provider (PMP) named in my complaint. The PMP has my permission to respond to the Patient 1st staff concerning my complaint and release medical records regarding the patient when necessary.

_____ _____
Signature of Complainant Date

_____ _____
Signature of Patient/Parent/Legal Guardian Complainant's Date of Birth

OR

2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:

_____ _____
Signature of Complainant Date

_____ _____
Signature of Patient/Parent/Legal Guardian Complainant's Date of Birth

If you have any questions about the use of this form or the Patient 1st complaint process, please contact the Quality Improvement Initiative Unit at 334-353-5435. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

Patient 1st PMP Name: _____ NPI # _____

Patient 1st Practice Name: _____

County Where Patient 1st Practice is Located: _____

Comments: _____

_____

Form 393
Revised 2/15/08

Page 2 of 2

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.25 PATIENT 1ST Override Request Form

PATIENT 1ST Override Request Form

Complete this form to request a Patient 1st override when you have received a denial for referral services or the Primary Medical Provider (PMP) has refused to authorize treatment for past date(s) of service. The request must be submitted to Medicaid's Patient 1st Program within 90 days of the date of service. Overrides will not be considered unless the PMP has been **contacted and refused** to authorize treatment. Attach a "clean claim" with any supporting documentation to this form and mail to Patient 1st at the address below. Patient 1st will process your request within 60 days of receipt. If your request is approved, the corrected claim will be sent to HP and will be processed. If your request is denied, Patient 1st will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at www.medicaid.alabama.gov.

Mail To:
Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Recipient's name: _____ Medicaid number: _____

Recipient's telephone number: (_____)_____ Date(s) of service: _____

Name of PMP: _____ PMP's telephone number: (_____)_____

Name of person contacted at PMP's office: _____Date contacted: _____

Reason PMP stated he would not authorize treatment: _____

_____

I am requesting an override due to:

☐ Recipient assigned incorrectly to PMP. Please explain: _____

_____

☐ This recipient has moved.

☐ Unable to contact PMP. Please explain:_____

_____

☐ Other. Please explain: _____

_____

Provider name: _____

NPI #_____

Form completed by: _____

Telephone _____ Fax _____

Form 391
Revised 2-10-10

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.26 Request for Administrative Review of Outdated Medicaid Claim

Alabama Medicaid Agency

REQUEST FOR ADMINISTRATIVE REVIEW OF OUTDATED MEDICAID CLAIM

This form is to be completed only if the claim is more than one year old as specified on the reverse side.

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 determination you made on my claim as described on my Explanation of Payment dated:

Section B

My reasons are:

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

Form # 402
Rev. 2-10-2010

This form may be downloaded from the Medicaid website at: www.medicaid.alabama.gov

ma Medicaid Agency

7.2.1 - *Administrative Review and Fair Hearings*
Alabama Medicaid Provider Manual

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code.*

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated.** In addition to a clean claim, the provider should send all relevant EOPs and previous correspondence with HP or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

Administrative Review
Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery AL 36103-5624

Include the program area in the address (for instance, write "Attn: System Support").

NOTE:

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing.

E.27 Prior Authorization Request Form for Durable Medical Equipment

Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery, Alabama 36103-5624

ALABAMA MEDICAID AGENCY
DURABLE MEDICAL EQUIPMENT

☐ Certification ☐ Recertification

Section I: Patient Information -- Complete All Items Pertaining to the Patient's Condition and Equipment

1. Patient's Name	2. Medicaid Number	3. Date of Last EPSDT Screening
4. Indicate all relevant diagnoses		5. Prognosis ☐ Good ☐ Fair ☐ Poor
6. Estimated number of months equipment needed (Do not put "Indefinite." Be specific.) _____	7. Date Prescribed _____	8. Requested HCPC code(s) _____

9. Rental Period this certification applies to
(Certification length CANNOT exceed 12 months)
From _____ To _____

Short Term (6 months or less) _____ (MM-DD-YYYY)

Continuous Rental _____ (MM-DD-YYYY)

10. Supplier's Name _____
Street Address _____
City, State, Zip _____
Telephone # _____
Supplier's Provider Number _____

11. What is The Patient's Condition Concerning Mobility?

a. Bed Confined? ☐ No ☐ Yes - If Yes, complete below
☐ <50% of the time ☐ 50% of the time ☐ 75% of the time ☐ 100% of the time

b. Room Confined? ☐ No ☐ Yes

c. Wheelchair Confined? ☐ No ☐ Yes

d. Ambulatory ☐ No ☐ Yes - If Yes, complete below
☐ Assistance not required ☐ Assisted by a walker or cane ☐ Assisted by a person

e. Is Patient Disoriented? ☐ No ☐ Yes

f. Can patient position self? ☐ No ☐ Yes

g. Does patient have severe contractions? ☐ No ☐ Yes If yes, where? _____

h. Is the patient comatose? ☐ No ☐ Yes

i. Is the patient semi comatose? ☐ No ☐ Yes

j. Is the patient highly susceptible to decubitis ulcers? ☐ No ☐ Yes If yes, explain _____

k. Does patient have decubitis ulcers? ☐ No ☐ Yes If yes, what stage? _____

Section II: General Equipment -- Complete All Applicable Responses

12. General equipment selected for patient (complete all applicable items above in 11)
☐ New Equipment ☐ Replacement Equipment (Attach documentation)

a. Wheelchair
☐ Standard (11a-11k must be completed)
☐ Electric (Form 384 must be completed)
☐ Custom (Form 384 must be completed)

Accessories _____
(Type of Accessory / Weight of Patient / Depth)
_____
_____
_____

b. Hospital Bed ☐ variable ☐ fixed
☐ Semi electric
☐ Other (please specify) _____

Accessories _____
(Type of Accessory / Weight)
_____
_____

c. Hospital Bed Accessories:
Patient has physical and mental capacity to use equipment ☐ Yes ☐ No

Hydraulic lift with:	☐ Seat	or	☐ Sling	
Trapeze bar	☐ Standard	or	☐ Heavy Duty	Patient's weight _____
Bed Rail	☐ Yes		☐ No	Height _____

d. Ambulatory Devices
☐ Walker ☐ Crutches ☐ Quad Cane ☐ Three pronged cane

Form 342-A
4/2/08

Alabama Medicaid Agency
www.medicaid.alabama.gov

Section III: Respiratory Equipment -- Complete All Applicable Responses

*** Indicates EPSDT Only**

13. Apnea Monitor *
    - ☐ Apnea ☐ SIDS Sibling Biological (Brother or Sister) ☐ High Risk for Apparent Life Threatening Event (ALTE)
    - ☐ Infant less than 2 years of age with Trach ☐ Preterm infant with period of pathologic apnea

14. Overnight Pulse Oximetry *
    - ☐ Evaluation for serious respiratory diagnosis and requires short term oximetry to rule out hypoxemia or determine the need for supplemental oxygen

15. Pulse Oximetry * - Patient on supplemental oxygen approved by Medicaid and patient has one of the following conditions
    - ☐ Trach ☐ Ventilator dependant ☐ Unstable saturations with weaning in progress

16. Percussor *

    Patient has one of following diagnoses
    - ☐ Cystic Fibrosis ☐ Bronchiectasis, and

    Failed chest physiotherapy (Attach clinical documentation)
    - ☐ Hand Percussion ☐ Postural drainage Date used _____ through _____ , and

    Caregiver ability to perform chest physiotherapy
    - ☐ Caregiver not available to perform physiotherapy ☐ Caregiver not capable of performing physiotherapy

17. Air Vest*

a. Acute Pulmonary exacerbation during last 12 months documented by
   - ☐ Hospitalization ≥ 2, and ☐ Episode of home IV antibiotic therapy, and

b. ☐ FEV1 in one second < 80% of predicted value, or ☐ FVC is < 50% of predicted value, and

c. ☐ Need for chest physiotherapy ≥ 2 times daily, and

d. Documented failure of other forms of chest physiotherapy
   (Attach clinical documentation)
   - ☐ Hand percussion ☐ Mechanical percussion ☐ Positive Expiratory Pressure

18. Ventilator (check one) * ☐ Laptop ☐ Volume Ventilator

a. Dependent on vent 6 hours or more per day, and ☐ Yes ☐ No

b. Dependent on vent for at least 30 consecutive days, and ☐ Yes ☐ No
   (Medical documentation from the recipient's primary physician indicates long term dependency on ventilator support)

c. Would need care in hospital, NF, ICF, MR and eligible inpatient care under state plan, and ☐ Yes ☐ No

d. Patient has social supports to remain in home, and ☐ Yes ☐ No

e. Physician has determined that home vent care is safe, and ☐ Yes ☐ No

f. Patient has at least one or more of the following
   - ☐ Chronic respiratory failure
   - ☐ Spinal cord injury
   - ☐ Chronic pulmonary disorders
   - ☐ Neuromuscular disorders
   - ☐ Other neurological disorders and thoracic restrictive diseases

19. CPAP/BIPAP *

a. Physician ☐ Pulmonologist ☐ Neurologist ☐ Board certified sleep specialist

b. Patient diagnosis of☐ Obstructive sleep apnea ☐ Upper airway resistance syndrome ☐ Mixed sleep apnea

c. Sleep study recorded for ≥ 360 minutes/6 hours ☐ Yes ☐ No

   OR

   For patients < 6 months old -- sleep study recorded for ≥ 240 minutes/4 hours ☐ Yes ☐ No

d. Sleep study documents
   - ☐ RDI or AHI ≥ 5 per hour ☐ At least 30 apneas/hypopneas found in sleep study
   - ☐ CPAP reduces sleep events by ≥ 50%

   For BIPAP only ☐ Unsuccessful trial of CPAP or ☐ Patient is ≤ 5 years

20. Suction Pump -- Patient unable to clear airway of secretions by cough due to one of the following conditions:
    - ☐ Cancer/surgery of throat ☐ Paralysis of swallowing muscles ☐ Other _____ (specify)
    - ☐ Tracheostomy ☐ Comatose or semi-comatose condition

SECTION IV: MEDICAL APPLIANCES AND SUPPLIES

21. Disposable Diapers *

(Patient meets all of following)

- ☐ ≥ 3 years old, and
- ☐ Patient non-ambulatory or minimally ambulatory (cannot walk 10 feet or more without assistance)

Patient at risk for skin breakdown and has at least two of the following:

- ☐ Unable to control bowel or bladder functions
- ☐ Unable to use regular toilet facilities due to medical condition
- ☐ Unable to physically turn or reposition self
- ☐ Unable to transfer self from bed to chair or wheelchair without assistance

---

22. Augmentative Communication Device

- ☐ Patient is mentally, physically and emotionally capable of operating ACD device
- ☐ Medical evaluation completed within 90 days of request for device and patient has a medical condition which impairs the ability to communicate and ACD device is needed to communicate
- ☐ Patient has evaluation by interdisciplinary team which includes a physician, speech pathologist or PT, OT or social worker.
- ☐ Request is for modification or replacement,and one of the following conditions exist
  Include supporting documentation.
  - ☐ Patient had medical change
  - ☐ ACD no longer under warranty, device does not operate to capacity or repair is no longer cost effective
  - ☐ New technology is significantly meets medical need of client that is not meet with current equipment

---

23. Home Phototherapy

- ☐ Infant is term (≥ 37 weeks of gestation) >48 hours of age and otherwise healthy, and
- ☐ Serum bilirubin levels >12, and
- ☐ Elevated bilirubin levels are not due to a primary liver disorder, and
- ☐ Diagnostic evaluation is negative (see instructions), and
- ☐ Infants' age and bilirubin concentration is <u>one</u> of the following
  - ☐ Infant 25-48 hours of age with serum bilirubin ≥ 12 (170)
  - ☐ Infant 49-72 hours of age with serum bilirubin ≥ 15 (260)
  - ☐ Infant great than 72 hours of age with serum bilirubin ≥ 17 (290)

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24. Alternating Pressure Pad with Pump or Gel or Gel like Pressure Pad for Mattress

- ☐ Patient is bed confined 75 to 100% of the time, and
- ☐ Patient is unable to physically turn or reposition alone, or

- ☐ Patient is medically at risk for skin break down and meets one of the following criteria
  - ☐ Impaired nutritional status defined as BMI ≤ 18.5
  - ☐ Fecal or urinary incontinence
  - ☐ Presence of any stage pressure ulcer on the trunk or pelvis
  - ☐ Compromised circulatory status

AND

- ☐ Documentation of all of the following;
  - ☐ Recipient/caregiver educated on prevention/management of pressure ulcers
  - ☐ Assessment at least every 30 days by a nurse, doctor or other licensed healthcare professional
  - ☐ Recipient/caregiver can perform appropriate positioning and wound care
  - ☐ Recipient/caregiver understands management of moisture/incontinence
  - ☐ Recipient receives nutritional assessment documenting weight, height, BMI and nutritional intake
  - ☐ Compromised circulatory status

- ☐ Patient is unable to physically turn or reposition alone

E.28 Request for National Correct Coding Initiative (NCCI) Administrative Review

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:

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

Form 403
Created 3-21-2011

Alabama Medicaid Agency

Added: Form

NCCI Administrative Review and Fair Hearings
Alabama Medicaid Provider Manual

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under the Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code*.

When a redetermination request results in a denial by the Fiscal Agent, the provider may request an *NCCI administrative review* of the claim. A request for an NCCI administrative review **must be received by the Medicaid Agency within 60 days of the date of the redetermination denial from the Fiscal Agent**.
In addition to a clean claim, the provider must send a copy of the redetermination denial, all relevant Remittance Advices (RAs) and previous correspondence with the Fiscal Agent or the Agency in order to demonstrate a good faith effort at submitting a claim and supporting documentation. This information will be reviewed and a written reply will be sent to the provider.

Send requests for NCCI Administrative Reviews to the following address:

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

NOTE:
If all NCCI administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the NCCI Administrative Review does not result in a favorable decision, the provider may request a fair hearing.

E.29 Request for NCCI Redetermination Review Form

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

Complete ALL Fields Below - Print or Type

ICN #	**Date of Service**
Recipient Name	**Recipient Medicaid Number**
Provider Name	**Provider NPI Number**
NCCI Denial Code(s) **1.** ☐ **2.** ☐ **3.** ☐	
Date of Denial	

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:

_____

_____

_____

Signature of either the provider or his/her representative

Date
Address
City, State and Zip code
Telephone Number, including area code
Signature

E.30 Medicaid Other Insurance Attachment Form

Added: Form

Do not write in this space. Do not use red ink to complete this form.

MEDICAID
OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a. NPI	**Name**	b.
2. Medicaid ID	a.	**Name**	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1.				
2.				
3.				

4**.** Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

F Medicaid Internal Control Numbers (ICN)

HP assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail.

Processing or returning the claim constitutes HP final action on that claim. A resubmission of the same service is considered a new claim.

Each claim sent to HP is assigned an ICN automatically, which is used to track the claim. The ICN is made up of 13 digits following a specific format. The format of the ICN enables you to determine when HP actually received the claim.

Example:	11	07	001	200	001
	Region	Year	Julian Date	Batch Range	Sequence

Region

The first two digits in the ICN are the region code, which identifies the source of the claim. In this case, the term *region* refers to the claim's submission method. The following region codes define the claim's media as well.

Region Code	***Where the Claim Originated***
00	All Claim Regions
10	Paper claims with no attachements
11	Paper claim
20	Electronic claims with no attachments
21	Electronic claims with attachments
22	Web claims
25	Point of service claims
30	Crossover
31	Crossover SNF
40	Converted Region 05 electronic claims
41	Converted Region 10 tape claims
42	Converted Region 22 cap claims (System Generated)
43	Converted Region 33 special batch claims
44	Converted Region 50 online adjustments
45	Converted Region 51 reversals and mass adjustments
46	Converted Region 52 elect provider adjustments
47	Converted Region 98 paper claims
48	Converted Region 07 managed care claims
49	Beneficiary linking claims
50	Adjustments – Non-check related
51	Adjustments – Check related
52	Mass adjustments – Non-check related
53	Mass adjustments – Check related
54	Mass adjustments – Void transaction
55	Mass adjustments – Provider rates
56	Adjustments – Void Non-check related
57	Adjustments – Void Check related

Region Code	*Where the Claim Originated*
58	Adjustments – processed by HP SE
59	POS reversal and internet adjustments
70	Encounters
76	Bene billed spenddown claims
77	Adjustments - encounters
80	Claims reprocessed by HP Systems Engineers
90	Special projects
91	Batches requiring NCCI review
92	HMO copays

Year

The next two digits represent the year. For example, 01 is the year 2001.

Julian Date

The next three digits represent the Julian date. Use the table in this appendix to determine the Julian date.

Batch Range

The next three digits represent the batch range.

Batch Sequence

The last three digits of the ICN represent the sequence in the batch. The Batch sequence is used by Medicaid only.

Julian Date Reference Table - Regular Year

Use this table for years 2013, 2014, 2015, 2017, 2018, 2019, 2021, 2022, and 2023.

1-Jan	1	1-Mar	60	1-May	121	1-Jul	182	1-Sep	244	1-Nov	305
2-Jan	2	2-Mar	61	2-May	122	2-Jul	183	2-Sep	245	2-Nov	306
3-Jan	3	3-Mar	62	3-May	123	3-Jul	184	3-Sep	246	3-Nov	307
4-Jan	4	4-Mar	63	4-May	124	4-Jul	185	4-Sep	247	4-Nov	308
5-Jan	5	5-Mar	64	5-May	125	5-Jul	186	5-Sep	248	5-Nov	309
6-Jan	6	6-Mar	65	6-May	126	6-Jul	187	6-Sep	249	6-Nov	310
7-Jan	7	7-Mar	66	7-May	127	7-Jul	188	7-Sep	250	7-Nov	311
8-Jan	8	8-Mar	67	8-May	128	8-Jul	189	8-Sep	251	8-Nov	312
9-Jan	9	9-Mar	68	9-May	129	9-Jul	190	9-Sep	252	9-Nov	313
10-Jan	10	10-Mar	69	10-May	130	10-Jul	191	10-Sep	253	10-Nov	314
11-Jan	11	11-Mar	70	11-May	131	11-Jul	192	11-Sep	254	11-Nov	315
12-Jan	12	12-Mar	71	12-May	132	12-Jul	193	12-Sep	255	12-Nov	316
13-Jan	13	13-Mar	72	13-May	133	13-Jul	194	13-Sep	256	13-Nov	317
14-Jan	14	14-Mar	73	14-May	134	14-Jul	195	14-Sep	257	14-Nov	318
15-Jan	15	15-Mar	74	15-May	135	15-Jul	196	15-Sep	258	15-Nov	319
16-Jan	16	16-Mar	75	16-May	136	16-Jul	197	16-Sep	259	16-Nov	320
17-Jan	17	17-Mar	76	17-May	137	17-Jul	198	17-Sep	260	17-Nov	321
18-Jan	18	18-Mar	77	18-May	138	18-Jul	199	18-Sep	261	18-Nov	322
19-Jan	19	19-Mar	78	19-May	139	19-Jul	200	19-Sep	262	19-Nov	323
20-Jan	20	20-Mar	79	20-May	140	20-Jul	201	20-Sep	263	20-Nov	324
21-Jan	21	21-Mar	80	21-May	141	21-Jul	202	21-Sep	264	21-Nov	325
22-Jan	22	22-Mar	81	22-May	142	22-Jul	203	22-Sep	265	22-Nov	326
23-Jan	23	23-Mar	82	23-May	143	23-Jul	204	23-Sep	266	23-Nov	327
24-Jan	24	24-Mar	83	24-May	144	24-Jul	205	24-Sep	267	24-Nov	328
25-Jan	25	25-Mar	84	25-May	145	25-Jul	206	25-Sep	268	25-Nov	329
26-Jan	26	26-Mar	85	26-May	146	26-Jul	207	26-Sep	269	26-Nov	330
27-Jan	27	27-Mar	86	27-May	147	27-Jul	208	27-Sep	270	27-Nov	331
28-Jan	28	28-Mar	87	28-May	148	28-Jul	209	28-Sep	271	28-Nov	332
29-Jan	29	29-Mar	88	29-May	149	29-Jul	210	29-Sep	272	29-Nov	333
30-Jan	30	30-Mar	89	30-May	150	30-Jul	211	30-Sep	273	30-Nov	334
31-Jan	31	31-Mar	90	31-May	151	31-Jul	212				
1-Feb	32	1-Apr	91	1-Jun	152	1-Aug	213	1-Oct	274	1-Dec	335
2-Feb	33	2-Apr	92	2-Jun	153	2-Aug	214	2-Oct	275	2-Dec	336
3-Feb	34	3-Apr	93	3-Jun	154	3-Aug	215	3-Oct	276	3-Dec	337
4-Feb	35	4-Apr	94	4-Jun	155	4-Aug	216	4-Oct	277	4-Dec	338
5-Feb	36	5-Apr	95	5-Jun	156	5-Aug	217	5-Oct	278	5-Dec	339
6-Feb	37	6-Apr	96	6-Jun	157	6-Aug	218	6-Oct	279	6-Dec	340
7-Feb	38	7-Apr	97	7-Jun	158	7-Aug	219	7-Oct	280	7-Dec	341
8-Feb	39	8-Apr	98	8-Jun	159	8-Aug	220	8-Oct	281	8-Dec	342
9-Feb	40	9-Apr	99	9-Jun	160	9-Aug	221	9-Oct	282	9-Dec	343
10-Feb	41	10-Apr	100	10-Jun	161	10-Aug	222	10-Oct	283	10-Dec	344
11-Feb	42	11-Apr	101	11-Jun	162	11-Aug	223	11-Oct	284	11-Dec	345
12-Feb	43	12-Apr	102	12-Jun	163	12-Aug	224	12-Oct	285	12-Dec	346
13-Feb	44	13-Apr	103	13-Jun	164	13-Aug	225	13-Oct	286	13-Dec	347
14-Feb	45	14-Apr	104	14-Jun	165	14-Aug	226	14-Oct	287	14-Dec	348
15-Feb	46	15-Apr	105	15-Jun	166	15-Aug	227	15-Oct	288	15-Dec	349
16-Feb	47	16-Apr	106	16-Jun	167	16-Aug	228	16-Oct	289	16-Dec	350
17-Feb	48	17-Apr	107	17-Jun	168	17-Aug	229	17-Oct	290	17-Dec	351
18-Feb	49	18-Apr	108	18-Jun	169	18-Aug	230	18-Oct	291	18-Dec	352
19-Feb	50	19-Apr	109	19-Jun	170	19-Aug	231	19-Oct	292	19-Dec	353
20-Feb	51	20-Apr	110	20-Jun	171	20-Aug	232	20-Oct	293	20-Dec	354
21-Feb	52	21-Apr	111	21-Jun	172	21-Aug	233	21-Oct	294	21-Dec	355
22-Feb	53	22-Apr	112	22-Jun	173	22-Aug	234	22-Oct	295	22-Dec	356
23-Feb	54	23-Apr	113	23-Jun	174	23-Aug	235	23-Oct	296	23-Dec	357
24-Feb	55	24-Apr	114	24-Jun	175	24-Aug	236	24-Oct	297	24-Dec	358
25-Feb	56	25-Apr	115	25-Jun	176	25-Aug	237	25-Oct	298	25-Dec	359
26-Feb	57	26-Apr	116	26-Jun	177	26-Aug	238	26-Oct	299	26-Dec	360
27-Feb	58	27-Apr	117	27-Jun	178	27-Aug	239	27-Oct	300	27-Dec	361
28-Feb	59	28-Apr	118	28-Jun	179	28-Aug	240	28-Oct	301	28-Dec	362
		29-Apr	119	29-Jun	180	29-Aug	241	29-Oct	302	29-Dec	363
		30-Apr	120	30-Jun	181	30-Aug	242	30-Oct	303	30-Dec	364
						31-Aug	243	31-Oct	304	31-Dec	365

Julian Date Reference Table - Leap Year

Use this table for 2012, 2016, 2020, and 2024.

1-Jan	1	1-Mar	61	1-May	122	1-Jul	183	1-Sep	245	1-Nov	306
2-Jan	2	2-Mar	62	2-May	123	2-Jul	184	2-Sep	246	2-Nov	307
3-Jan	3	3-Mar	63	3-May	124	3-Jul	185	3-Sep	247	3-Nov	308
4-Jan	4	4-Mar	64	4-May	125	4-Jul	186	4-Sep	248	4-Nov	309
5-Jan	5	5-Mar	65	5-May	126	5-Jul	187	5-Sep	249	5-Nov	310
6-Jan	6	6-Mar	66	6-May	127	6-Jul	188	6-Sep	250	6-Nov	311
7-Jan	7	7-Mar	67	7-May	128	7-Jul	189	7-Sep	251	7-Nov	312
8-Jan	8	8-Mar	68	8-May	129	8-Jul	190	8-Sep	252	8-Nov	313
9-Jan	9	9-Mar	69	9-May	130	9-Jul	191	9-Sep	253	9-Nov	314
10-Jan	10	10-Mar	70	10-May	131	10-Jul	192	10-Sep	254	10-Nov	315
11-Jan	11	11-Mar	71	11-May	132	11-Jul	193	11-Sep	255	11-Nov	316
12-Jan	12	12-Mar	72	12-May	133	12-Jul	194	12-Sep	256	12-Nov	317
13-Jan	13	13-Mar	73	13-May	134	13-Jul	195	13-Sep	257	13-Nov	318
14-Jan	14	14-Mar	74	14-May	135	14-Jul	196	14-Sep	258	14-Nov	319
15-Jan	15	15-Mar	75	15-May	136	15-Jul	197	15-Sep	259	15-Nov	320
16-Jan	16	16-Mar	76	16-May	137	16-Jul	198	16-Sep	260	16-Nov	321
17-Jan	17	17-Mar	77	17-May	138	17-Jul	199	17-Sep	261	17-Nov	322
18-Jan	18	18-Mar	78	18-May	139	18-Jul	200	18-Sep	262	18-Nov	323
19-Jan	19	19-Mar	79	19-May	140	19-Jul	201	19-Sep	263	19-Nov	324
20-Jan	20	20-Mar	80	20-May	141	20-Jul	202	20-Sep	264	20-Nov	325
21-Jan	21	21-Mar	81	21-May	142	21-Jul	203	21-Sep	265	21-Nov	326
22-Jan	22	22-Mar	82	22-May	143	22-Jul	204	22-Sep	266	22-Nov	327
23-Jan	23	23-Mar	83	23-May	144	23-Jul	205	23-Sep	267	23-Nov	328
24-Jan	24	24-Mar	84	24-May	145	24-Jul	206	24-Sep	268	24-Nov	329
25-Jan	25	25-Mar	85	25-May	146	25-Jul	207	25-Sep	269	25-Nov	330
26-Jan	26	26-Mar	86	26-May	147	26-Jul	208	26-Sep	270	26-Nov	331
27-Jan	27	27-Mar	87	27-May	148	27-Jul	209	27-Sep	271	27-Nov	332
28-Jan	28	28-Mar	88	28-May	149	28-Jul	210	28-Sep	272	28-Nov	333
29-Jan	29	29-Mar	89	29-May	150	29-Jul	211	29-Sep	273	29-Nov	334
30-Jan	30	30-Mar	90	30-May	151	30-Jul	212	30-Sep	274	30-Nov	335
31-Jan	31	31-Mar	91	31-May	152	31-Jul	213				
1-Feb	32	1-Apr	92	1-Jun	153	1-Aug	214	1-Oct	275	1-Dec	336
2-Feb	33	2-Apr	93	2-Jun	154	2-Aug	215	2-Oct	276	2-Dec	337
3-Feb	34	3-Apr	94	3-Jun	155	3-Aug	216	3-Oct	277	3-Dec	338
4-Feb	35	4-Apr	95	4-Jun	156	4-Aug	217	4-Oct	278	4-Dec	339
5-Feb	36	5-Apr	96	5-Jun	157	5-Aug	218	5-Oct	279	5-Dec	340
6-Feb	37	6-Apr	97	6-Jun	158	6-Aug	219	6-Oct	280	6-Dec	341
7-Feb	38	7-Apr	98	7-Jun	159	7-Aug	220	7-Oct	281	7-Dec	342
8-Feb	39	8-Apr	99	8-Jun	160	8-Aug	221	8-Oct	282	8-Dec	343
9-Feb	40	9-Apr	100	9-Jun	161	9-Aug	222	9-Oct	283	9-Dec	344
10-Feb	41	10-Apr	101	10-Jun	162	10-Aug	223	10-Oct	284	10-Dec	345
11-Feb	42	11-Apr	102	11-Jun	163	11-Aug	224	11-Oct	285	11-Dec	346
12-Feb	43	12-Apr	103	12-Jun	164	12-Aug	225	12-Oct	286	12-Dec	347
13-Feb	44	13-Apr	104	13-Jun	165	13-Aug	226	13-Oct	287	13-Dec	348
14-Feb	45	14-Apr	105	14-Jun	166	14-Aug	227	14-Oct	288	14-Dec	349
15-Feb	46	15-Apr	106	15-Jun	167	15-Aug	228	15-Oct	289	15-Dec	350
16-Feb	47	16-Apr	107	16-Jun	168	16-Aug	229	16-Oct	290	16-Dec	351
17-Feb	48	17-Apr	108	17-Jun	169	17-Aug	230	17-Oct	291	17-Dec	352
18-Feb	49	18-Apr	109	18-Jun	170	18-Aug	231	18-Oct	292	18-Dec	353
19-Feb	50	19-Apr	110	19-Jun	171	19-Aug	232	19-Oct	293	19-Dec	354
20-Feb	51	20-Apr	111	20-Jun	172	20-Aug	233	20-Oct	294	20-Dec	355
21-Feb	52	21-Apr	112	21-Jun	173	21-Aug	234	21-Oct	295	21-Dec	356
22-Feb	53	22-Apr	113	22-Jun	174	22-Aug	235	22-Oct	296	22-Dec	357
23-Feb	54	23-Apr	114	23-Jun	175	23-Aug	236	23-Oct	297	23-Dec	358
24-Feb	55	24-Apr	115	24-Jun	176	24-Aug	237	24-Oct	298	24-Dec	359
25-Feb	56	25-Apr	116	25-Jun	177	25-Aug	238	25-Oct	299	25-Dec	360
26-Feb	57	26-Apr	117	26-Jun	178	26-Aug	239	26-Oct	300	26-Dec	361
27-Feb	58	27-Apr	118	27-Jun	179	27-Aug	240	27-Oct	301	27-Dec	362
28-Feb	59	28-Apr	119	28-Jun	180	28-Aug	241	28-Oct	302	28-Dec	363
29-Feb	60	29-Apr	120	29-Jun	181	29-Aug	242	29-Oct	303	29-Dec	364
		30-Apr	121	30-Jun	182	30-Aug	243	30-Oct	304	30-Dec	365
						31-Aug	244	31-Oct	305	31-Dec	366

G Non-Emergency Transportation (NET) Program

The Non-Emergency Transportation (NET) Program provides necessary non-ambulance transportation services to Medicaid recipients. Medicaid pays for rides to a doctor or clinic for medical care or treatment that is covered by Medicaid.

The NET Program has the responsibility to ensure that non-emergency transportation services are provided in the manner described below:

- Similar in scope and duration state-wide, although there will be some variation depending on resources available in a particular geographical location of the state
- Consistent with the best interest of recipients
- Appropriate to available services, geographic location and limitations of recipients
- Prompt, cost-effective, and efficient

Coordinators in the NET Program have the following responsibilities:

- Determine availability of free transportation, including recipient's vehicle, transportation by relative or friend, or volunteer services. Medicaid will not reimburse services if recipient has access to free transportation, except in the case of evident hardship (determined by Alabama Medicaid).
- Establish eligibility (Medicaid does not reimburse for non-eligible transportation services)
- Determine medical necessity for transportation services
- Determine the least costly means of transportation services
- Coordinate in-state and out-of-state commercial bus, train, or air transportation; Medicaid may approve the use of commercial buses, trains or airplanes for in-state and out-of-state use for Medicaid recipients in special circumstances.

Prior Authorization for NET Program

All payments for NET services require prior authorization with the exception of the services listed in Chapter 8, Ambulance, Section 8.2.2, Non-Emergency Ambulance Services, and those services requiring urgent care.

Urgent care is defined as medical care that is required after normal business hours. Requests for reimbursements for Non-Emergency Transportation as a result of urgent care must be made the first business day after the need for transportation occurs.

Medicaid may issue a travel reimbursement for the cost of fare to recipients who are able to ride public transportation to medical services. Recipients should use public transportation whenever possible. Coordinators should determine that public transportation does not meet the recipient's needs before Medicaid authorizes other modes of transportation.

Recipients who request out-of-state transportation to medical facilities must have a physician send Medicaid a physician's statement that justifies the need for out-of-state services and assures that such services cannot be obtained in-state.

G.1 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

This section explains benefits the NET Program offers to eligible recipients and limitations of NET services.

Escorts

An escort is an individual who is not an employee of a NET transporter and whose presence is required to assist a recipient during transport while at the place of treatment. An escort is typically a relative, guardian, or volunteer. Only one escort is covered per recipient in need, and the recipient must prove an identifiable need for the escort.

Medicaid allows escorts for recipients under the age of 21. Escort Services are utilized in-state or out-of-state for recipients over 21 years of age. A recipient age 21 or older that requests an escort must submit a medical certification statement before Medicaid will reimburse the claim. The certification must document that the recipient has a physical or mental disability that would require assistance, such as the following:

- Blindness
- Deafness
- Mental retardation
- Mental illness
- Physical handicap to a degree that personal assistance is necessary

Covered Services

The NET Program may be used for the following medical services:

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Inpatient hospital care
- Outpatient hospital care
- Physician services
- Diagnostic devices (for example, x-ray and laboratory)

- Clinic services (family planning, rural health, and community mental health)
- Dental services
- Orthotic and prosthetic services
- Eye care
- Transportation provided by relatives or individuals living in the same household with the Medicaid recipient
- Transportation provided in the Medicaid recipient's vehicle or relative's vehicle

NOTE:

Medicaid reimburses transportation service to a physician's office through the NET Program only when prior authorized.

NET Resources

NET services include the following resources when the recipient requires medical care and has no other transportation resources. Coordinators must use the most inexpensive mode of transportation that meets the recipient's needs.

- Automobile (volunteer driver) - Medicaid encourages multiple passenger transportation. Volunteer drivers can be reimbursed for transport from the recipient's home (or place of admission or discharge) and return, unless Medicaid determines paying for additional mileage is the most economical transportation.
- Minibus
- Wheelchair vans - Escorts are allowed for wheelchair vans when prior approved by Medicaid.
- Bus (commercial or city transit) – This service may be provided in-state or out-of-state.
- Airplane transportation
- Train service
- Escort services for minibus, automobile, commercial bus, train, and airplane transportation - Escort services for commercial bus, train, and airplane transportation are reimbursed for the actual cost of the bus, train, or plane ticket.
- Meals and lodging for the recipient and one escort, when required, during overnight travel

Meals and Lodging

When overnight travel is necessary, Medicaid pays for meals and lodging for the recipient and one escort (when authorized). Medicaid must receive receipts or confirmation of expenses before reimbursement can be made. Reimbursement will not exceed $50 per person, per day.

Non-Covered Services

The NET program does not cover the following services:

- Any travel when the Medicaid recipient is not an occupant of the vehicle, unless that would be the most economical transportation available
- Meals and lodging for volunteer drivers
- The use of supplies such as oxygen and intravenous fluids
- Transportation for any services other than those covered by Medicaid
- Transportation provided after the death of a Medicaid recipient
- Minibus or wheelchair van travel 30 miles outside the state line
- Services for which prior approval is required but is not obtained
- Services that are not medically necessary or that are not provided in compliance with the provision of this chapter

G.2 Frequently Asked Questions

This section is intended to help NET program providers answer questions frequently asked by Medicaid recipients.

What is Non-Emergency Transportation?

Medicaid's NET program is set up to help pay for rides to and from a doctor's office, clinic, or other place for medical care that can be planned ahead of time. This ride can be in a car, bus, or van and can be given by a friend, neighbor, or family member. You can also get a ride on a city bus or from a group in your town or area.

Who can get a ride?

For Medicaid to pay for a ride, the person who is going to the doctor or clinic must be covered by Medicaid for the visit they are going to make and should be approved for the ride ahead of time.

How does the program work?

For Medicaid to pay for a ride, you (or someone who is helping you) will need to call Medicaid's toll-free number at 1-800-362-1504. When you call, the operator will ask you for some information to make sure you are covered by Medicaid and also about your need for a ride. This information will be used to decide if Medicaid can pay for your ride. The NET hotline is open from 8:00 a.m. to 4:00 p.m., Monday through Friday, except on state holidays.

What do I do?

You must first try to get a ride on your own. If you are approved for a ride, you will be told about people or groups in your areas who can help you get a ride for little or no cost.

If the people or groups in your community who usually give you a ride cannot give you a ride, then call the toll-free hotline to speak to an operator. The operator will try to help you. In some cases, a special Medicaid worker may work with you if you have to go for a lot of medical care or treatment (like kidney dialysis or cancer treatments).

What if I have an emergency?

If you have an emergency, call 911 (or the emergency number in your town) to reach an ambulance or paramedics who can help you. Medicaid covers ambulance rides when there is an emergency, such as when someone stops breathing or has been badly hurt.

What do I do if I have a medical problem that can't wait?

A medical problem that must be treated right away, but does not cause your life to be in danger is called an "urgent" medical problem. Broken arms, a bad cut, a baby with a bad earache, or mild chest pains are examples of "urgent" problems.

If you have to pay someone to take you to the emergency room or doctor's office after hours because of an "urgent" problem, you need to call Medicaid's toll-free hotline as soon as possible after the visit to apply for payment. Medicaid pays for the ride to the emergency room only if the visit is for an "urgent" medical problem. Medicaid does not pay for a ride to the emergency room for a problem that can wait until the doctor's office or clinic is open.

How much will Medicaid pay for a ride?

Medicaid pays what is reasonable and necessary to make sure you get the medical care you need. If you have questions about this, ask your operator when you call the toll-free number.

What do I do if I have to pay for a ride to see the doctor on the weekend?

Call the toll-free number the next working day after the ride. Tell the operator where you went for care and why you need help in paying for your ride. Depending on what happened, you might be able to get payment for a ride you had to pay for.

Will Medicaid pay for someone to go with me?

Medicaid pays for an escort for a child or for an adult who is unable to go alone because of a physical or mental disability.

How many rides will Medicaid pay for?

Medicaid pays for rides only to a doctor or clinic for medical care or treatment that is covered by Medicaid. For example, once you use up all of your doctor visits for the year, Medicaid will not pay for rides to any doctor visits.

How will Medicaid pay for my ride?

If your ride is approved, Medicaid will send your reimbursement through an Electronic Benefit Transfer (EBT). Once your transportation request to a Medicaid covered service/provider has been verified by a NET worker, your reimbursement will be loaded to an EBT (plastic) card. The EBT card can only be used at stores that display the Quest logo for cash withdrawal or cash purchase transactions.

If you have been approved for transportation reimbursements, an EBT card personalized with your information, along with a training brochure with detailed information on how to use the system, will be mailed to you. The EBT card must be PIN activated **before** it can be used to make cash withdrawals or cash purchases.

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H Alabama Medicaid Physician Administered Drugs

Effective October 1, 2010, the NDC is required on all physician-administered drugs in J, S, and Q code ranges. Physician-administered drugs include any covered outpatient drug billed either electronically or on paper CMS-1500 or UB-04 claim forms.

H.1 Policy

H.1.1 Injections

Medicaid covers physician drugs when billed by a physician using the new list of approved HCPCS codes.

The HCPCs drug codes are intended for use in Physician office and Outpatient billing of manufactured medications given in each respective place of service. The Alabama Medicaid Agency only reimburses for compounded medications by the billing of NDC numbers through the Pharmacy Program directives.

Appropriate administration code(s) in the Current Procedural Terminology (CPT) may be billed in addition to the HCPCS drug codes and office visit codes for the same date of service. Please refer to the following section "Evaluation and Management Codes Billed in Conjuction With Drug Administration Codes" for details concerning office visits, chemotherapy administration, hydration therapy and chemotherapy, and date specific changes.

Pricing of Physician Administered Drugs

For Dates of Service prior to July 1, 2005, physician drug prices were updated semi-annually by HP. Medicaid reimbursement was calculated by averaging the Average Wholesale Prices (AWP) from the *Red Book or 80-95% of DIMA (Drug, Improvement, and Modernization Act).*

Effective for Dates of Service July 1, 2005 and thereafter, the Alabama Medicaid Agency adopted Medicare's Drug Pricing Methodology using the Average Sale Price (ASP) for HCPCS injectable drug codes.

Compound Drugs for Non-Pharmacy Providers

The compound drug must not be commercially available, and the active ingredient of the compound drug must follow coverage policy of drugs (FDA approved, non-DESI, not obsolete, etc).

When a provider administers a drug that must be purchased from a compounding pharmacy because it is no longer commercially available (e.g. due to the manufacturer no longer marketing the product), the applicable claim form may be submitted for consideration of payment. 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.

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, 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 the section entitled “Calculation of Billing Units and Wastage” for information on calculating billing units.

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.

Mandatory National Drug Codes (NDC) for ALL Physician Administered Drugs

In compliance with the Deficit Reduction Act (DRA) of 2005, Alabama Medicaid (AMA) began accepting and later began requiring the NDC number for the top 20+ physician-administered multiple source drugs. Information on this requirement may be found in the July 2008 and April 2009 issues of the Provider Insider on the Agency’s website.

Effective October 1, 2010, the NDC number became 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 a paper CMS-1500 or UB-04 claim forms. This is for both straight Medicaid and Medicare/Medicaid crossover claims. The 11-digit NDC submitted must be the actual NDC number on the package or container from which the medicine was administered. The NDC is a number that identifies a prescription drug.

Medicaid provided a **grace period from August 15, 2010 to September 30, 2010**, to allow providers sufficient time to acclimate to the change. During this grace period, Medicaid validated the data and set informational denial codes, but DID NOT deny the claim.

This requirement applies to:

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

This requirement does **NOT** apply to:

- 340B Providers enrolled on the HHS website
- Vaccines or other drugs in the CPT code ranges 01000 – 99999.
- HCPCS that do not have an NDC
- HCPCS that are considered devices
- HCPCS that are considered radiopharmaceuticals
- 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

To identify if a product is a drug, look for these three items:

1. NDC - Number located on the package or container of the drug
2. Lot and Expiration Date - All drugs have both a lot number and expiration date on the vial or container
3. Legend - This refers to statements such as, “Caution; Federal law prohibits dispensing without prescription, “Rx only” or similar words. All prescription drugs have these types of statements

As this process is to facilitate Medicaid drug rebates from manufactures for physician-administered drugs, providers are required to utilize drugs manufactured by companies who hold a federal rebate agreement. These NDCs will be the only ones Medicaid will cover for payment. A link to a list of those drug manufacturers who hold a federal rebate agreement, as well as their labeler codes (the first 5 digits of the NDC number), are available on the Medicaid website at: 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.

The Alabama Medicaid Agency implemented a Drug Lookup System effective October 5, 2010. The system allows non-pharmacy providers needing NDC information for the billing of HCPCS codes to search for drugs by drug name or NDC and will display coverage information. Providers can access the Drug Lookup feature by visiting the Alabama Medicaid website and clicking on the following link: https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx .

Please note that the information found on the drug look up website applies to pharmacy claims only (i.e: pricing, PA requirements, and maximum quantity limits).

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

Multiple NDCs for a Single HCPCS Drug Code

At times it may be necessary for providers to report multiple NDCs for a single procedure code. If two or more NDCs are to be submitted for a procedure code, the procedure code must be repeated on separate lines for each unique NDC. On the first line, the procedure code, NDC and procedure quantity are reported with a **KP modifier** (first drug of a multi drug). On the second line, the procedure code, NDC and procedure quantity are reported with a **KQ modifier** (second/subsequent drug of a multi drug). When reporting more than two NDCs per procedure code, the KQ modifier is also used on the subsequent lines.

Unclassified Drugs

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

- J3490 - Unclassified Drugs
- J3590- Unclassified Biologics
- J9999 - Not otherwise classified, antineoplastic drugs.

Added: red drop-out, total

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

Added: The Alabama Medicaid…amount of medication.

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

Breathing/Inhalation Treatment: J2545 Pentamidine Isethionate (Nebupent)

Current coverage policy for breathing or inhalation treatments utilizing drugs such as Albuterol does not allow for the drug to be billed for separately as it is considered a component of the treatment charge. The exception to this policy is the administration of Pentamidine Isethionate.

Pentamidine isethionate (J2545), given by inhalation, is an anti-microbial agent specifically indicated for the prevention of Pneumocystis carinii pneumonia (PCP) in high-risk HIV infected patients. Administration of Pentamidine is done via the Respirgard II nebulizer which utilizes a series of one-way valves and a filter to minimize the release of aerosol droplets into the air. CPT code 94642 (aerosol inhalation of Pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis) is the appropriate code to bill for administration of the drug. This therapy is

generally given on a monthly basis and given in the hospital or clinic/office by a health care professional. The administration code does not include the cost of the drug. The inhalation drug code and the administration of the drug should both be reported on the same claim, same date of service.

340B Drug Pricing

The Veterans Health Care Act of 1992 enacted section 340 B of the Public Health Services Act, "Limitation on Prices of Drugs Purchased by Covered Entities". This Section provides that a manufacturer who sells covered outpatient drugs to eligible 340B entities must sign a pharmaceutical pricing agreement with the Secretary of Health and Human Services in which the manufacturer agrees to charge to Medicaid a price for covered outpatient drugs that will not exceed the average manufacturer price decreased by a rebate percentage.

Eligible 340B entities are defined in 42 U.S.C. are defined in 42 U.S.C. § 256b(a)(4).

When an eligible 340B entity, other than a disproportionate share hospital, a children's hospital excluded from the Medicare prospective payment system, a free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital, submits a bill to the Medicaid Agency for a drug purchased by or on behalf of a Medicaid recipient, the amount billed shall not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus the dispensing fee established by the Medicaid Agency.

A disproportionate share hospital, children's hospital excluded from the Medicare prospective payment system, free-standing cancer hospital exempt from the Medicare prospective payment system, sole community hospital, rural referral center, or critical access hospital may bill Medicaid the total charges for the drug. As manufacturer price changes occur, the entities must ensure that their billings are updated accordingly.

Eligible 340B entities are identified on the Department of Health and Human Service's website. These entities shall notify Medicaid of their designation as a 340B provider.

Audits of the eligible 340B entities' (claims submissions and invoices) will be conducted by the Medicaid Agency. Eligible 340B entities, other than the providers listed above, must be able to verify acquisition costs through review of actual invoices for the time frame specified. Charges to Medicaid in excess of the actual invoice costs will be subject to recoupment by the Medicaid Agency in accordance with Chapter 33 of the Administrative Code.

Medicare/Medicaid Drugs

Medicare Part B covers some drugs in a physician's office. If the recipient is dually eligible for Medicare and Medicaid, the Drug code as required by Medicare should be billed first to Medicare. The claim should crossover to Medicaid for consideration of payment. If the claim does not crossover to Medicaid, providers will need to submit the appropriate HCPCS code to Medicaid on a Medical Medicaid/Medicare Related Claim (aka Crossover Form 340) with Medicare allowance/payment/coinsurance/ and deductible.

Medicare Part D drugs are a pharmacy benefit and should not be billed to Medicaid by physicians or outpatient facilities. Part D drugs are billed to Medicare on a pharmacy claim with the NDC number.

Not all drugs listed on the Physician Drug Fee Schedule are considered Part B drugs. Self Administered drugs are generally considered non-covered for Part B benefits. Coverage of Physician Drugs may be found on Medicaid's website at www.medicaid.alabama.gov or by AVRS or Provider Assistance Center at 1-800-688-7989.

Site-Specific Injections

Both the relevant CPT and J codes are billed. For example, a subconjunctival injection to the eye would be billed as 68200 (CPT) with a separate J code for the drug; thus, site specific injections are submitted as two lines.

EVALUATION AND MANAGEMENT CODES BILLED IN CONJUNCTION WITH DRUG ADMINISTRATION CODES

Effective for Dates of Service 01/01/2006 and Thereafter

When an Evaluation and Management service is provided *and* a Drug Administration code (96372, 96373, 96374, 96375 and 96376) is provided at the same time, the E & M code, Drug Administration Code, and the HCPCs Code for the drug may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with the Drug Administration code for consideration of payment for the Evaluation and Management Code. A **Modifier 25** must be appended to the E&M service for recognition as a "**Significant Separately Identifiable Service".** Medical Record documentation must support the medical necessity of the visit as well as the level of care provided.

However, when no **Significant Separately Identifiable** E & M service is actually provided at the time of a Drug Administration, an E & M code should not be billed. In this instance, the Drug Administration Code and the HCPCs Code for the drug may be billed. An example of this is routine monthly injections like B-12, iron, or Depo-Provera given on a regular basis without a **Significant Separately Identifiable** E & M service being provided.

When an Evaluation and Management service is provided and an Administration Code for Hydration (96360, 96361), Therapeutic, Prophylactic, and Diagnostic Infusion (96365, 96366, 96367 and 96368) and Chemotherapy Administration Code (96401-96542) is provided at the same time/encounter, the E&M code and Administration code may be billed. A **Significant Separately Identifiable Service** must be performed in conjunction with these administration codes for consideration of payment for the Evaluation and Management Code. A **Modifier 25** must be appended to the E & M service for recognition as a **"Significant Separately Identifiable Service".** Procedure Codes 99211 will not be allowed with Modifier 25 or in conjunction with the administration codes for the same date of service. Medical record documentation must support the medical necessity and level of care of the visit. These services are subject to post payment review.

Chemotherapy Injections

Alabama Medicaid has established the following new guidelines that should be utilized by physicians when billing for administration codes.

- For non-chemotherapy injections, services described by CPT codes 96372, 96374, and 96375may be billed in addition to other physician fee schedule services billed by the same provider on the same day of service.

- For IV infusions and chemotherapy infusions, if a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25.

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.

- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.

- If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are considered separately billable with a modifier 76.

- Medicaid will not pay for chemotherapy administration in a hospital setting, and claims for these codes with modifier 26 will not be recognized.

Please refer to Chapter 19 (Hospitals) for details on chemotherapy administration and infusion therapy.

Procedure Code Changes For Sodium Hyaluronate (Hyaluronan)
The Agency received CMS notification that the following temporary Q codes listed below have been assigned permanent J codes beginning January 1, 2008.

J7321 replaces Q4083 Hyaluronan or Derivative, Hyalgan or Supartz, for intra-articular injection, per dose,
J7322 replaces Q4084 Hyaluronan or Derivative, Synvisc, for intra-articular injection, per dose,
J7323 replaces Q4085 Hyaluronan or Derivative, Euflexxa, for intra-articular injection, per dose, and/or
J7324 replaces Q4086 Hyaluronan or Derivative, Orthovisc, for intra-articular injection, per dose.

Effective January 1, 2010 J7325 replaces J7322. The description has changed to “Hyaluronan or derivative, Synvisc or Synvisc-one, for intra-articular injection, 1mg”.

Please refer to the Physicians’ Drug Fee Schedule on Medicaid’s website at www.medicaid.alabama.gov or call the HP Provider Assistance Center 1-800-688-7989 for reimbursement and guidelines.

Drugs Requiring Prior Authorization

EXAMPLE:

Effective September 1, 2006, injectable drugs Orencia (New Code in 2007 - J0129) and Kineret will require prior authorization as Biologicals through Health Information Designs (HID) prior to treatment. Although kineret has not been assigned HCPCS codes, you must request the Prior Authorization using procedure code J3490. After receiving authorization from HID, a CMS-1500 paper claim must be submitted to HP including the dosage and NDC number. The letter of approval from HID must be attached to the claim, and "attachment" in block 19. These drugs must be approved through HID prior to administering and billing. HID may be contacted at 1-800-748-0130. The Prior Authorization forms are located on our website at www.medicaid.alabama.gov.

Immune Globulin Replacement Codes

The Agency received CMS notification that the following temporary Q codes have been assigned permanent J codes beginning January 1, 2008.

J1568 replaces Q4087 Injection, Immune Globulin, (Octogam), Intravenous, non-lyophilized, (e.g., liquid), 500 mg.
J1569 replaces Q4088 Injection, Immune Globulin, (Gammagard), intravenous, non-lyophilized, (e.g. liquid), 500 mg.
J2791 replaces Q4089 Injection, RHO (D) Immune Globulin (Human), Rhophylac), intravenous, 100 I.U.
J1571 replaces Q4090 Injection, Hepatitis B Immune Globulin (Hepagam B), intramuscular, 0.5 ML
J1572 replaces Q4091 Injection, Immune Globulin, (Flebogamma), intravenous, non-lyophilized, (e.g. liquid) 500 mg.
J1561 replaces Q4092 Injection, Immune Globulin, (Gamunex), intravenous, non-lyophilized, (e.g. liquid), 500 mg.

Please refer to the Physicians' Drug Fee Schedule on Medicaid's website at www.medicaid.alabama.gov or call the HP Provider Assistance Center 1-800-688-7989 for reimbursement and guidelines.

Allergy Treatments

Physicians may bill for antigen services using only the component codes (i.e., the injection only codes 95115 or 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170). Physicians providing only an injection service must bill for only code 95115 or code 95117. Professional services for allergen immunotherapy multiple injections (procedure codes 95117 and 95125) should be billed using only one unit. Effective April 1, 2003, the Agency will deny claims for these procedure codes when more than one unit is billed.

Physicians providing only the antigen/antigen preparation service would bill the appropriate code in the range of 95144 through 95170. Physicians providing both services would bill for both services. This includes allergists who provide both services through the use of treatment boards.

Physicians will no longer use the "complete" service codes, and instead must bill for both the injection and the antigen services separately, even though the current CPT definitions of the antigen codes refer to vials and the physicians using treatment boards do not create vials.

Procedure codes 95144 - 95170 are used for the provision of single or multi-dose vials of allergenic extract for single patient use only. These procedures should only be billed at the time that these vials are supplied to the patient.

In the November 2006 Insider, an article was published to announce a change in the maximum number of allowed units for allergen immunotherapy. Medicaid is providing clarification to guide physicians who bill for the provision of allergen immunotherapy. Medicaid allows billing for the allergen at the time an individual vial is first used for a patient, but not for the entire amount of allergen/dilution prepared for the patient at once as this would likely exceed the maximum number of allowed units.

Procedure Code 95165 represents the preparation of vials of non-venom antigens. The reimbursement for procedure code 95165 is based on preparing a vial containing a mixture of all the appropriate antigens plus diluents and calculating the number of 1/2cc billing units in the vial. Using this calculation, a 10cc vial would yield 20 billing units.

Therefore, one-half (1/2) cc equals one (1) billing unit. The actual number of doses received by a patient may differ significantly from the number of billing units. If a physician removes 1/2cc billing units from a 10cc multidose vial, and 20 billing units are obtained from one vial, he/she will still bill Medicaid for 20 billing units (aliquots). Billing for more than 20 billing units per 10cc vial would represent an overpayment and be subject to post payment review and adjustment.

When a multidose vial contains less than 10cc, physicians should bill Medicaid for the number of 1/2cc billing units that may be removed from the vial. If a physician prepares two 10cc vials containing **different allergens**, he/she may bill Medicaid for a total of 40 billing units (20 billing units per vial).

The maximum number of billable units (two-10cc vials) for procedure code 95165 was set as “20” effective November 1, 2006. If multiple vials are prepared at one time, each vial should be billed when that vial is opened for use for the patient. Administration of vaccine may continue to be billed as each dose is given in the physician’s office. Medical record documentation must clearly support the treatment plan, each vial used, antigens, dosage, and changes in the treatment regime.

Claims exceeding 20 billing units (such as two 10cc vials containing different allergens) will require manual processing by sending a clean claim with medical justification, medical records, and supporting fact based documentation to:

Alabama Medicaid Agency
P.O. Box 5624
Montgomery, Alabama, 36104
Attention: Medical Support Programs

Calculation of Billing Units and Wastage

HCPCS code for J0587 reads “per 100 units”. Therefore, 100 units of J0587 will equal one billing unit. However, because of the expense of the drug, physicians are encouraged to schedule patients in a manner that they can use botulinum toxin most efficiently. For example, a physician schedules three patients requiring botulinum toxin type A on the same day within the designated shelf life of the drug (shelf life is four hours). The physician administers 30 units to all three patients and bills 30 units for the first two patients and 40 units for the last patient. The physician would bill 40 units for the last patient because the patient received 30 units but the physician had to discard 10 units.

HCPCS code for J0585 reads “per unit”. Therefore this code requires the units of service on the claim to reflect the number of units used. However, if a physician must discard the remainder of a single does vial (sdv) after administering it to a patient, the Agency will cover the amount of the drug discarded along with the amount administered. For example, a physician administers 15 units of botulinum toxin type A and it is not practical to schedule another patient who requires botulinum toxin. Situations that are impractical to schedule another patient include (a) it is the first time the physician has seen the patient and did not know the patient’s condition or (b) the physician has no other patients who require botulinum toxin injections.

Documentation requirements must include the exact dosage of the drug given and the exact amount of the discarded portion in the patient’s medical record as well as the corresponding diagnosis. However, if no benefit is demonstrable by two sets of injections, further injections will not be considered medically necessary.

Modifier JW

The Agency supports the avoidance of wasted (discarded) medicine whenever possible. Medicare requests the use of modifier JW on a second line item to indicate the wasted (discarded) amount of medication. Medicaid accepts the use of modifier JW, but total units must not exceed maximum number of allowed units.

Units of Service

Physician drug maximum number of units allowed are calculated based on a “per dose” basis, and by the narrative description of the HCPCS code. Some dosages are inherent in the narrative description of the codes and will assist in determining the number of units to file. When administering a lesser or greater dosage than the narrative description providers should round the billing unit up to the closest amount charted. For example, J0290, Ampicillin, up to 500 mg:

If administering 1000mg, bill 2 units

750 mg, bill 2 units

500 mg, bill 1 unit

125 mg, bill 1 unit

Exception: Bicillin CR and Bicillin LA

Effective January 1, 2011, Bicillin CR and Bicillin LA will be priced on a 100,000 unit per ML basis. As well, the HCPCS codes have been condensed into two vs. six codes:

If administering Bicillin CR, bill J0558 (replaces J0530, J0540 and J0550)

If administering Bicillin LA, bill J0561 (replaces J0560, 05670 and J0580)

One of the two HCPCS codes should be chosen based on the drug description. The number of billing units would then be derived by dividing the dosage by 100,000 units. Fractions of billing units are rounded up to the next whole unit.

Example: If the dosage of Bicillin LA is 1,800,000 units, choose the appropriate procedure code. In this case procedure code J0561 is the appropriate code to be used. Next, take the dosage given (1,800,000 units) and divide by 100,000 units to obtain the billing units. This dosage would yield 18 billing units (1,800,000 /100,000 = 18 units) for code J0561.

Flu Vaccination

Procedure code 90657 is covered for the administration fee under the Vaccine for Children (VFC) program for eligible children under three years of age. Procedure codes 90656 and 90658 are a covered service for the administration fee under the VFC program from age three through age eighteen. Code 90658 is covered fee-for-service (vaccine medication) from age nineteen and above.

Vaccines for Children (VFC)

The Vaccines for Children (VFC) program offers free vaccines to qualified health care providers for children who are 18 years of age and under who are Medicaid eligible, uninsured, American Indian or Alaskan Native, or the under insured. Providers must be enrolled in the VFC Program to receive any reimbursement for the administration of immunizations provided to recipients 0-18 years of age. The Alabama Department of Public Health administers this program.

Medicaid tracks usage of the vaccine through billing of the administration fee using CPT codes. Refer to Section A.6, Vaccines for Children, in the EPSDT Chapter 6 (Appendix A) in this manual, for covered CPT codes.

ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us for more information.

Adult Immunizations

Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service. Immunizations that are provided to Medicaid eligible recipients 19 years old and older must submit a claim for the appropriate CPT code. Vaccines are reimbursable on a fee-for-service basis. The administration fee may be billed separately if an office visit is not billed.

H.2 Physician Drug Fee Schedule

Physician Adminstered Drugs are those that are administered in the Physician's office or outpatient facility. A covered outpatient drug is broadly defined as a drug that may be dispensed only upon prescription and is approved for safety and effectiveness by the FDA. Physician administered drugs are not restricted to injectable drugs only but include any drug regardless of the method of administration.

The inclusion or exclusion of a procedure code does not imply Medicaid coverage, reimbursement, or lack thereof. To inquire regarding any restrictions/limits on these procedure codes, please consult the Provider Assistance Center at 1-800-688-7989 or AVRS at 1-800-727-7848. The pricing file must be verified to determine coverage and reimbursement amounts.

Deleted: ~~http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6~~

The Physician Drug Fee Schedule is located on the Alabama Medicaid website and can be accessed by clicking the following link: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

Added: http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

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I ASC Procedures List

These CPT codes are currently covered for outpatient hospital and ambulatory surgical centers billing.

NOTE:

The following list is used for scheduling Medicaid recipients for outpatient surgeries. Occasionally Medicaid recipients question what procedures Medicaid covers.

Before performing any procedure, providers need to inform the recipient that the recipient is responsible for payment of services that Medicaid does not cover.

Use the AVRS line at HP (1(800) 727-7848) to verify if it is a covered procedure code. Submit requests to add procedure codes to this list in writing to the Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624, Attention: Medical Services Division.

An" X" in the PA column indicates that the procedure requires prior authorization. Mail your written request for prior authorization and supporting documentation of extenuating circumstances and the procedure code to HP, Attn: Prior Authorization; P O Box 244032; Montgomery, AL 36124-4032.

An "X" in the Under 21 column indicates that the procedure requires an EPSDT referral or is for QMB recipients only.

NOTE:

Benefit limits may also apply in addition to the hard-coded maximum units.

A dollar amount in the 'Maximum Allowed Amount' column indicates the maximum amount Medicaid will reimburse for the procedure code listed.

The inclusion or exclusion of a procedure code on the ASC Procedures List does not imply Medicaid coverage or reimbursement. The pricing file must be verified to determine coverage and reimbursement amounts for the specific date of service. ASCs may bill surgical procedures within the range of 10000 - 69XXX as well as the dental code D9420. Hospitals may bill these codes as well as other codes listed on the Outpatient Fee Schedule located on the Medicaid website. (www.medicaid.alabama.gov).

Effective for dates of service February 15, 2010, ASC's will be reimbursed at 90% of the maximum allowed amount on this fee schedule.

Appendix I as of 06/11/2013

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
10060	$184.29		1	X	31830	$246.67		1	
10061	$246.67		1		32400	$184.29		1	
10120	$184.29		1		32405	$184.29		1	
10121	$184.29		1		32550	$184.29		1	
10140	$246.67		1	X	32551	$246.67		1	
10180	$184.29		1		32552	$184.29		1	
11010	$184.29		1		32553	$283.53		1	
11011	$184.29		1		32554	$246.67		1	
11012	$246.67		1		32555	$246.67		1	
11042	$184.29		1	X	32556	$246.67		1	
11043	$246.67		1		32557	$246.67		1	
11044	$246.67		1		32560	$246.67		1	
11055	$184.29		1	X	32561	$246.67		1	
11056	$184.29		1	X	32562	$246.67		1	
11057	$184.29		1	X	32601	$198.02		1	
11100	$184.29		1	X	32604	$246.67		1	
11200	$184.29		1	X	32606	$246.67		1	
11400	$184.29		1	X	32650	$283.53		1	
11401	$184.29		1	X	32651	$283.53		1	
11402	$184.29		1	X	32652	$283.53		1	
11403	$184.29		1		32653	$283.53		1	
11404	$184.29		1		32654	$283.53		1	
11406	$246.67		1		32655	$283.53		1	
11420	$184.29		1	X	32656	$283.53		1	
11421	$184.29		1	X	32658	$283.53		1	
11422	$184.29		1	X	32659	$283.53		1	
11423	$184.29		1	X	32661	$283.53		1	
11424	$184.29		1		32662	$283.53		1	
11426	$184.29		1		32663	$283.53		1	
11440	$184.29		1	X	32664	$283.53		1	
11441	$184.29		1	X	32665	$283.53		1	
11442	$184.29		1	X	32701	$283.53		1	
11443	$184.29		1	X	32997	$246.67		1	
11444	$184.29		1		33010	$246.67		1	
11446	$184.29		3		33011	$246.67		1	
11450	$184.29		2		33206	$246.67		1	
11451	$184.29		2		33207	$246.67		1	
11462	$184.29		2		33208	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
11463	$184.29		2		33210	$246.67		1	
11470	$246.67		1		33211	$246.67		1	
11471	$246.67		2		33212	$283.53		1	
11600	$184.29		1	X	33213	$283.53		1	
11601	$184.29		1	X	33214	$246.67		1	
11602	$184.29		1	X	33215	$246.67		1	
11603	$184.29		1	X	33216	$246.67		1	
11604	$184.29		1		33217	$246.67		1	
11606	$184.29		1		33218	$246.67		1	
11620	$184.29		1	X	33220	$246.67		1	
11621	$184.29		1	X	33221	$283.53		1	
11622	$184.29		1	X	33222	$246.67		1	
11623	$184.29		1	X	33223	$246.67		1	
11624	$184.29		1		33224	$246.67		1	
11626	$184.29		1		33226	$246.67		1	
11640	$184.29		1	X	33227	$397.66		1	
11641	$184.29		1	X	33228	$397.66		1	
11642	$184.29		1	X	33229	$397.66		1	
11643	$184.29		1	X	33230	$246.67		1	
11644	$184.29		1		33231	$246.67		1	
11646	$184.29		1		33233	$246.67		1	
11720	$184.29		1	X	33234	$246.67		1	
11730	$184.29		1	X	33235	$246.67		1	
11750	$184.29		1		33241	$246.67		1	
11752	$184.29		1	X	33244	$246.67		1	
11760	$184.29		1	X	33249	$246.67		1	
11762	$184.29		1	X	33262	$397.66		1	
11770	$283.53		1		33263	$397.66		1	
11771	$283.53		1		33264	$397.66		1	
11772	$283.53		1		33282	$184.29		1	
11960	$246.67		3		33284	$184.29		1	
11970	$246.67	YES	2		34101	$184.29		1	
11971	$184.29	YES	2		34111	$184.29		1	
11981	$184.29		1		34201	$184.29		1	
11982	$184.29		1		34203	$184.29		1	
11983	$184.29		1		34421	$184.29		1	
12002	$184.29		1	X	34471	$184.29		1	
12005	$184.29		1		34490	$184.29		1	
12006	$184.29		1		34804	$397.66		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
12007	$184.29		1		35206	$552.18		1	
12011	$184.29		1	X	35301	$246.67		1	
12016	$246.67		1		35311	$246.67		1	
12017	$246.67		1		35321	$246.67		1	
12018	$246.67		1		35331	$246.67		1	
12020	$184.29		3		35341	$246.67		1	
12021	$184.29		3		35351	$246.67		1	
12032	$184.29		1		35355	$246.67		1	
12034	$184.29		1		35361	$246.67		1	
12035	$184.29		1		35363	$246.67		1	
12036	$246.67		1		35371	$246.67		1	
12037	$246.67		1		35372	$246.67		1	
12041	$184.29		1	X	35761	$184.29		2	
12042	$184.29		1		35860	$184.29		2	
12044	$184.29		1		35875	$184.29		2	
12045	$246.67		1		35876	$184.29		2	
12046	$246.67		1		36010	$246.67		2	
12047	$246.67		1		36147	$184.29		1	
12052	$184.29		1	X	36221	$246.67		1	
12053	$184.29		1	X	36222	$246.67		1	
12054	$184.29		1		36223	$246.67		1	
12055	$184.29		1		36224	$246.67		1	
12056	$246.67		1		36225	$246.67		1	
12057	$246.67		1		36226	$246.67		1	
13100	$184.29		1		36260	$348.74		1	
13101	$283.53		1		36261	$246.67		1	
13120	$184.29		1		36262	$184.29		1	
13121	$283.53		1		36440	$184.29		1	
13131	$246.67		1		36455	$184.29		1	
13132	$283.53		1		36475	$184.29	YES	2	
13150	$246.67		1		36478	$184.29	YES	2	
13151	$246.67		1		36500	$184.29		1	
13152	$283.53		1		36511	$184.29		1	
13160	$283.53		3		36512	$184.29		1	
14000	$246.67		1		36513	$184.29		1	
14001	$283.53		1		36514	$184.29		1	
14020	$283.53		1		36515	$184.29		1	
14021	$283.53		1		36555	$184.29		2	
14040	$283.53		1		36556	$246.67		2	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
14041	$283.53		1		36557	$246.67		2	
14060	$283.53		1		36558	$283.53		2	
14061	$283.53		1		36560	$283.53		2	
14301	$348.74		1		36561	$283.53		2	
14350	$283.53		1		36563	$283.53		2	
15002	$246.67		1		36565	$283.53		2	
15004	$246.67		1		36566	$184.29		2	
15005	$184.29		40		36568	$184.29		2	
15050	$246.67		1		36569	$283.53		2	
15100	$246.67		1		36570	$283.53		2	
15110	$184.29		1		36571	$246.67		2	
15115	$184.29		1		36575	$246.67		2	
15120	$283.53		1		36576	$246.67		2	
15130	$184.29		1		36578	$184.29		2	
15135	$184.29		1		36580	$246.67		2	
15150	$184.29		1		36581	$283.53		2	
15155	$184.29		1		36582	$283.53		2	
15200	$283.53		1		36583	$184.29		2	
15201	$246.67		1		36584	$283.53		2	
15220	$246.67		1		36585	$184.29		2	
15240	$283.53		1		36589	$184.29		2	
15260	$246.67		1		36590	$184.29		2	
15271	$184.29		1		36593	$246.67		2	
15273	$184.29		1		36595	$184.29		2	
15275	$184.29		1		36596	$184.29		2	
15570	$283.53		3		36597	$184.29		2	
15572	$283.53		2		36640	$184.29		1	
15574	$283.53		2		36800	$283.53		1	
15576	$283.53		2		36810	$283.53		1	
15600	$283.53		2		36815	$283.53		1	
15610	$283.53		2		36818	$283.53		1	
15620	$283.53		2		36819	$283.53		1	
15630	$283.53		2		36820	$283.53		2	
15650	$397.66		1		36821	$283.53		2	
15731	$283.53		1		36825	$348.74		1	
15732	$283.53		1		36830	$348.74		2	
15734	$283.53		1		36831	$184.29		1	
15736	$283.53		1		36832	$340.15		2	
15738	$283.53		1		36833	$348.74		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
15740	$246.67		3		36835	$348.74		1	
15750	$246.67		2		36838	$246.67		2	
15756	$246.67		2		36860	$246.67		2	
15757	$184.29		3		36861	$283.53		2	
15758	$184.29		3		36870	$246.67		2	
15760	$246.67		2		37197	$184.29		1	
15770	$283.53		2		37204	$184.29		1	
15780	$184.29	YES	1		37205	$184.29		1	
15781	$184.29	YES	2		37211	$184.29		1	
15782	$184.29	YES	2		37212	$184.29		1	
15822	$246.67	YES	1		37213	$184.29		1	
15823	$246.67	YES	1		37214	$184.29		1	
15830	$283.53	YES	1		37607	$184.29		1	
15840	$348.74		1		37609	$246.67		2	
15841	$348.74		2		37650	$246.67		1	
15842	$348.74		2		37700	$246.67		1	
15845	$348.74		2		37718	$184.29		1	
15850	$184.29		1		37722	$184.29		1	
15851	$184.29		1		37735	$283.53		1	
15852	$184.29		2		37760	$283.53		1	
15920	$283.53		1		37761	$283.53		1	
15922	$348.74		1		37766	$283.53	YES	2	
15931	$246.67		1		37780	$283.53		1	
15933	$283.53		1		37785	$283.53		1	
15934	$246.67		1		37788	$283.53		1	
15935	$283.53		1		37790	$283.53		1	
15936	$246.67		1		38300	$184.29		2	
15937	$283.53		1		38305	$246.67		2	
15940	$246.67		1		38308	$246.67		1	
15941	$283.53		1		38500	$246.67		2	
15944	$246.67		1		38505	$184.29		3	
15945	$283.53		1		38510	$246.67		2	
15946	$246.67		1		38520	$246.67		2	
15950	$246.67		1		38525	$246.67		2	
15951	$283.53		1		38530	$246.67		2	
15952	$246.67		1		38542	$246.67		2	
15953	$283.53		1		38550	$283.53		1	
15956	$246.67		1		38555	$348.74		1	
15958	$283.53		1		38570	$743.16		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
16020	$184.29		1		38571	$743.16		1	
16025	$184.29		1		38572	$743.16		1	
16030	$184.29		1		38700	$246.67		1	
16035	$246.67		1		38740	$246.67		2	
17000	$184.29		1	X	38745	$348.74		2	
17004	$184.29		1	X	38760	$246.67		1	
17106	$184.29		1	X	38790	$184.29		1	
17107	$184.29		1	X	38792	$184.29		2	
17108	$184.29		1	X	39400	$246.67		1	
17110	$184.29		1	X	40500	$246.67		1	
17111	$184.29		1		40510	$246.67		1	
17261	$184.29		1		40520	$246.67		1	
17263	$184.29		1		40525	$246.67		1	
17264	$184.29		3		40527	$246.67		1	
17266	$246.67		2		40530	$246.67		1	
17270	$184.29		1		40650	$283.53		1	
17273	$184.29		1		40652	$283.53		1	
17274	$184.29		1		40654	$283.53		1	
17276	$246.67		3		40700	$283.53		1	
17281	$184.29		1		40701	$283.53		1	
17282	$184.29		1		40702	$283.53		1	
17283	$184.29		1		40720	$283.53		1	
17284	$184.29		1		40761	$348.74		1	
17286	$246.67		3		40801	$246.67		1	
19020	$246.67		2		40805	$246.67		1	
19100	$184.29		1		40806	$184.29		1	
19101	$246.67		3		40810	$184.29		1	
19102	$184.29		1		40812	$184.29		1	
19103	$246.67		1		40814	$246.67		1	
19105	$246.67		1		40816	$246.67		1	
19110	$184.29		1		40818	$184.29		1	
19112	$184.29		1		40819	$184.29		1	
19120	$283.53		1		40820	$184.29		1	
19125	$283.53		1		40831	$184.29		1	
19260	$397.66		1		40840	$246.67		1	
19296	$348.74		1		40842	$283.53		1	
19298	$348.74		1		40843	$283.53		1	
19301	$283.53		1		40844	$397.66		1	
19302	$552.18		1		40845	$397.66		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
19303	$348.74		1		41000	$184.29		1	
19304	$348.74		1		41005	$184.29		1	
19307	$283.53		1		41006	$184.29		1	
19316	$246.67	YES	1		41007	$184.29		1	
19318	$348.74	YES	1		41008	$184.29		1	
19328	$184.29	YES	1		41009	$184.29		1	
19330	$184.29	YES	1		41010	$184.29		1	
19340	$246.67	YES	1		41015	$184.29		1	
19342	$283.53	YES	1		41016	$184.29		1	
19350	$246.67	YES	1		41017	$184.29		1	
19355	$283.53	YES	1		41018	$184.29		1	
19357	$283.53	YES	1		41019	$246.67		1	
19361	$348.74	YES	1		41100	$184.29		1	
19364	$397.66	YES	1		41105	$246.67		1	
19366	$397.66	YES	1		41108	$184.29		1	
19367	$348.74	YES	1		41110	$184.29		1	
19368	$348.74	YES	1		41112	$246.67		1	
19369	$348.74	YES	1		41113	$246.67		1	
19370	$283.53	YES	1		41114	$246.67		1	
19371	$283.53	YES	1		41115	$184.29		1	
19380	$348.74	YES	1		41116	$184.29		1	
20005	$246.67		1		41120	$397.66		1	
20100	$246.67		1		41250	$246.67		1	
20101	$246.67		1		41251	$246.67		1	
20102	$246.67		1		41252	$246.67		1	
20103	$246.67		1		41500	$184.29		1	
20150	$246.67		1		41510	$184.29		1	
20200	$184.29		3		41512	$184.29		1	
20205	$246.67		4		41520	$246.67		1	
20206	$184.29		3		41530	$184.29		1	
20220	$184.29		1		41800	$184.29		1	
20225	$246.67		1		41805	$184.29		1	
20240	$246.67		1		41806	$184.29		1	
20245	$283.53		1		41825	$246.67		1	
20250	$283.53		3		41826	$246.67		1	
20251	$283.53		3		41827	$246.67		1	
20501	$184.29		1		41850	$246.67		1	
20520	$184.29		1	X	42000	$246.67		1	
20525	$283.53		1		42100	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
20555	$283.53		1		42104	$246.67		1	
20605	$184.29		1		42106	$246.67		1	
20610	$184.29		1		42107	$246.67		1	
20615	$184.29		1		42120	$348.74		1	
20650	$283.53		1		42140	$246.67		1	
20660	$246.67		1		42145	$397.66		1	
20661	$283.53		1		42160	$184.29		1	
20662	$283.53		1		42180	$184.29		1	
20663	$283.53		1		42182	$246.67		1	
20664	$257.58		1		42200	$397.66		1	
20665	$184.29		1		42205	$397.66		1	
20670	$184.29		1		42210	$397.66		1	
20680	$283.53		1		42215	$552.18		1	
20690	$283.53		1		42220	$397.66		1	
20692	$283.53		1		42225	$397.66		1	
20693	$184.29		1		42226	$397.66		1	
20694	$184.29		1		42235	$397.66		1	
20696	$283.53		1		42260	$348.74		1	
20697	$283.53		1		42281	$348.74		1	
20816	$246.67		1		42300	$184.29		1	
20900	$283.53		1		42305	$246.67		1	
20902	$348.74		1		42310	$184.29		1	
20910	$246.67		1		42320	$184.29		1	
20912	$283.53		1		42330	$184.29		1	
20920	$283.53		1		42335	$283.53		1	
20922	$283.53		1		42340	$246.67		1	
20924	$283.53		4		42405	$246.67		1	
20926	$283.53		1		42408	$283.53		1	
20955	$348.74		1		42409	$283.53		1	
20956	$348.74		1		42410	$397.66		1	
20957	$283.53		1		42415	$397.66		1	
20962	$348.74		1		42420	$397.66		1	
20969	$348.74		1		42425	$397.66		1	
20970	$348.74		1		42440	$283.53		1	
20972	$348.74		1		42450	$246.67		1	
20973	$348.74		1		42500	$283.53		1	
20975	$246.67		1		42505	$348.74		1	
20982	$246.67		1		42507	$283.53		1	
21010	$246.67	YES	1		42508	$348.74		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
21011	$184.29		1		42509	$348.74		1	
21012	$184.29		1		42510	$348.74		1	
21013	$184.29		1		42600	$184.29		1	
21014	$246.67		1		42650	$184.29		1	
21015	$283.53		1		42665	$184.29		1	
21016	$283.53		1		42700	$184.29		1	
21025	$246.67		1		42720	$184.29		1	
21026	$246.67		1		42725	$246.67		1	
21029	$246.67		1		42800	$184.29		1	
21034	$283.53		1		42802	$184.29		1	
21040	$246.67		1		42804	$184.29		1	
21044	$246.67		1		42806	$246.67		1	
21046	$246.67		1		42808	$246.67		1	
21050	$283.53	YES	1		42809	$184.29		1	
21060	$246.67	YES	1		42810	$283.53		1	
21070	$283.53	YES	1		42815	$348.74		1	
21073	$184.29	YES	1		42820	$348.74		1	
21076	$283.53	YES	1		42821	$348.74		1	
21077	$283.53	YES	1		42825	$348.74		1	
21079	$283.53	YES	1		42826	$348.74		1	
21080	$283.53	YES	1		42830	$283.53		1	
21081	$283.53	YES	1		42831	$283.53		1	
21082	$283.53	YES	1		42835	$283.53		1	
21083	$283.53	YES	1		42836	$348.74		1	
21084	$283.53	YES	1		42860	$283.53		1	
21086	$283.53	YES	1		42870	$283.53		1	
21087	$184.29	YES	1		42890	$552.18		1	
21088	$283.53	YES	1		42892	$552.18		1	
21100	$184.29		1		42900	$184.29		1	
21120	$283.53	YES	1		42950	$246.67		1	
21121	$184.29	YES	1		42953	$246.67		1	
21122	$566.47	YES	1		42955	$246.67		1	
21123	$566.47	YES	1		42960	$184.29		1	
21125	$348.74	YES	1		42962	$246.67		1	
21127	$566.47	YES	1		42972	$283.53		1	
21137	$566.47	YES	1		43030	$348.74		1	
21138	$566.47	YES	1		43200	$184.29		1	
21139	$566.47	YES	1		43201	$184.29		1	
21141	$566.47	YES	1		43202	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
21142	$566.47	YES	1		43204	$184.29		1	
21143	$566.47	YES	1		43205	$246.67		1	
21145	$566.47	YES	1		43215	$184.29		1	
21146	$566.47	YES	1		43216	$184.29		1	
21147	$566.47	YES	1		43217	$184.29		1	
21150	$566.47	YES	1		43219	$184.29		1	
21151	$566.47	YES	1		43220	$184.29		1	
21154	$566.47	YES	1		43226	$184.29		1	
21155	$566.47	YES	1		43227	$246.67		1	
21159	$566.47	YES	1		43228	$246.67		1	
21160	$566.47	YES	1		43231	$246.67		1	
21181	$552.18		1		43232	$246.67		1	
21182	$566.47	YES	2		43235	$184.29		1	
21183	$566.47	YES	2		43236	$246.67		1	
21184	$566.47	YES	2		43237	$246.67		1	
21188	$566.47	YES	1		43238	$246.67		1	
21193	$397.66	YES	1		43239	$246.67		1	
21194	$566.47	YES	1		43240	$246.67		1	
21195	$566.47	YES	1		43241	$246.67		1	
21196	$566.47	YES	1		43242	$246.67		1	
21199	$397.66	YES	1		43243	$246.67		1	
21206	$397.66		1		43244	$246.67		1	
21208	$552.18		1		43245	$246.67		1	
21209	$397.66		1		43246	$246.67		1	
21210	$552.18		1		43247	$246.67		1	
21215	$552.18		1		43248	$246.67		1	
21230	$552.18		1		43249	$184.29		1	
21235	$552.18		1		43250	$246.67		1	
21240	$348.74	YES	1		43251	$246.67		1	
21242	$397.66	YES	1		43255	$246.67		1	
21243	$397.66	YES	1		43256	$283.53		1	
21244	$552.18		1		43257	$283.53		1	
21245	$552.18		1		43258	$283.53		1	
21246	$552.18		1		43259	$283.53		1	
21247	$552.18		1		43260	$246.67		1	
21248	$552.18		1		43261	$246.67		1	
21249	$552.18		1		43262	$246.67		1	
21267	$552.18		1		43263	$246.67		1	
21270	$397.66	YES	1		43264	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
21275	$552.18		1		43265	$246.67		1	
21280	$397.66		1		43267	$246.67		1	
21282	$397.66		1		43268	$246.67		1	
21295	$184.29		1		43269	$246.67		1	
21296	$184.29		1		43271	$246.67		1	
21315	$184.29		1	X	43272	$246.67		1	
21320	$246.67		1		43280	$348.74		1	
21325	$246.67		1		43281	$348.74		1	
21330	$283.53		1		43282	$340.15		1	
21335	$283.53		1		43305	$283.53		1	
21336	$348.74		1		43400	$283.53		1	
21337	$184.29		1	X	43450	$184.29		1	
21338	$246.67		1		43453	$184.29		1	
21339	$246.67		1		43456	$246.67		1	
21340	$283.53		1		43458	$246.67		1	
21343	$283.53		1		43647	$184.29		1	
21344	$552.09		1		43648	$184.29		1	
21345	$283.53		1		43653	$301.00		1	
21355	$283.53		1		43755	$184.29		1	
21356	$283.53		1		43756	$184.29		1	
21360	$283.53		1		43757	$184.29		1	
21365	$348.74		1		43760	$184.29		1	
21385	$397.66		1		43761	$184.29		1	
21386	$397.66		1		43870	$348.74		1	
21387	$397.66		1		43880	$552.18		1	
21390	$552.18		1		44015	$184.29		1	
21395	$552.18		1		44100	$184.29		1	
21400	$246.67		1		44180	$246.67		1	
21401	$283.53		1		44186	$184.29		1	
21406	$348.74		1		44312	$184.29		1	
21407	$397.66		1		44340	$283.53		1	
21421	$348.74		1		44345	$348.74		1	
21422	$397.66		1		44346	$348.74		1	
21431	$283.53		1		44360	$246.67		1	
21445	$348.74		1		44361	$246.67		1	
21450	$184.29		1		44363	$246.67		1	
21451	$283.53		1		44364	$246.67		1	
21452	$246.67		1		44365	$246.67		1	
21453	$283.53		1		44366	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
21454	$283.53		1		44369	$246.67		1	
21461	$348.74		1		44370	$246.67		1	
21462	$283.53		1		44372	$246.67		1	
21465	$348.74		1		44373	$246.67		1	
21470	$348.74		1		44376	$246.67		1	
21480	$184.29		1		44377	$246.67		1	
21485	$184.29		1		44378	$246.67		1	
21490	$283.53		1		44379	$743.16		1	
21495	$283.53		1		44380	$184.29		1	
21497	$246.67		1		44382	$184.29		1	
21501	$246.67		1		44383	$743.16		1	
21502	$246.67		1		44385	$184.29		1	
21510	$283.53		1		44386	$184.29		1	
21550	$184.29		1		44388	$184.29		1	
21552	$184.29		1		44389	$184.29		1	
21554	$246.67		1		44390	$184.29		1	
21555	$246.67		1		44391	$184.29		1	
21556	$283.53		3		44392	$184.29		1	
21557	$348.74		1		44393	$184.29		1	
21558	$283.53		1		44394	$246.67		1	
21600	$246.67		1		44397	$184.29		1	
21610	$283.53		1		44500	$184.29		1	
21620	$246.67		1		44950	$283.53		1	
21630	$348.74		1		44955	$184.29		1	
21632	$348.74		1		44970	$348.74		1	
21685	$246.67		1		45000	$184.29		1	
21700	$246.67		1		45005	$246.67		1	
21720	$246.67		1		45020	$246.67		1	
21725	$283.53		1		45100	$184.29		1	
21800	$184.29		1	X	45108	$246.67		1	
21805	$246.67		1		45130	$246.67		1	
21810	$246.67		1		45150	$246.67		1	
21820	$184.29		1		45160	$283.53		1	
21920	$184.29		3		45171	$246.67		1	
21925	$184.29		3		45172	$246.67		1	
21930	$184.29		1		45190	$283.53		1	
21931	$184.29		1		45300	$184.29		1	
21932	$246.67		1		45303	$184.29		1	
21933	$246.67		1		45305	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
21936	$283.53		1		45307	$184.29		1	
22100	$283.53		1		45308	$246.67		1	
22101	$283.53		1		45309	$246.67		1	
22102	$283.53		1		45315	$246.67		1	
22103	$283.53		3		45317	$246.67		1	
22305	$184.29		1		45320	$246.67		1	
22310	$184.29		1		45321	$246.67		1	
22315	$246.67		1		45327	$184.29		1	
22325	$283.53		1		45330	$184.29		1	
22326	$283.53		1		45331	$184.29		1	
22327	$283.53		1		45332	$184.29		1	
22505	$246.67		1		45333	$184.29		1	
22520	$184.29		1		45334	$184.29		1	
22521	$184.29		1		45335	$184.29		1	
22522	$184.29		5		45337	$246.67		1	
22523	$246.67		1		45338	$246.67		1	
22524	$246.67		1		45339	$184.29		1	
22849	$246.67		1		45340	$184.29		1	
22852	$246.67		1		45341	$184.29		1	
22855	$246.67		1		45342	$184.29		1	
22900	$283.53		3		45345	$184.29		1	
22901	$283.53		1		45355	$184.29		1	
22902	$184.29		1		45378	$246.67		1	
22903	$246.67		1		45379	$246.67		1	
22904	$283.53		1		45380	$246.67		1	
22905	$283.53		1		45381	$246.67		1	
23000	$246.67		2		45382	$246.67		1	
23020	$246.67		1		45383	$246.67		1	
23030	$184.29		1		45384	$246.67		1	
23031	$184.29		1		45385	$246.67		1	
23035	$283.53		1		45386	$246.67		1	
23040	$283.53		1		45387	$246.67		1	
23044	$283.53		1		45391	$184.29		1	
23066	$184.29		1		45392	$246.67		1	
23071	$184.29		1		45500	$246.67		1	
23073	$184.29		1		45505	$246.67		1	
23075	$184.29		4		45520	$246.67		1	
23076	$184.29		2		45560	$246.67		1	
23077	$283.53		1		45562	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
23078	$283.53		1		45800	$184.29		1	
23100	$246.67		1		45805	$184.29		1	
23101	$348.74		1		45820	$184.29		1	
23105	$348.74		1		45825	$184.29		1	
23106	$348.74		1		45900	$184.29		1	
23107	$348.74		1		45905	$184.29		1	
23120	$283.53		1		45910	$184.29		1	
23125	$397.66		1		45915	$184.29		1	
23130	$283.53		1		45990	$184.29		1	
23140	$283.53		1		46020	$283.53		1	
23145	$397.66		1		46030	$184.29		1	
23146	$397.66		1		46040	$283.53		1	
23150	$348.74		1		46045	$246.67		1	
23155	$397.66		1		46050	$184.29		1	
23170	$246.67		1		46060	$246.67		1	
23172	$246.67		1		46080	$283.53		1	
23174	$246.67		1		46200	$246.67		1	
23180	$348.74		1		46220	$184.29		1	
23182	$348.74		1		46221	$246.67		1	
23184	$348.74		1		46230	$246.67		1	
23190	$348.74		1		46250	$283.53		1	
23195	$397.66		1		46255	$283.53		1	
23330	$184.29		1		46257	$283.53		1	
23331	$184.29		1		46258	$283.53		1	
23350	$184.29		999		46260	$283.53		1	
23395	$397.66		1		46261	$283.53		1	
23397	$552.18		1		46262	$283.53		1	
23400	$552.18		1		46270	$283.53		1	
23405	$246.67		1		46275	$283.53		1	
23406	$246.67		1		46280	$283.53		1	
23410	$397.66		1		46285	$184.29		1	
23412	$552.18		1		46288	$283.53		1	
23415	$397.66		1		46320	$283.53		1	
23420	$552.18		1		46505	$184.29		1	
23430	$348.74		1		46600	$184.29		1	
23440	$348.74		1		46604	$184.29		1	
23450	$397.66		1		46606	$184.29		1	
23455	$552.18		1		46608	$184.29		1	
23460	$397.66		1		46610	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
23462	$552.18		1		46611	$184.29		1	
23465	$397.66		1		46612	$184.29		1	
23466	$552.18		1		46614	$184.29		1	
23480	$348.74		1		46615	$184.29		1	
23485	$552.18		1		46700	$283.53		1	
23490	$283.53		1		46705	$283.53		1	
23491	$283.53		1		46706	$184.29		1	
23515	$246.67		1		46707	$184.29		1	
23520	$184.29		1		46750	$283.53		1	
23525	$184.29		1		46751	$283.53		1	
23530	$246.67		1		46753	$283.53		1	
23532	$283.53		1		46754	$246.67		1	
23540	$184.29		1		46760	$246.67		1	
23545	$184.29		1		46761	$283.53		1	
23550	$246.67		1		46762	$552.18		1	
23552	$283.53		1		46900	$184.29		1	
23570	$184.29		1		46910	$184.29		1	
23575	$184.29		1		46916	$184.29		1	
23585	$283.53		1		46917	$246.67		1	
23605	$246.67		1		46922	$184.29		1	
23615	$348.74		1		46924	$184.29		1	
23616	$348.74		1		46930	$184.29		1	
23625	$246.67		1		46940	$184.29		1	
23630	$397.66		1		46945	$246.67		1	
23655	$184.29		1		46946	$246.67		1	
23660	$283.53		1		46947	$184.29		1	
23665	$246.67		1		47000	$184.29		1	
23670	$283.53		1		47001	$184.29		3	
23675	$246.67		1		47382	$762.24		1	
23680	$283.53		1		47500	$184.29		1	
23700	$184.29		1		47505	$184.29		1	
23800	$348.74		1		47510	$246.67		1	
23802	$552.18		1		47511	$246.67		1	
23921	$283.53		1		47525	$184.29		1	
23935	$246.67		1		47530	$184.29		1	
24000	$283.53		1		47552	$246.67		1	
24006	$246.67		1		47553	$283.53		1	
24065	$184.29		1		47554	$283.53		1	
24066	$184.29		1		47555	$283.53		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
24071	$184.29		1		47556	$283.53		1	
24073	$184.29		1		47560	$283.53		1	
24075	$246.67		1	X	47561	$283.53		1	
24076	$246.67		1		47562	$283.53		1	
24077	$283.53		2		47563	$283.53		1	
24079	$283.53		1		47564	$348.74		1	
24100	$184.29		1		47600	$397.66		1	
24101	$283.53		1		47630	$283.53		1	
24102	$348.74		1		48102	$184.29		1	
24105	$246.67		1		49000	$348.74		1	
24110	$246.67		1		49020	$348.74		1	
24115	$283.53		1		49021	$348.74		1	
24116	$283.53		1		49082	$283.53		1	
24120	$283.53		1		49083	$283.53		1	
24125	$283.53		1		49084	$283.53		1	
24126	$283.53		1		49180	$184.29		1	
24130	$348.74		1		49250	$246.67		1	
24134	$246.67		1		49255	$246.67		1	
24136	$246.67		1		49320	$283.53		1	
24138	$246.67		1		49321	$348.74		1	
24140	$283.53		1		49322	$348.74		1	
24145	$283.53		1		49323	$348.74		1	
24147	$246.67		1		49324	$283.53		1	
24149	$348.74		1		49325	$283.53		1	
24150	$283.53		1		49400	$184.29		1	
24152	$283.53		1		49402	$246.67		1	
24155	$283.53		1		49411	$283.53		1	
24160	$246.67		1		49418	$283.53		1	
24164	$283.53		1		49419	$184.29		1	
24200	$184.29		1	X	49421	$184.29		1	
24201	$246.67		1		49422	$184.29		1	
24300	$184.29		1		49423	$184.29		1	
24301	$348.74		1		49424	$184.29		1	
24305	$348.74		4		49425	$246.67		1	
24310	$283.53		1		49426	$246.67		1	
24320	$283.53		1		49427	$184.29		1	
24330	$283.53		1		49428	$184.29		1	
24331	$283.53		1		49429	$184.29		1	
24332	$283.53		1		49436	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
24340	$283.53		1		49465	$184.29		1	
24341	$283.53		1		49491	$348.74		1	
24342	$283.53		1		49492	$348.74		1	
24345	$246.67		1		49495	$348.74		1	
24357	$283.53		1		49496	$348.74		1	
24358	$283.53		1		49500	$348.74		1	
24359	$283.53		1		49501	$348.74		1	
24360	$397.66		1		49505	$348.74		1	
24361	$397.66		1		49507	$348.74		1	
24362	$397.66		1		49520	$348.74		1	
24363	$552.18		1		49521	$348.74		1	
24365	$246.67		1		49525	$348.74		1	
24366	$283.53		1		49540	$283.53		1	
24370	$397.66		1		49550	$348.74		1	
24371	$397.66		1		49553	$743.16		1	
24400	$348.74		1		49555	$348.74		1	
24410	$348.74		1		49557	$743.16		1	
24420	$283.53		1		49560	$348.74		1	
24430	$283.53		1		49561	$348.74		1	
24435	$348.74		1		49565	$348.74		1	
24470	$283.53		1		49566	$348.74		1	
24495	$246.67		1		49568	$184.29		1	
24498	$283.53		1		49570	$348.74		1	
24505	$184.29		1		49572	$348.74		1	
24515	$283.53		1		49580	$348.74		1	
24516	$348.74		1		49582	$348.74		1	
24530	$184.29		1		49585	$246.67		1	
24535	$184.29		1		49587	$348.74		1	
24538	$246.67		1		49590	$283.53		1	
24545	$348.74		1		49600	$283.53		1	
24546	$397.66		1		49650	$348.74		1	
24565	$246.67		1		49651	$552.18		1	
24566	$246.67		1		49652	$348.74		1	
24575	$283.53		1		49653	$348.74		1	
24576	$184.29		1		49654	$348.74		1	
24577	$184.29		1		49655	$348.74		1	
24579	$283.53		1		49656	$348.74		1	
24582	$246.67		1		49657	$348.74		1	
24586	$348.74		1		50020	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
24587	$397.66		1		50040	$283.53		1	
24600	$184.29		1		50200	$184.29		1	
24605	$246.67		1		50205	$283.53		1	
24615	$283.53		1		50382	$184.29		1	
24620	$246.67		1		50384	$184.29		1	
24635	$283.53		1		50385	$184.29		1	
24655	$184.29		1		50386	$184.29		1	
24665	$283.53		1		50387	$184.29		1	
24666	$348.74		1		50389	$184.29		1	
24675	$184.29		1		50390	$184.29		1	
24685	$283.53		1		50391	$184.29		1	
24800	$246.67		1		50392	$184.29		1	
24802	$348.74		1		50393	$184.29		1	
24925	$246.67		1		50394	$184.29		1	
25000	$283.53		1		50395	$184.29		1	
25001	$283.53		1		50396	$184.29		1	
25020	$283.53		1		50398	$184.29		1	
25023	$283.53		1		50520	$184.29		1	
25024	$283.53		1		50541	$283.53		1	
25025	$283.53		1		50551	$184.29		1	
25028	$184.29		1		50553	$184.29		1	
25031	$246.67		1		50555	$184.29		1	
25035	$283.53		1		50557	$184.29		1	
25040	$246.67		1		50561	$184.29		1	
25066	$246.67		3		50562	$184.29		1	
25071	$184.29		1		50570	$184.29		1	
25073	$184.29		1		50572	$184.29		1	
25075	$184.29		1		50574	$184.29		1	
25076	$246.67		1		50576	$184.29		1	
25077	$283.53		1		50580	$184.29		1	
25078	$283.53		1		50592	$184.29		1	
25085	$283.53		1		50593	$184.29		1	
25100	$246.67		1		50684	$184.29		1	
25101	$246.67		1		50686	$184.29		1	
25105	$283.53		1		50688	$184.29		1	
25107	$283.53		1		50690	$184.29		1	
25110	$246.67		1		50920	$184.29		1	
25111	$246.67		1		50947	$743.16		1	
25112	$246.67		1		50948	$743.16		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
25115	$283.53		1		50951	$184.29		1	
25116	$283.53		1		50953	$184.29		1	
25118	$246.67		1		50955	$184.29		1	
25119	$283.53		1		50957	$184.29		1	
25120	$246.67		1		50961	$184.29		1	
25125	$283.53		1		50970	$184.29		1	
25126	$283.53		1		50972	$184.29		1	
25130	$246.67		1		50974	$184.29		1	
25135	$283.53		1		50976	$184.29		1	
25136	$283.53		1		50980	$184.29		1	
25145	$283.53		1		51020	$348.74		1	
25150	$283.53		1		51030	$348.74		1	
25151	$283.53		1		51040	$283.53		1	
25170	$283.53		1		51045	$348.74		1	
25210	$283.53		1		51050	$348.74		1	
25215	$348.74		1		51060	$348.74		1	
25230	$283.53		1		51065	$348.74		1	
25240	$348.74		1		51080	$283.53		1	
25246	$184.29		1		51100	$184.29		1	
25248	$246.67		1		51101	$184.29		1	
25250	$184.29		1		51102	$184.29		1	
25251	$184.29		1		51500	$283.53		1	
25259	$184.29		1		51520	$283.53		1	
25260	$246.67		1		51525	$348.74		1	
25263	$246.67		1		51530	$348.74		1	
25265	$283.53		1		51535	$348.74		1	
25270	$283.53		1		51550	$348.74		1	
25272	$246.67		1		51600	$184.29		1	
25274	$348.74		1		51605	$184.29		1	
25275	$348.74		1		51610	$184.29		1	
25280	$348.74		10		51710	$184.29		1	
25290	$246.67		1		51715	$246.67		1	
25295	$246.67		9		51726	$184.29		1	
25300	$283.53		1		51727	$184.29		1	
25301	$283.53		1		51728	$184.29		1	
25310	$283.53		1		51729	$184.29		1	
25312	$348.74		1		51785	$184.29		1	
25315	$283.53		1		51840	$283.53		1	
25316	$283.53		1		51845	$283.53		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
25320	$283.53		1		51860	$246.67		1	
25332	$397.66		1		51865	$348.74		1	
25335	$283.53		1		51880	$184.29		1	
25337	$283.53		1		51900	$348.74		1	
25350	$283.53		1		51920	$283.53		1	
25355	$283.53		1		51990	$283.53		1	
25360	$283.53		1		51992	$397.66		1	
25365	$283.53		1		52000	$184.29		1	
25370	$283.53		1		52001	$246.67		1	
25375	$348.74		1		52005	$246.67		1	
25390	$283.53		1		52007	$246.67		1	
25391	$348.74		1		52010	$246.67		1	
25392	$283.53		1		52204	$246.67		1	
25393	$348.74		1		52214	$246.67		1	
25394	$283.53		1		52224	$246.67		1	
25400	$283.53		1		52234	$246.67		1	
25405	$348.74		1		52235	$283.53		1	
25415	$283.53		1		52240	$283.53		1	
25420	$348.74		1		52250	$348.74		1	
25425	$283.53		1		52260	$246.67		1	
25426	$348.74		1		52265	$246.67		1	
25430	$283.53		1		52270	$246.67		1	
25431	$283.53		2		52275	$246.67		1	
25440	$348.74		1		52276	$283.53		1	
25441	$397.66		1		52277	$246.67		1	
25442	$397.66		1		52281	$246.67		1	
25443	$397.66		1		52282	$246.67		1	
25444	$397.66		1		52283	$246.67		1	
25445	$397.66		1		52285	$246.67		1	
25446	$552.18		1		52287	$246.67		1	
25447	$397.66		1		52290	$246.67		1	
25449	$397.66		1		52300	$246.67		1	
25450	$283.53		1		52301	$246.67		1	
25455	$283.53		1		52305	$246.67		1	
25490	$283.53		1		52310	$246.67		1	
25491	$283.53		1		52315	$246.67		1	
25492	$283.53		1		52317	$184.29		1	
25505	$184.29		1		52318	$246.67		1	
25515	$283.53		1		52320	$348.74		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
25520	$184.29		1		52325	$348.74		1	
25525	$348.74		1		52327	$348.74		1	
25526	$397.66		1		52330	$283.53		1	
25535	$184.29		1		52332	$283.53		1	
25545	$283.53		1		52334	$283.53		1	
25565	$246.67		1		52341	$184.29		1	
25574	$283.53		1		52342	$246.67		1	
25575	$283.53		1		52343	$283.53		1	
25605	$283.53		1		52344	$184.29		1	
25606	$283.53		1		52345	$283.53		1	
25607	$397.66		1		52346	$283.53		1	
25608	$397.66		1		52351	$283.53		1	
25609	$397.66		1		52352	$348.74		1	
25624	$184.29		1		52353	$348.74		1	
25628	$283.53		1		52354	$348.74		1	
25635	$184.29		2		52355	$348.74		1	
25645	$283.53		1		52400	$283.53		1	
25651	$184.29		1		52402	$283.53		1	
25652	$184.29		1		52450	$283.53		1	
25660	$184.29		1		52500	$283.53		1	
25670	$283.53		1		52601	$348.74		1	
25671	$184.29		1		52630	$246.67		1	
25675	$184.29		1		52640	$246.67		1	
25676	$246.67		1		52647	$348.74		1	
25680	$246.67		1		52648	$348.74		1	
25685	$283.53		1		52649	$348.74		1	
25690	$184.29		1		52700	$246.67		1	
25695	$246.67		1		53000	$184.29		1	
25800	$283.53		1		53010	$184.29		1	
25805	$348.74		1		53020	$184.29		1	
25810	$348.74		1		53025	$184.29		1	
25820	$283.53		1		53040	$246.67		1	
25825	$348.74		1		53080	$246.67		1	
25907	$246.67		1		53085	$283.53		1	
25922	$246.67		1		53200	$184.29		1	
25929	$246.67		1		53210	$348.74		1	
26011	$184.29		1		53215	$348.74		1	
26020	$246.67		1		53220	$246.67		1	
26025	$184.29		1		53230	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
26030	$246.67		1		53235	$283.53		1	
26034	$246.67		1		53240	$246.67		1	
26035	$348.74		1		53250	$246.67		1	
26037	$348.74		1		53260	$246.67		1	
26040	$283.53		1		53265	$246.67		1	
26045	$283.53		1		53270	$246.67		1	
26055	$246.67		1		53275	$246.67		1	
26060	$246.67		1		53400	$283.53		1	
26070	$246.67		1		53405	$246.67		1	
26075	$246.67		1		53410	$246.67		1	
26080	$246.67		1		53415	$246.67		1	
26100	$246.67		2		53420	$283.53		1	
26105	$184.29		2		53425	$246.67		1	
26110	$184.29		3		53430	$246.67		1	
26111	$184.29		1		53431	$246.67		1	
26113	$246.67		1		53440	$246.67		1	
26115	$246.67		1		53442	$184.29		1	
26116	$246.67		1		53444	$246.67		1	
26117	$283.53		1		53445	$246.67		1	
26118	$283.53		1		53446	$184.29		1	
26121	$348.74		1		53447	$184.29		1	
26123	$348.74		1		53449	$184.29		1	
26125	$348.74		1		53450	$184.29		1	
26130	$283.53		1		53460	$184.29		1	
26135	$283.53		1		53500	$246.67		1	
26140	$246.67		1		53502	$246.67		1	
26145	$283.53		1		53505	$246.67		1	
26160	$246.67		1		53510	$246.67		1	
26170	$283.53		1		53515	$246.67		1	
26180	$283.53		1		53520	$246.67		1	
26185	$184.29		1		53605	$246.67		1	
26200	$246.67		1		53620	$184.29		1	
26205	$283.53		1		53621	$184.29		1	
26210	$246.67		1		53660	$184.29		1	
26215	$283.53		1		53661	$184.29		1	
26230	$246.67		1		53665	$184.29		1	
26235	$246.67		1		53850	$743.16		1	
26236	$246.67		1		53852	$397.66		1	
26250	$283.53		1		53855	$397.66		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
26260	$246.67		1		53860	$246.67		1	
26262	$246.67		1		54000	$246.67		1	
26320	$246.67		1		54001	$184.29		1	
26340	$184.29		1		54015	$184.29		1	
26350	$246.67		12		54057	$184.29		1	
26352	$283.53		1		54060	$184.29		1	
26356	$246.67		1		54065	$184.29		1	
26357	$246.67		3		54100	$184.29		3	
26358	$283.53		3		54105	$184.29		2	
26370	$283.53		1		54110	$246.67		1	
26372	$348.74		1		54111	$283.53		1	
26373	$283.53		1		54112	$283.53		1	
26390	$283.53		3		54115	$184.29		1	
26392	$246.67		3		54120	$246.67		1	
26410	$246.67		1		54125	$246.67		1	
26412	$283.53		1		54150	$184.29		1	
26415	$283.53		1		54160	$246.67		1	
26416	$283.53		2		54161	$246.67		1	
26418	$283.53		1		54162	$246.67		1	
26420	$283.53		1		54163	$246.67	YES	1	
26426	$246.67		1		54164	$246.67		1	
26428	$283.53		2		54205	$184.29		1	
26432	$246.67		1		54220	$184.29		1	
26433	$246.67		1		54230	$184.29		1	
26434	$283.53		1		54231	$246.67		1	
26437	$283.53		1		54300	$283.53		1	
26440	$283.53		1		54304	$397.66		1	
26442	$283.53		1		54308	$283.53		1	
26445	$283.53		1		54312	$283.53		1	
26449	$283.53		1		54316	$283.53		1	
26450	$283.53		1		54318	$283.53		1	
26455	$283.53		1		54322	$283.53		1	
26460	$283.53		1		54324	$348.74		1	
26471	$246.67		1		54326	$348.74		1	
26474	$246.67		1		54328	$283.53		1	
26476	$246.67		1		54332	$283.53		1	
26477	$246.67		1		54340	$283.53		1	
26478	$246.67		1		54344	$283.53		1	
26479	$246.67		1		54348	$283.53		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
26480	$246.67		2		54352	$283.53		1	
26483	$283.53		1		54360	$283.53		1	
26485	$246.67		1		54380	$283.53		1	
26489	$283.53		1		54385	$283.53		1	
26490	$283.53		1		54420	$348.74		1	
26492	$348.74		1		54430	$348.74		1	
26494	$283.53		1		54435	$348.74		1	
26496	$283.53		1		54440	$348.74		1	
26497	$283.53		1		54450	$184.29		1	
26498	$348.74		1		54500	$184.29		1	
26500	$283.53		1		54505	$184.29		1	
26502	$348.74		1		54510	$246.67		1	
26508	$246.67		1		54512	$246.67		1	
26510	$246.67		1		54520	$283.53		1	
26516	$184.29		1		54530	$348.74		1	
26517	$246.67		1		54550	$283.53		1	
26518	$246.67		1		54560	$284.20		1	
26520	$246.67		1		54600	$348.74		1	
26525	$246.67		1		54620	$246.67		1	
26530	$283.53		1		54640	$348.74		1	
26531	$397.66		1		54650	$348.74		1	
26535	$246.67		1		54660	$246.67		1	
26536	$283.53		1		54670	$283.53		1	
26540	$283.53		1		54680	$283.53		1	
26541	$348.74		1		54690	$283.53		1	
26542	$348.74		1		54692	$283.53		1	
26545	$283.53		1		54700	$246.67		1	
26546	$348.74		1		54800	$184.29		1	
26548	$283.53		1		54830	$283.53		1	
26550	$246.67		1		54840	$348.74		1	
26551	$348.74		1		54860	$283.53		1	
26553	$283.53		1		54861	$348.74		1	
26554	$283.53		1		54865	$184.29		1	
26555	$283.53		1		55040	$283.53		1	
26556	$283.53		1		55041	$397.66		1	
26560	$246.67		1		55060	$348.74		1	
26561	$283.53		1		55100	$184.29		1	
26562	$283.53		1		55110	$246.67		1	
26565	$283.53		1		55120	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
26567	$246.67		1		55150	$184.29		1	
26568	$283.53		1		55175	$184.29		1	
26580	$397.66		1		55180	$246.67		1	
26585	$397.66		1		55200	$246.67		1	
26587	$246.67		1		55250	$184.29		1	
26590	$283.53		1		55500	$283.53		1	
26591	$283.53		1		55520	$348.74		1	
26593	$283.53		1		55530	$348.74		1	
26596	$246.67		1		55535	$348.74		1	
26597	$283.53		1		55540	$397.66		1	
26605	$184.29		1		55550	$743.16		1	
26607	$246.67		1		55600	$184.29		1	
26608	$246.67		1		55605	$184.29		1	
26615	$283.53		1		55650	$184.29		1	
26641	$184.29		1		55680	$184.29		1	
26645	$184.29		1		55700	$246.67		1	
26650	$246.67		1		55705	$246.67		1	
26665	$283.53		1		55706	$246.67		1	
26675	$246.67		1		55720	$184.29		1	
26676	$246.67		1		55725	$246.67		1	
26685	$246.67		1		55860	$283.53		1	
26686	$283.53		1		55873	$743.16		1	
26705	$246.67		1		55875	$283.53		1	
26706	$246.67		1		55876	$283.53		1	
26715	$283.53		1		56405	$184.29		1	
26725	$184.29		1		56420	$184.29		1	
26727	$283.53		1		56440	$246.67		1	
26735	$283.53		1		56441	$184.29		1	
26742	$184.29		3		56442	$184.29		1	
26746	$283.53		3		56501	$184.29		1	
26755	$184.29		1		56515	$283.53		1	
26756	$246.67		1		56605	$184.29		1	
26765	$283.53		1		56620	$184.29	YES	1	
26776	$246.67		1		56625	$246.67	YES	1	
26785	$246.67		1		56700	$184.29		1	
26820	$348.74		1		56740	$283.53		1	
26841	$283.53		1		56800	$283.53		1	
26842	$348.74		1		56805	$283.53		1	X
26843	$283.53		1		56810	$283.53		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
26844	$348.74		1		56821	$184.29		1	
26850	$283.53		1		57000	$246.67		1	
26852	$348.74		1		57010	$246.67		1	
26860	$246.67		1		57020	$246.67		1	
26861	$184.29		1		57023	$184.29		1	
26862	$283.53		1		57061	$184.29		1	
26863	$283.53		1		57065	$246.67		1	
26910	$348.74		1		57100	$184.29		3	
26951	$246.67		1		57105	$246.67		2	
26952	$283.53		1		57130	$246.67		1	
26990	$184.29		1		57135	$246.67		1	
26991	$184.29		1		57155	$184.29		1	
26992	$246.67		1		57156	$184.29		1	
27000	$246.67		1		57180	$184.29		1	
27001	$283.53		1		57200	$184.29		1	
27003	$283.53		1		57210	$246.67		1	
27006	$283.53		1		57220	$283.53		1	
27025	$283.53		1		57230	$283.53		1	
27027	$283.53		1		57240	$397.66		1	
27030	$283.53		1		57250	$397.66		1	
27033	$283.53		1		57260	$397.66		1	
27035	$348.74		1		57265	$552.18		1	
27036	$397.66		1		57268	$283.53		1	
27040	$184.29		2		57284	$348.74		1	
27041	$246.67		3		57285	$246.67		1	
27043	$184.29		1		57287	$246.67		1	
27045	$246.67		1		57288	$246.67		1	
27047	$246.67		1		57289	$397.66		1	
27048	$283.53		1		57291	$397.66		1	X
27049	$283.53		1		57295	$283.53		1	
27050	$283.53		1		57300	$283.53		1	
27052	$283.53		1		57305	$283.53		1	
27054	$283.53		1		57307	$283.53		1	
27057	$283.53		1		57308	$283.53		1	
27059	$283.53		1		57310	$283.53		1	
27060	$283.53		1		57311	$348.74		1	
27062	$283.53		1		57320	$283.53		1	
27065	$348.74		1		57330	$283.53		1	
27066	$397.66		1		57400	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27067	$397.66		1		57410	$246.67		1	
27080	$283.53		1		57415	$348.74		1	
27086	$184.29		1		57420	$184.29		1	
27087	$246.67		1		57421	$184.29		1	
27093	$184.29		1		57423	$246.67		1	
27095	$184.29		1		57425	$246.67		1	
27096	$184.29		1		57426	$246.67		1	
27097	$283.53		1		57452	$184.29		1	
27098	$283.53		1		57454	$184.29		1	
27100	$348.74		1		57455	$184.29		1	
27105	$348.74		1		57456	$184.29		1	
27110	$348.74		1		57460	$184.29		1	
27111	$348.74		1		57461	$184.29		1	
27120	$348.74		1		57500	$184.29		1	
27125	$348.74		1		57505	$184.29		1	
27165	$348.74		1		57510	$184.29		1	
27176	$283.53		1		57511	$184.29		1	
27177	$246.67		1		57513	$246.67		1	
27187	$246.67		1		57520	$246.67		1	
27193	$184.29		1		57522	$246.67		1	
27194	$246.67		1		57530	$283.53		1	
27202	$246.67		1		57550	$283.53		1	
27216	$184.29		1		57556	$397.66		1	
27220	$246.67		1		57558	$283.53		1	
27222	$246.67		1		57700	$184.29		1	
27230	$184.29		1		57720	$283.53		1	
27232	$184.29		1		57800	$184.29		1	
27235	$184.29		1		58100	$184.29		1	
27236	$246.67		1		58120	$246.67		1	
27238	$184.29		1		58145	$397.66		1	
27240	$184.29		1		58260	$246.67		1	
27244	$246.67		1		58262	$246.67		1	
27246	$184.29		1		58263	$246.67		1	
27250	$184.29		1		58267	$246.67		1	
27252	$246.67		1		58270	$246.67		1	
27256	$246.67		1		58275	$246.67		1	
27257	$283.53		1		58280	$246.67		1	
27258	$283.53		1		58290	$246.67		1	
27259	$283.53		1		58291	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27265	$184.29		1		58292	$246.67		1	
27266	$184.29		1		58293	$246.67		1	
27267	$184.29		1		58294	$246.67		1	
27268	$184.29		1		58301	$184.29		1	
27275	$246.67		1		58340	$184.29		1	
27284	$246.67		1		58346	$246.67		1	
27286	$246.67		1		58350	$283.53		1	
27301	$246.67		1		58353	$184.29		1	
27303	$283.53		1		58356	$184.29		1	
27305	$283.53		1		58400	$348.74		1	
27306	$283.53		1		58410	$348.74		1	
27307	$283.53		1		58541	$283.53		1	
27310	$283.53		1		58542	$283.53		1	
27323	$184.29		1		58543	$283.53		1	
27324	$184.29		1		58544	$283.53		1	
27325	$246.67		1		58550	$397.66		1	
27326	$246.67		1		58552	$397.66		1	
27327	$184.29		1		58553	$397.66		1	
27328	$246.67		1		58554	$397.66		1	
27330	$283.53		1		58555	$184.29		1	
27331	$283.53		1		58558	$283.53		1	
27332	$283.53		1		58559	$246.67		1	
27333	$283.53		1		58560	$246.67		1	
27334	$283.53		1		58561	$283.53		1	
27335	$283.53		1		58562	$246.67		1	
27337	$283.53		1		58563	$348.74		1	
27339	$283.53		1		58565	$246.67	YES	1	
27340	$283.53		1		58570	$283.53		1	
27345	$283.53		1		58571	$283.53		1	
27347	$283.53		1		58572	$283.53		1	
27350	$348.74		1		58573	$283.53		1	
27355	$283.53		1		58600	$348.74		1	
27356	$348.74		1		58615	$348.74		1	
27357	$397.66		1		58660	$397.66		1	
27360	$397.66		1		58661	$397.66		1	
27370	$184.29		1		58662	$397.66		1	
27372	$348.74		1		58670	$283.53		1	
27380	$348.74		1		58671	$283.53		1	
27381	$348.74		1		58672	$397.66		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27385	$283.53		1		58673	$397.66		1	
27386	$283.53		1		58700	$348.74		1	
27390	$184.29		1		58740	$246.67		1	
27391	$246.67		1		58800	$397.66		1	
27392	$283.53		1		58805	$397.66		1	
27393	$246.67		1		58820	$397.66		1	
27394	$283.53		1		58823	$348.74		1	
27395	$283.53		1		58825	$397.66		1	
27396	$283.53		1		58900	$283.53		1	
27397	$283.53		1		58940	$283.53		1	
27400	$283.53		1		59000	$184.29		1	
27403	$283.53		1		59070	$184.29		1	
27405	$348.74		1		59072	$184.29		1	
27407	$348.74		1		59074	$184.29		1	
27409	$348.74		1		59076	$184.29		1	
27418	$348.74		1		59100	$397.66		1	
27420	$283.53		1		59120	$246.67		1	
27422	$348.74		1		59121	$246.67		1	
27424	$348.74		1		59130	$246.67		1	
27425	$283.53		1		59135	$246.67		1	
27427	$283.53		1		59136	$246.67		1	
27428	$348.74		1		59140	$246.67		1	
27429	$348.74		1		59150	$348.74		1	
27430	$348.74		1		59151	$348.74		1	
27435	$348.74		1		59160	$246.67		1	
27437	$348.74		1		59320	$184.29		1	
27438	$397.66		1		59812	$246.67		1	
27440	$397.66		1		59820	$246.67		1	
27441	$397.66		1		59821	$246.67		1	
27442	$397.66		1		59830	$246.67		1	
27443	$397.66		1		59840	$184.29		1	
27446	$348.74		1		59841	$246.67		1	
27447	$348.74		1		59850	$246.67		1	
27448	$246.67		1		59851	$246.67		1	
27450	$246.67		1		59852	$348.74		1	
27455	$246.67		1		59855	$246.67		1	
27457	$246.67		1		59856	$246.67		1	
27465	$246.67		1	X	59857	$348.74		1	
27466	$246.67		1	X	59866	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27468	$246.67		1	X	59870	$184.29		1	
27475	$348.74		1	X	59871	$184.29		1	
27477	$348.74		1	X	60000	$184.29		1	
27479	$348.74		1	X	60200	$246.67		1	
27485	$348.74		1		60210	$246.67		1	
27495	$283.53		1		60212	$246.67		1	
27497	$283.53		1		60220	$246.67		1	
27500	$184.29		1		60225	$283.53		1	
27501	$246.67		1		60240	$284.20		1	
27502	$246.67		1		60260	$283.53		1	
27503	$283.53		1		60280	$348.74		1	
27506	$283.53		1		60281	$348.74		1	
27507	$348.74		1		60521	$283.53		1	
27508	$184.29		1		61020	$184.29		2	
27509	$283.53		1		61026	$184.29		2	
27510	$184.29		1		61050	$184.29		1	
27511	$348.74		1		61055	$184.29		1	
27513	$397.66		1		61070	$184.29		2	
27516	$184.29		1		61107	$743.16		1	
27517	$184.29		1		61154	$283.53		2	
27520	$184.29		1		61215	$283.53		1	
27524	$283.53		1		61250	$283.53		1	
27530	$184.29		1		61323	$762.24		1	
27532	$184.29		1		61500	$348.74		3	
27535	$283.53		1		61770	$246.67		1	
27538	$184.29		1		61790	$283.53		2	
27550	$184.29		1		61791	$283.53		2	
27552	$184.29		1		61796	$184.29		1	
27556	$283.53		1		61798	$184.29		1	
27557	$283.53		1		61880	$184.29		1	
27560	$184.29		1		61885	$246.67		2	
27562	$184.29		1		61886	$246.67		1	
27566	$246.67		1		61888	$184.29		2	
27570	$184.29		1		62010	$762.24		1	
27580	$348.74		1		62194	$184.29		2	
27600	$283.53		1		62225	$184.29		2	
27602	$283.53		1		62230	$246.67		2	
27603	$246.67		1		62252	$246.67		2	
27604	$246.67		1		62256	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27605	$184.29		1		62263	$184.29		1	
27606	$184.29		1		62264	$184.29		1	
27607	$246.67		1		62267	$184.29		2	
27610	$246.67		1		62268	$184.29		1	
27612	$283.53		1		62269	$184.29		2	
27614	$184.29		1		62270	$184.29		2	
27616	$283.53		1		62272	$184.29		1	
27618	$246.67		1		62273	$184.29		2	
27619	$283.53		1		62280	$184.29		1	
27620	$348.74		1		62281	$184.29		1	
27625	$348.74		1		62282	$184.29		1	
27626	$348.74		1		62287	$743.16		1	
27630	$283.53		1		62290	$184.29		1	
27632	$283.53		1		62291	$184.29		999	
27634	$283.53		1		62294	$283.53		2	
27635	$283.53		1		62310	$184.29		1	
27637	$283.53		1		62311	$184.29		1	
27638	$283.53		1		62318	$184.29		1	
27640	$283.53		1		62319	$184.29		1	
27648	$184.29		1		62350	$246.67		1	
27650	$283.53		1		62351	$246.67		1	
27652	$283.53		1		62355	$246.67		1	
27654	$283.53		1		62360	$246.67		1	
27656	$246.67		1		62361	$246.67		1	
27658	$184.29		2		62362	$246.67		1	
27659	$246.67		2		62365	$246.67		1	
27664	$246.67		2		62367	$246.67		1	
27665	$246.67		2		62368	$246.67		1	
27675	$246.67		1		62369	$246.67		1	
27676	$283.53		1		62370	$246.67		1	
27680	$283.53		1		63012	$397.66		1	
27681	$283.53		1		63030	$397.66		1	
27685	$283.53		1		63042	$397.66		1	
27686	$283.53		1		63600	$246.67		2	
27687	$283.53		1		63610	$184.29		1	
27690	$348.74		1		63650	$246.67		2	
27691	$348.74		1		63661	$184.29		1	
27692	$283.53		1		63662	$184.29		1	
27695	$246.67		1		63663	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27696	$246.67		1		63664	$184.29		1	
27698	$246.67		1		63685	$246.67		2	
27700	$397.66		1		63688	$184.29		2	
27704	$246.67		1		63744	$283.53		1	
27705	$246.67		1		63746	$246.67		1	
27707	$246.67		1		64400	$184.29		1	
27709	$246.67		1		64402	$184.29		2	
27715	$348.74		1		64405	$184.29		1	
27720	$246.67		1		64408	$184.29		2	
27726	$246.67		1		64410	$184.29		2	
27730	$246.67		1		64412	$184.29		2	
27732	$246.67		1		64413	$184.29		2	
27734	$246.67		1		64415	$184.29		2	
27740	$246.67		1		64417	$184.29		2	
27742	$246.67		1		64418	$184.29		2	
27745	$283.53		1		64420	$184.29		3	
27750	$184.29		1		64421	$184.29		3	
27752	$184.29		1		64425	$184.29		2	
27756	$283.53		1		64430	$184.29		2	
27758	$348.74		1		64435	$184.29		2	
27759	$348.74		1		64445	$184.29		1	
27760	$184.29		1		64449	$184.29		2	
27762	$184.29		1		64450	$184.29		1	
27766	$283.53		1		64455	$184.29		2	
27767	$184.29		1		64479	$184.29		1	
27768	$184.29		1		64480	$184.29		1	
27769	$283.53		1		64483	$184.29		1	
27780	$184.29		1		64484	$184.29		1	
27781	$184.29		1		64490	$184.29		1	
27784	$283.53		1		64493	$184.29		1	
27786	$184.29		1		64505	$184.29		2	
27788	$184.29		1		64508	$184.29		2	
27792	$283.53		1		64510	$184.29		2	
27808	$184.29		1		64517	$184.29		1	
27810	$184.29		1		64520	$184.29		2	
27814	$283.53		1		64530	$184.29		2	
27816	$184.29		1		64555	$184.29		2	
27818	$184.29		1		64561	$283.53		2	
27822	$283.53		1		64565	$184.29		2	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
27823	$283.53		1		64570	$184.29		1	
27824	$184.29		1		64575	$184.29		2	
27825	$246.67		1		64580	$184.29		2	
27826	$283.53		1		64581	$283.53		2	
27827	$283.53		1		64585	$184.29		2	
27828	$348.74		1		64590	$246.67		1	
27829	$246.67		1		64595	$184.29		1	
27830	$184.29		1		64600	$184.29		2	
27831	$184.29		1		64605	$184.29		2	
27832	$246.67		1		64610	$184.29		2	
27840	$184.29		1		64611	$184.29		1	
27842	$184.29		1		64612	$184.29		2	
27846	$283.53		1		64613	$184.29		1	
27848	$283.53		1		64614	$184.29		1	
27860	$184.29		1		64615	$184.29		1	
27870	$348.74		1		64620	$184.29		1	
27871	$348.74		1		64630	$246.67		1	
27889	$283.53		1		64632	$246.67		2	
27892	$283.53		1		64633	$246.67		1	
27893	$283.53		1		64634	$184.29		1	
27894	$283.53		1		64635	$184.29		1	
27899	$283.53	YES	1		64636	$184.29		1	
28002	$283.53		1		64640	$184.29		1	
28003	$283.53		1		64680	$246.67		1	
28005	$283.53		1		64681	$184.29		1	
28008	$283.53		1		64702	$184.29		2	
28010	$246.67		1		64704	$184.29		1	
28011	$283.53		1		64708	$246.67		1	
28020	$246.67		1		64712	$246.67		2	
28022	$246.67		1		64713	$246.67		2	
28024	$246.67		1		64714	$246.67		2	
28035	$283.53		1		64716	$283.53		1	
28039	$283.53		1		64718	$246.67		2	
28041	$246.67		1		64719	$246.67		2	
28043	$184.29		1		64721	$246.67		2	
28045	$283.53		1		64722	$184.29		1	
28047	$283.53		1		64726	$184.29		2	
28050	$246.67		1		64727	$184.29		3	
28052	$246.67		1		64732	$246.67		2	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
28054	$184.29		1		64734	$246.67		2	
28055	$348.74		1		64736	$246.67		2	
28060	$246.67		1		64738	$246.67		2	
28062	$283.53		1		64740	$246.67		2	
28070	$246.67		1		64742	$246.67		2	
28072	$246.67		1		64744	$246.67		2	
28080	$246.67		1		64746	$246.67		2	
28086	$246.67		1		64771	$246.67		2	
28088	$246.67		1		64772	$246.67		2	
28090	$246.67		1		64774	$246.67		3	
28092	$246.67		1		64776	$283.53		1	
28100	$246.67		1		64778	$246.67		3	
28102	$283.53		1		64782	$283.53		2	
28103	$283.53		1		64783	$246.67		2	
28104	$246.67		1		64784	$283.53		1	
28106	$283.53		1		64786	$283.53		2	
28107	$283.53		1		64787	$246.67		1	
28108	$184.29		1		64788	$283.53		1	
28110	$246.67		1		64790	$283.53		1	
28111	$283.53		1		64792	$283.53		2	
28112	$283.53		1		64795	$246.67		2	
28113	$283.53		1		64802	$246.67		1	
28114	$283.53		1		64831	$348.74		2	
28116	$283.53		1		64832	$184.29		1	
28118	$348.74		1		64834	$246.67		2	
28119	$348.74		1		64835	$283.53		2	
28120	$283.53		1		64836	$283.53		2	
28122	$283.53		1		64837	$184.29		3	
28124	$246.67		1		64840	$246.67		2	
28126	$246.67		1		64856	$246.67		2	
28130	$283.53		1		64857	$246.67		3	
28150	$283.53		1		64858	$246.67		2	
28153	$283.53		1		64859	$184.29		2	
28160	$283.53		1		64861	$283.53		2	
28171	$283.53		1		64862	$283.53		2	
28175	$283.53		1		64864	$283.53		2	
28190	$184.29		1	X	64865	$348.74		1	
28192	$246.67		1		64870	$348.74		1	
28193	$283.53		1		64872	$246.67		3	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
28200	$283.53		1		64874	$283.53		1	
28202	$283.53		1		64876	$283.53		1	
28208	$283.53		1		64885	$246.67		1	
28210	$283.53		1		64886	$246.67		1	
28220	$184.29		1		64890	$246.67		3	
28222	$184.29		1		64891	$246.67		2	
28225	$184.29		1		64892	$246.67		2	
28226	$184.29		1		64893	$246.67		2	
28230	$283.53		1		64895	$283.53		2	
28232	$184.29		1		64896	$283.53		2	
28234	$184.29		1		64897	$283.53		2	
28238	$283.53		1		64898	$283.53		2	
28240	$246.67		1		64901	$246.67		2	
28250	$283.53		1		64902	$246.67		1	
28260	$283.53		1		64905	$246.67		1	
28261	$283.53		1		64907	$184.29		1	
28262	$283.53		1		64910	$283.53		1	
28264	$184.29		1		64911	$283.53		2	
28270	$283.53		1		65091	$283.53		1	
28272	$283.53		1		65093	$283.53		1	
28280	$184.29		1		65101	$283.53		1	
28285	$283.53		1		65103	$283.53		1	
28286	$283.53		1		65105	$348.74		1	
28288	$283.53		1		65110	$397.66		1	
28289	$283.53		1		65112	$397.66		1	
28290	$246.67		1		65114	$552.18		1	
28292	$246.67		1		65125	$246.67		1	
28293	$246.67		1		65130	$283.53		1	
28294	$283.53		1		65135	$246.67		1	
28296	$283.53		1		65140	$283.53		1	
28297	$283.53		1		65150	$246.67		1	
28298	$283.53		1		65155	$283.53		1	
28299	$283.53		1		65175	$184.29		1	
28300	$246.67		1		65220	$184.29		1	
28302	$246.67		1		65222	$184.29		1	
28304	$246.67		1		65235	$246.67		1	
28305	$283.53		1		65260	$283.53		1	
28306	$348.74		1		65265	$348.74		1	
28307	$283.53		1		65270	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
28308	$246.67		1		65272	$246.67		1	
28309	$348.74		1		65273	$246.67		1	
28310	$283.53		1		65275	$283.53		1	
28312	$283.53		1		65280	$348.74		1	
28313	$246.67		1		65285	$348.74		1	
28315	$246.67		1		65286	$246.67		1	
28320	$283.53		1		65290	$283.53		1	
28322	$348.74		1		65400	$184.29		1	
28340	$348.74		1		65410	$246.67		1	
28341	$348.74		1		65420	$246.67		1	
28344	$184.29		1		65426	$397.66		1	
28345	$246.67		1		65436	$184.29		2	
28405	$246.67		1		65450	$246.67		1	
28406	$246.67		1		65710	$552.18		1	
28415	$283.53		1		65730	$552.18		1	
28420	$348.74		1		65750	$552.18		1	
28435	$246.67		1		65755	$552.18		1	
28436	$246.67		1		65756	$552.18		1	
28445	$283.53		1		65757	$552.18		1	
28446	$348.74		1		65770	$552.18		1	
28455	$184.29		1		65772	$348.74		1	
28456	$246.67		1		65775	$348.74		1	
28465	$283.53		1		65778	$184.29		1	
28475	$184.29		1		65779	$184.29		1	
28476	$246.67		1		65780	$184.29		1	
28485	$283.53		1		65781	$184.29		1	
28495	$184.29		1		65782	$184.29		1	
28496	$246.67		1		65800	$184.29		1	
28505	$246.67		1		65810	$283.53		1	
28515	$184.29		1		65815	$246.67		1	
28525	$246.67		1		65820	$246.67		1	
28531	$246.38		1		65850	$246.67		1	
28545	$184.29		1		65855	$246.67		1	
28546	$246.67		1		65860	$184.29		1	
28555	$246.67		1		65865	$184.29		1	
28575	$184.29		1		65870	$348.74		1	
28576	$283.53		1		65875	$348.74		1	
28585	$283.53		1		65880	$348.74		1	
28605	$184.29		1		65900	$397.66		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
28606	$246.67		1		65920	$552.18		1	
28615	$283.53		1		65930	$397.66		1	
28630	$184.29		1		66020	$184.29		1	
28635	$184.29		1		66030	$184.29		1	
28636	$283.53		1		66130	$552.18		1	
28645	$246.67		1		66150	$348.74		1	
28665	$184.29		1		66155	$348.74		1	
28666	$283.53		1		66160	$246.67		1	
28675	$246.67		1		66165	$348.74		1	
28705	$348.74		1		66170	$348.74		1	
28715	$348.74		1		66172	$348.74		1	
28725	$348.74		1		66174	$348.74		1	
28730	$348.74		1		66175	$348.74		1	
28735	$348.74		1		66180	$348.74		1	
28737	$348.74		1		66185	$246.67		1	
28740	$283.53		1		66220	$283.53		1	
28750	$283.53		1		66225	$348.74		1	
28755	$283.53		1		66250	$246.67		1	
28760	$348.74		1		66500	$184.29		1	
28810	$246.67		1		66505	$184.29		1	
28820	$246.67		1		66600	$283.53		1	
28825	$246.67		1		66605	$283.53		1	
29800	$184.29	YES	1		66625	$283.53		1	
29804	$184.29	YES	1		66630	$283.53		1	
29805	$283.53		1		66635	$283.53		1	
29806	$283.53		1		66680	$283.53		1	
29807	$283.53		1		66682	$246.67		1	
29815	$283.53		1		66700	$246.67		1	
29819	$283.53		1		66710	$246.67		1	
29820	$283.53		1		66711	$246.67		1	
29821	$283.53		1		66720	$246.67		1	
29822	$283.53		1		66740	$246.67		1	
29823	$283.53		1		66761	$184.29		1	
29824	$397.66		1		66762	$184.29		1	
29825	$283.53		1		66770	$184.29		1	
29826	$283.53		1		66820	$348.74		1	
29827	$283.53		1		66821	$348.74		1	
29828	$283.53		1		66825	$246.67		1	
29830	$283.53		1		66830	$348.74		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
29834	$283.53		1		66840	$348.74		1	
29835	$283.53		1		66850	$552.18		1	
29836	$283.53		1		66852	$552.18		1	
29837	$283.53		1		66920	$348.74		1	
29838	$283.53		1		66930	$397.66		1	
29840	$283.53		1		66940	$397.66		1	
29843	$283.53		1		66982	$647.28		1	
29844	$283.53		1		66983	$647.28		1	
29845	$283.53		1		66984	$647.28		1	
29846	$283.53		1		66985	$566.47		1	
29847	$283.53		1		66986	$397.66		1	
29848	$283.53		1		67005	$348.74		1	
29850	$348.74		1		67010	$348.74		1	
29851	$348.74		1		67015	$184.29		1	
29855	$348.74		1		67025	$184.29		1	
29856	$348.74		1		67027	$348.74		1	
29860	$283.53		1		67028	$246.67		1	
29861	$283.53		1		67030	$184.29		1	
29862	$283.53		1		67031	$246.67		1	
29863	$283.53		1		67036	$348.74		1	
29868	$283.53		1		67039	$397.66		1	
29870	$283.53		1		67040	$397.66		1	
29871	$283.53		1		67041	$397.66		1	
29873	$283.53		1		67042	$397.66		1	
29874	$283.53		1		67043	$397.66		1	
29875	$348.74		1		67101	$348.74		1	
29876	$348.74		1		67105	$397.66		1	
29877	$348.74		1		67107	$397.66		1	
29879	$283.53		1		67108	$397.66		1	
29880	$348.74		1		67110	$397.66		1	
29881	$283.53		1		67112	$397.66		1	
29882	$283.53		1		67113	$397.66		1	
29883	$283.53		1		67115	$246.67		1	
29884	$283.53		1		67120	$246.67		1	
29885	$283.53		1		67121	$246.67		1	
29886	$283.53		1		67141	$246.67		1	
29887	$283.53		1		67145	$184.29		1	
29888	$283.53		1		67208	$184.29		1	
29889	$283.53		1		67210	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
29891	$283.53		1		67218	$397.66		1	
29892	$283.53		1		67220	$283.53		1	
29893	$184.29		1		67221	$184.29		1	
29894	$283.53		1		67227	$184.29		1	
29895	$283.53		1		67228	$246.67		1	
29897	$283.53		1		67229	$246.67		1	
29898	$283.53		1		67250	$283.53		1	
29899	$283.53		1		67255	$283.53		1	
29900	$283.53		1		67311	$283.53		1	
29901	$283.53		1		67312	$348.74		1	
29902	$283.53		1		67314	$348.74		1	
29904	$184.29		1		67316	$348.74		1	
29905	$184.29		1		67318	$348.74		1	
29906	$184.29		1		67343	$348.74		1	
29907	$184.29		1		67345	$283.53		1	
29909	$348.74	YES	1		67346	$184.29		1	
29914	$283.53		1		67400	$283.53		1	
29915	$283.53		1		67405	$348.74		1	
29916	$283.53		1		67412	$397.66		1	
30000	$184.29		1		67413	$397.66		1	
30020	$184.29		1		67414	$283.53		1	
30100	$184.29		1		67415	$184.29		1	
30110	$184.29		1		67420	$397.66		1	
30115	$246.67		1		67430	$397.66		1	
30117	$283.53		1		67440	$397.66		1	
30118	$283.53		1		67445	$397.66		1	
30124	$184.29		1		67450	$397.66		1	
30125	$246.67		1		67500	$184.29		1	
30130	$246.67		1		67550	$348.74		1	
30140	$246.67		1		67560	$246.67		1	
30150	$283.53		1		67570	$283.53		1	
30160	$348.74		1		67700	$184.29		1	
30220	$184.29		1	X	67710	$246.67		1	
30310	$184.29		1		67715	$184.29		1	
30320	$246.67		1		67800	$184.29		1	
30400	$283.53	YES	1		67801	$184.29		1	
30410	$348.74	YES	1		67805	$184.29		1	
30420	$348.74	YES	1		67808	$246.67		1	
30430	$283.53	YES	1		67820	$184.29		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
30435	$348.74	YES	1		67825	$184.29		1	
30450	$397.66	YES	1		67830	$246.67		1	
30460	$283.53		1		67835	$246.67		1	
30462	$283.53		1		67840	$184.29		1	
30465	$348.74		1		67850	$184.29		1	
30520	$348.74		1		67875	$184.29		1	
30540	$348.74		1		67880	$283.53		1	
30545	$348.74		1		67882	$283.53		1	
30560	$246.67		1		67900	$283.53	YES	1	
30580	$348.74		1		67901	$397.66	YES	1	
30600	$348.74		1		67902	$397.66	YES	1	
30620	$397.66		1		67903	$283.53	YES	1	
30630	$397.66		1		67904	$348.74	YES	1	
30801	$184.29		1		67906	$397.66	YES	1	
30802	$246.67		1		67908	$348.74	YES	1	
30901	$184.29		1		67909	$283.53	YES	1	
30903	$184.29		1		67911	$184.29		1	
30905	$184.29		1		67912	$283.53		1	
30906	$184.29		1		67914	$184.29		1	
30915	$246.67		1		67916	$348.74		1	
30920	$283.53		1		67917	$348.74		1	
30930	$184.29		1		67921	$184.29		1	
31020	$246.67		1		67922	$283.53		1	
31030	$283.53		1		67923	$348.74		1	
31032	$283.53		1		67924	$348.74		1	
31050	$246.67		1		67930	$246.67		1	
31051	$283.53		1		67935	$246.67		1	
31070	$246.67		1		67938	$184.29		1	
31075	$348.74		1		67950	$246.67	YES	1	
31080	$348.74		1		67961	$283.53		1	
31081	$348.74		1		67966	$283.53		1	
31084	$348.74		1		67971	$283.53		1	
31085	$348.74		1		67973	$283.53		1	
31086	$348.74		1		67974	$283.53		1	
31087	$348.74		1		67975	$283.53		1	
31090	$397.66		1		68020	$184.29		1	
31200	$246.67		1		68040	$184.29		1	
31201	$348.74		1		68100	$184.29		1	
31205	$283.53		1		68110	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
31225	$283.53		1		68115	$246.67		1	
31231	$246.67		1		68130	$246.67		1	
31233	$246.67		1		68320	$348.74		1	
31235	$184.29		1		68325	$348.74		1	
31237	$246.67		1		68326	$348.74		1	
31238	$246.67		1		68328	$348.74	YES	1	
31239	$246.67		1		68330	$348.74		1	
31240	$246.67		1		68335	$348.74		1	
31250	$184.29		1		68340	$348.74		1	
31252	$246.67		1		68360	$246.67		1	
31254	$283.53		1		68362	$246.67		1	
31255	$283.53		1		68371	$184.29		1	
31256	$283.53		1		68500	$283.53		1	
31258	$283.53		1		68505	$283.53		1	
31260	$246.67		1		68510	$184.29		1	
31263	$283.53		1		68520	$283.53		1	
31265	$283.53		1		68525	$184.29		1	
31267	$283.53		1		68530	$246.67		1	
31268	$283.53		1		68540	$283.53		1	
31270	$184.29		1		68550	$283.53		1	
31275	$246.67		1		68700	$246.67		1	
31276	$283.53		1		68705	$184.29		1	
31277	$283.53		1		68720	$348.74		1	
31285	$283.53		1		68745	$348.74		1	
31287	$283.53		1		68750	$348.74		1	
31288	$283.53		1		68760	$246.67		1	
31290	$348.74		1		68770	$348.74		1	
31291	$348.74		1		68801	$184.29		1	
31292	$348.74		1		68810	$184.29		1	
31293	$348.74		1		68811	$184.29		1	
31294	$348.74		1		68815	$184.29		1	
31295	$283.53		1		68816	$246.67		1	
31296	$283.53		1		69000	$184.29		1	
31300	$397.66		1		69005	$246.67		1	
31320	$246.67		1		69020	$184.29		1	
31400	$246.67		1		69100	$184.29		1	
31420	$246.67		1		69105	$184.29		1	
31500	$184.29		1		69110	$184.29		1	
31505	$184.29		1		69120	$246.67		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
31510	$184.29		1		69140	$246.67		1	
31511	$184.29		1		69145	$246.67		1	
31512	$184.29		1		69150	$283.53		1	
31513	$184.29		1		69205	$184.29		1	
31515	$246.67		1		69210	$184.29	YES	1	
31520	$246.67		1		69220	$184.29		1	
31525	$246.67		1		69222	$246.67		1	
31526	$246.67		1		69300	$246.67	YES	1	
31527	$246.67		1		69310	$283.53		1	
31528	$246.67		1		69320	$552.18		1	
31529	$246.67		1		69400	$184.29		1	
31530	$246.67		1		69401	$184.29		1	
31531	$283.53		1		69405	$184.29		1	
31535	$246.67		1		69420	$184.29		1	
31536	$283.53		1		69421	$184.29		1	
31540	$283.53		1		69424	$184.29		1	
31541	$348.74		1		69433	$184.29		1	
31545	$283.53		1		69436	$184.29		1	
31546	$397.66		1		69440	$283.53		1	
31560	$397.66		1		69450	$184.29		1	
31561	$397.66		1		69501	$552.18		1	
31570	$246.67		1		69502	$552.18		1	
31571	$246.67		1		69505	$552.18		1	
31575	$246.67		1		69511	$552.18		1	
31576	$246.67		1		69530	$552.18		1	
31577	$246.67		1		69550	$397.66		1	
31578	$246.67		1		69552	$552.18		1	
31579	$246.67		1		69601	$552.18		1	
31580	$397.66		1		69602	$551.90		1	
31582	$397.66		1		69603	$552.18		1	
31584	$348.74		1		69604	$552.18		1	
31588	$397.66		1		69605	$552.18		1	
31590	$397.66		1		69610	$246.67		1	
31595	$246.67		2		69620	$246.67		1	
31600	$246.67		1		69631	$397.66		1	
31601	$246.67		1		69632	$397.66		1	
31603	$184.29		1		69633	$397.66		1	
31611	$348.74		1		69635	$552.18		1	
31612	$184.29		1		69636	$552.18		1	

Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator	Procedure Code	Maximum Allowed Amount	Requires PA	Maximum Quantity	Under 21 Restriction Indicator
31613	$246.67		1		69637	$552.18		1	
31614	$246.67		1		69641	$552.18		1	
31615	$184.29		1		69642	$552.18		1	
31622	$184.29		1		69643	$552.18		1	
31623	$184.29		1		69644	$552.18		1	
31624	$184.29		1		69645	$552.18		1	
31625	$246.67		1		69646	$552.18		1	
31626	$246.67		1		69650	$552.18		1	
31628	$246.67		1		69660	$397.66		1	
31629	$246.67		1		69661	$397.66		1	
31630	$246.67		1		69662	$348.74		1	
31631	$246.67		1		69666	$348.74		1	
31632	$246.67		4		69667	$348.74		1	
31633	$246.67		4		69670	$283.53		1	
31634	$246.67		1		69676	$283.53		1	
31635	$246.67		1		69700	$283.53		1	
31636	$246.67		1		69710	$283.53		1	
31638	$246.67		1		69711	$184.29		1	
31640	$246.67		1		69714	$743.16		1	
31641	$246.67		1		69715	$743.16		1	
31643	$246.67		1		69717	$743.16		1	
31645	$184.29		1		69718	$743.16		1	
31646	$184.29		1		69720	$397.66		1	
31647	$184.29		1		69725	$397.66		1	
31648	$184.29		1		69740	$397.66		1	
31717	$184.29		1		69745	$397.66		1	
31720	$184.29		1		69801	$397.66		1	
31730	$184.29		1		69805	$552.18		1	
31750	$397.66		1		69806	$552.18		1	
31755	$246.67		1		69820	$397.66		1	
31785	$348.74		1		69840	$397.66		1	
31800	$246.67		1		69905	$552.18		1	
31820	$184.29		1		69910	$552.18		1	
31825	$246.67		1		69915	$552.18		1	
					D9420	$246.67	YES	1	

J. Provider Remittance Advice (RA) Codes

Section J.1 lists the Explanation of Benefit (EOB), Adjustment Reason Codes and Remark Codes that may appear on a Provider Remittance Advice (RA) for paid, denied, or adjusted claims.

Replaced table

J.1 Explanation of Benefit (EOB) Codes

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
201	INVALID PAY-TO PROVIDER NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N280	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER PRIMARY IDENTIFIER.
203	RECIPIENT I.D. NUMBER MISSING	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.
204	RECIPIENT ID - OLD FORMAT	A1	Claim/Service denied.	N382	Missing/incomplete/invalid patient identifier.
206	PRESCRIBING PROVIDER NUMBER NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N31	MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER.
212	MISSING PRESCRIPTION NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N388	Missing/incomplete/invalid prescription number.
215	DATE DISPENSED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
216	DATE DISPENSED IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
217	MISSING DRUG CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
218	INVALID DRUG CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			codes whenever appropriate		
219	QUANTITY DISPENSED IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N378	Missing/incomplete/invalid prescription quantity.
220	QUANTITY DISPENSED IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N378	Missing/incomplete/invalid prescription quantity.
223	MISSING DIAGNOSIS INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
224	DIAGNOSIS TREATMENT INDICATOR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
225	REFERRING PROVIDER - INVALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
226	ANESTHESIA CLAIMS REQUIRE REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
233	UNITS OF SERVICE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
234	PROCEDURE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
235	PROCEDURE CODE NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
236	NO PROCEDURE FOR REVENUE CODE; MEDICAID HAS NO PAYMENT LIABILITY FOR THIS LINE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
239	DETAIL TO DATE OF SERVICE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M59	Missing/incomplete/invalid to date(s) of service.
240	THE DETAIL "TO" DATE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M59	Missing/incomplete/invalid to date(s) of service.
243	MISSING MEDICARE PAID DATE	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
248	PLACE OF SERVICE IS MISSING OR BLANK	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
249	PLACE OF SERVICE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
250	CLAIM HAS NO DETAILS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
255	PATIENT RSN FOR VISIT REQ ON OUTPATIENT HOSP CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
256	ADMIT DIAGNOSIS INVALID ON OUTPATIENT HOSP CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
257	PATIENT RSN FOR VISIT INVALID ON INPATIENT CLAIM	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
258	MISSING DIAGNOSIS CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
260	UNITS OF SERVICE NOT IN VALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
261	MISSING TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N37	Missing/incomplete/invalid tooth number/letter.
262	INVALID TOOTH NUMBER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N37	Missing/incomplete/invalid tooth number/letter.
263	INVALID TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.
264	DETAIL FROM DATE OF SERVICE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
265	DETAIL FROM DATE OF SERVICE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
266	MISSING TOOTH SURFACE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.
268	BILLED AMOUNT INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M79	Missing/incomplete/invalid charge.
269	DETAIL BILLED AMOUNT MISSING OR INVALID FORMAT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M79	Missing/incomplete/invalid charge.
270	MISSING TOTAL CLAIM CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.
271	INVALID TOTAL CLAIM CHARGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.
273	TYPE OF BILL	16	Claim/service lacks information	MA30	Missing/incomplete/invalid type of

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	MISSING		which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		bill.
274	TYPE OF BILL CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
275	ADMIT DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA40	Missing/incomplete/invalid admission date.
276	ADMIT DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA40	Missing/incomplete/invalid admission date.
277	INVALID ADMISSION HOUR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N46	Missing/incomplete/invalid admission hour.
278	ADMIT TYPE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA41	Missing/incomplete/invalid admission type.
279	INVALID TYPE OF ADMISSION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA41	Missing/incomplete/invalid admission type.
280	PATIENT STATUS IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA43	Missing/incomplete/invalid patient status.
281	PATIENT STATUS IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA43	Missing/incomplete/invalid patient status.
282	MISSING COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA32	Missing/incomplete/invalid number of covered days during the billing period.
283	COVERED DAYS INVALID	16	Claim/service lacks information which is needed for	MA32	Missing/incomplete/invalid number of covered days during the billing period.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
284	PRIMARY CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
285	SECOND CONDITON CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
286	THIRD CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
287	FOURTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
288	FIFTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
289	SIXTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
290	SEVENTH CONDITION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
295	DATE FOR PRIMARY OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
296	DATE FOR PRIMARY OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
297	DATE FOR SECOND OCCURRENCE	16	Claim/service lacks information which is needed for adjudication. Additional	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	CODE MISSING		information is supplied using remittance advice remarks codes whenever appropriate		
298	DATE FOR SECOND OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
299	DATE FOR THIRD OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
300	DATE FOR THIRD OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
301	DATE FOR FOURTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
302	DATE FOR FOURTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
309	ICD-10 PROCEDURE BILLED BEFORE COMPLIANCE DATE	181	PAYMENT ADJUSTED BECAUSE THIS PROCEDURE CODE WAS INVALID ON THE DATE OF SERVICE	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
310	ICD-10 DIAGNOSIS BILLED BEFORE COMPLIANCE DATE	146	Diagnosis was invalid for the date(s) of service reported.	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
339	REVENUE CODE IS MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
340	REVENUE CODE IS INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
364	PRINCIPAL ICD9	16	Claim/service lacks information	N303	MISSING/INCOMPLETE/INVALID

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	PROCEDURE DATE MISSING		which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		PRINCIPAL PROCEDURE DATE.
365	PRINCIPAL ICD9 PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N303	MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE DATE.
367	FIRST OTHER ICD9 PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
368	FIRST OTHER ICD9 PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
369	SECOND OTHER PROCEDURE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S)
370	SECOND OTHER ICD9 PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
371	SECOND OTHER ICD9 PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
373	THIRD OTHER ICD9 PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
374	THIRD OTHER ICD9 PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
376	FOURTH OTHER ICD9 PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
377	FOURTH OTHER ICD9 PROCEDURE	16	Claim/service lacks information which is needed for	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	DATE INVALID		adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
379	FIFTH OTHER ICD9 PROCEDURE DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
380	FIFTH OTHER ICD9 PROCEDURE DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).
381	ATTENDING PHYSICIAN PROVIDER NUMBER MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N253	MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER PRIMARY IDENTIFIER.
395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
411	DATE FOR FIFTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
412	DATE FOR FIFTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		
413	DATE FOR SIXTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
414	DATE FOR SIXTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
415	DATE FOR SEVENTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
416	DATE FOR SEVENTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
417	DATE FOR EIGHTH OCCURRENCE CODE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
418	DATE FOR EIGHTH OCCURRENCE CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
433	MEDICARE DEDUCTIBLE AMOUNT INVALID	1	DEDUCTIBLE AMOUNT	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N219	PAYMENT BASED ON PREVIOUS PAYER'S ALLOWED AMOUNT.
450	INVALID QUADRANT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N346	Missing/incomplete/invalid oral cavity designation code.
455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever	N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate.		benefits.
456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
465	DATE FOR OCCURRENCE CODE 9-24 MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
466	DATE FOR OCCURRENCE CODE 9-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N299	MISSING/INCOMPLETE/INVALID OCCURRENCE DATE(S).
471	CONDITION CODE 8-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
473	ICD9 PROCEDURE 7-24 INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
474	ICD9 PROCEDURE 7-24 OR DATE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N301	MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S).
475	ICD9 PROCEDURE 7-24 DATE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N301	MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S).
500	DATE PRESCRIBED AFTER BILLING DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N57	MISSING/INCOMPLETE/INVALID PRESCRIBING DATE.
502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
503	DATE DISPENSED AFTER BILLING DATE	110	BILLING DATE PREDATES SERVICE DATE.	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
507	FIRST DATE OF SERV GREATER THAN LAST DATE OF SERV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M54	Missing/incomplete/invalid total charges.
512	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	The time limit for filing has expired.	M46	MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE.
513	NAME ON CLAIM MUST MATCH NAME ON FILE	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.
514	DATE RECEIVED FOR PROCESSING-PRIOR TO DATE OF SERV	110	BILLING DATE PREDATES SERVICE DATE.	M59	Missing/incomplete/invalid to date(s) of service.
519	ADMIT DATE GREATER THAN FIRST DATE OF SERVICE	110	BILLING DATE PREDATES SERVICE DATE.	MA40	Missing/incomplete/invalid admission date.
526	DETAIL DATES NOT WITHIN HEADER DATES	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M52	Missing/incomplete/invalid from date(s) of service.
537	HDR FROM DATE OF SERVICE > HDR TO DATE OF SERVICE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.
555	SERVICE(S) PAST THE MAXIMUM MEDICAID FILING LIMIT	29	The time limit for filing has expired.	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
557	MEPD LATE FILING	29	The time limit for filing has expired.	N59	Please refer to your provider manual for additional program and provider information.
570	TOTAL DAYS LESS THAN COVERED DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	MA32	Missing/incomplete/invalid number of covered days during the billing period.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			codes whenever appropriate		
571	SURGICAL PROCEDURE MISSING	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA32	Missing/incomplete/invalid number of covered days during the billing period.
574	SERVICE DATES ARE NOT IN SAME MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N341	MISSING/INCOMPLETE/INVALID SURGERY DATE.
577	DETAIL SERVICE DATES ARE NOT IN SAME MONTH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
589	ADJUSTMENT HAS AUTO DENIAL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M85	Subjected to review of physician evaluation and management services.
590	MEPD CLAIM SPANS FISCAL YEAR END	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N61	Rebill services on separate claims.
595	MANUALLY SUSPEND FOR REVIEW	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M85	Subjected to review of physician evaluation and management services.
596	FILE SEPARATE CLAIMS FOR DIFFERENT YEARS	129	Payment denied - Prior processing information appears incorrect.	N61	Rebill services on separate claims.
602	UNITS NOT EQUAL TO TEETH BILLED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
606	INVALID OTHER PAYER DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
620	TPL DEDUCTIBLE	16	Claim/service lacks information	M58	Missing/incomplete/invalid claim

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	AMOUNT NOT NUMERIC		which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		information. Resubmit claim after corrections.
621	TPL COINSURANCE AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
622	TPL COPAY AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
623	TPL PAID AMOUNT NOT NUMERIC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
624	TPL DETAIL PAYER DOES NOT HAVE MATCHING HDR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
625	TPL DETAIL PAYER HAS MULTIPLE MATCHING HDR PAYERS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
626	TPL DETAIL PAYER ID HAS DUPLICATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
627	TPL HDR COINSURANCE <> SUM OF DTL COINSURANCE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
628	TPL HDR DEDUCTIBLE NOT EQUAL SUM OF DTL DEDUCTIBLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
629	TPL HDR COPAY NOT EQUAL SUM OF DTL COPAY	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
630	TPL HDR PAID AMT NOT EQUAL	16	Claim/service lacks information which is needed for	M58	Missing/incomplete/invalid claim information. Resubmit claim after

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	SUM OF DTL PAID AMT		adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		corrections.
631	TPL - PATIENT RESPONSIBILITY IS ZERO FOR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
632	TPL HDR PAYER HAS NO DETAIL PAYER INFORMATION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
633	TPL HDR PAYER ID IS DUPLICATE OF ANOTHER HDR PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
634	TPL PAYER RESPONSIBILITY MISSING OR INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
635	TPL PAYER RESPONSIBILITY HIERARCHY IS DUPLICATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
636	TPL TOTAL PAID AMT NOT EQUAL SUM OF HDR PAID AMT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
637	CLAIM WITH TPL AMOUNT MISSING TPL PAYER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
643	INVALID OTHER COVERAGE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N245	INCOMPLETE/INVALID PLAN INFORMATION FOR OTHER INSURANCE.
644	OTHER PAYER PAT RESP AMT IS INVALID	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
645	OTHER PAYER PAT RESP QUALIFIER IS INVALID	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
675	ADJ - RECIPIENT ID NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional	N382	Missing/incomplete/invalid patient identifier.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		
676	ADJ - PROVIDER ID NOT SUBMITTED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N77	Missing/incomplete/invalid designated provider number.
677	ADJ - ORIGINAL ICN NOT FOUND	107	The related or qualifying claim/service was not identified on this claim.	M47	Missing/incomplete/invalid internal or document control number.
678	ADJ - ORIGINAL ICN NOT SUBMITTED	107	The related or qualifying claim/service was not identified on this claim.	M47	Missing/incomplete/invalid internal or document control number.
679	ADJ - REQUEST RECIPIENT ID NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N382	Missing/incomplete/invalid patient identifier.
680	ADJ - REQUEST PROVIDER DOES NOT MATCH ORIGINAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N152	Missing/incomplete/invalid replacement claim information.
681	ADJ - ORIGINAL ICN NOT FOUND	107	The related or qualifying claim/service was not identified on this claim.	M47	Missing/incomplete/invalid internal or document control number.
684	ADJ - REQUEST RECIPIENT DOES NOT MATCH ORIGINAL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N152	Missing/incomplete/invalid replacement claim information.
685	ADJ - ORIGINAL CLAIM NOT IN A PAID STATUS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N142	The original claim was denied. Resubmit a new claim, not a replacement claim.
686	ADJ - REPLACEMENT CLAIM NOT SAME CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N152	Missing/incomplete/invalid replacement claim information.
687	CANNOT ADJUST THIS CLAIM DUE TO PROVIDER CHANGES. VOID THIS CLAIM AND RESUBMIT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M56	Missing/incomplete/invalid payer identifier.
800	DETAIL RATE NOT NUMERIC	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M79	Missing/incomplete/invalid charge.
801	DTL RATE * DTL	125	Payment adjusted due to a	M79	Missing/incomplete/invalid charge.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	UNITS NOT EQUAL DTL BILLED AMOUNT		submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		
803	DATED EXCEED SOBRA/QMB ELIGIBILITY	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.
805	NONCOVERED CHARGE IS NOT NUMERIC	96	Non-covered charge(s).	M79	Missing/incomplete/invalid charge.
806	MEDICARE PAID AMOUNT MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
807	INVALID TPL ADJUDICATION DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
808	TPL ADJUDUCATION DATE CANNOT BE A FUTURE DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
809	VERIFY LIFETIME RESERVE AND COINS DAYS TO COV DAYS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA35	Missing/incomplete/invalid number of lifetime reserve days.
811	HEADER FROM DATE OF SERVICE > ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M52	Missing/incomplete/invalid from date(s) of service.
812	ADMIT DATE IS GREATER THAN ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA40	Missing/incomplete/invalid admission date.
813	MEDICARE PAID DATE > ICN DATE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N307	MISSING/INCOMPLETE/INVALID ADJUDICATION OR PAYMENT DATE.
814	DETAIL TO DATE OF SERVICE > ICN DATE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M59	Missing/incomplete/invalid to date(s) of service.
815	SURGICAL ICD9 REQUIRES	125	Payment adjusted due to a submission/billing error(s).	N262	MISSING/INCOMPLETE/INVALID OPERATING PROVIDER PRIMARY

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	OPERATING PHYSICIAN		Additional information is supplied using the remittance advice remarks codes whenever appropriate.		IDENTIFIER.
816	COINSURANCE DAYS NOT NUMERIC	2	Coinsurance Amount	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
817	INVALID COINSURANCE DAYS	2	Coinsurance Amount	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.
818	LIFETIME RESERVE DAYS NOT NUMERIC	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA35	Missing/incomplete/invalid number of lifetime reserve days.
819	LIFETIME RESERVE DAYS > MAX ALLOWED	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	MA35	Missing/incomplete/invalid number of lifetime reserve days.
820	FROM DOS AND TO DOS MAY NOT SPAN THE FISCAL YEAR	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N61	Rebill services on separate claims.
821	NON-COVERED DAYS MISSING OR NOT NUMERIC	78	Non-Covered days/Room charge adjustment.	MA33	Missing/incomplete/invalid noncovered days during the billing period.
822	SURGICAL REVENUE CODE REQUIRES ICD9 SURGERY CODE	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S)
823	RECIPIENT CHECK DIGIT IS MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N382	Missing/incomplete/invalid patient identifier.
825	MEDICARE ALLOWED AMOUNT MISSING OR INVALID	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N219	PAYMENT BASED ON PREVIOUS PAYER'S ALLOWED AMOUNT.
826	TYPE OF BILL INVALID FOR CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
830	MEDICARE HDR ALLOW AMNT NOT EQUAL SUM OF DTL ALLOW	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N219	PAYMENT BASED ON PREVIOUS PAYER'S ALLOWED AMOUNT.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
900	PROVIDER TYPE SPECIALITY GROUP NOT FOUND	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
901	GROUP NUMBER NOT FOUND IN PROVIDER GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
902	PROCEDURE CODE GROUP NOT FOUND	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N55	Procedures for billing with group/referring/performing providers were not followed.
903	GROUP NUMBER NOT FOUND IN PLACE OF SERVICE GROUP T	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
905	GROUP NUMBER NOT FOUND IN LEVEL OF CARE GROUP TABL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N188	The approved level of care does not match the procedure code submitted.
906	GROUP NUMBER NOT FOUND IN ICD-9 GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
909	GROUP NUMBER NOT FOUND IN DIAGNOSIS GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
913	GROUP NUMBER NOT FOUND IN REVENUE GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
914	GROUP NUMBER NOT FOUND IN TYPE OF BILL GROUP TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
915	GROUP NUMBER NOT FOUND IN COUNTY GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
916	GROUP NOT FOUND IN PROVIDER GROUP TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
917	GROUP NUMBER NOT FOUND IN PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	GROUP TABLE		information is supplied using remittance advice remarks codes whenever appropriate		
918	TOOTH SURFACE NUMBER NOT FOUND IN TOOTH SURFACE GR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N75	Missing/incomplete/invalid tooth surface information.
919	GROUP NUMBER NOT FOUND IN AID CODE TABLE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N216	PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.
921	GROUP NUMBER NOT FOUND IN PROVIDER LIST TABLE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA112	Missing/incomplete/invalid group practice information.
924	SYSTEM ERROR - ADJ - ORIGINAL CLAIM NOT FOUND	63	Correction to a prior claim.	M47	Missing/incomplete/invalid internal or document control number.
925	GROUP NUMBER NOT FOUND IN REFERENCE GROUP TABLE.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
1000	NO PAY-TO PROVIDER RECORD	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N279	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER NAME.
1001	BILLING PROVIDER NOT ENROLLED FOR DATES OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.
1002	PERFORMING PROV NOT ELIGIBLE FOR DOS	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N277	MISSING/INCOMPLETE/INVALID OTHER PAYER RENDERING PROVIDER IDENTIFIER.
1003	PROVIDER INELIGIBLE ON DATE OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.
1007	RENDERING PROVIDER IDENTIFIER NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1010	PERFORMING PROVIDER NOT IN BILLING GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N55	Procedures for billing with group/referring/performing providers were not followed.
1018	CLINIC RATE NOT ON FILE FOR	16	Claim/service lacks information which is needed for	N65	Procedure code or procedure rate count cannot be determined, or was

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	HOSPITAL		adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		not on file, for the date of service/provider.
1024	BILLING PROVIDER NOT LISTED AS RECIPIENT LTC PROV	38	Services not provided or authorized by designated (network/primary care) providers.	N31	MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER.
1032	PROVIDER TYPE - CLAIM INPUT CONFLICT	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
1038	DEA NOT ON FILE FOR PRESCRIBER	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1041	PRESCRIBER PRACTICE TYPE NOT VALID FOR DRUG SCHED	3	Co-payment Amount	M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.
1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N277	MISSING/INCOMPLETE/INVALID OTHER PAYER RENDERING PROVIDER IDENTIFIER.
1065	PROVIDER NAME MISMATCH	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N279	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER NAME.
1803	BILLING PROVIDER MUST BE GROUP PROVIDER NUMBER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N55	Procedures for billing with group/referring/performing providers were not followed.
1804	VERIFY PERFORMING PROVIDER NOT GROUP PROVIDER	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N55	Procedures for billing with group/referring/performing providers were not followed.
1805	BILLING PROVIDER SPECIALTY NOT FOUND FOR CLAIM DOS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N95	This provider type/provider specialty may not bill this service.
1807	CROSSOVER ONLY PROVIDER	16	Claim/service lacks information which is needed for	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	CANNOT BILL CLAIM TYPE		adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
1810	PERFORMING PROVIDER SPECIALTY NOT FOUND FOR DOS	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N95	This provider type/provider specialty may not bill this service.
1815	PERF PROV ENROLL STATUS NOT VALID FOR DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1817	MATERNITY CARE PROV CAN ONLY BILL MATERNITY SVCS	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.
1819	INVALID POS FOR FQHC PROVIDER	5	The procedure code/bill type is inconsistent with the place of service.	M77	Missing/incomplete/invalid place of service.
1820	PATIENT FIRST CLAIM REQUIRES A REFERRAL	38	Services not provided or authorized by designated (network/primary care) providers.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
1825	COBA DENIAL - DO NOT CROSSOVER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
1826	SERVICE FOR MATERNITY WAIVER/CARE RECIPIENT MUST BE BILLED WITH GLOBAL SERVICE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N95	This provider type/provider specialty may not bill this service.
1827	NON-MEPD CLAIM FOR MEPD RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M115	This item is denied when provided to this patient by a non-demonstration supplier.
1900	TAXONOMY IS INVALID BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1901	TAXONOMY IS INVALID PREFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1906	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1907	TAXONOMY IS	16	Claim/service lacks information	N288	MISSING/INCOMPLETE/INVALID

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	NOT VALID FOR PERFORMING PROVIDER		which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		RENDERING PROVIDER TAXONOMY.
1912	TAXONOMY IS MISSING: BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1913	TAXONOMY IS MISSING: PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1919	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1921	TAXONOMY IS MISSING: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1925	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1927	BILLING PROVIDER - NPI MISSING OR INVALID - AN NPI NUMBER IS REQUIRED AND WAS N	206	National Provider Identifier - missing	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.
1928	NPI REQUIRED HEALTHCARE=Y PREMING PROV	206	National Provider Identifier - missing	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1931	NPI REQUIRED HEALTHCARE=Y RENDERING PROV	206	National Provider Identifier - missing	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV	206	National Provider Identifier - missing	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.
1960	NPI REQUIRED: ATTENDING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N253	MISSING/INCOMPLETE/INVALID ATTENDING PROVIDER PRIMARY IDENTIFIER.
1961	NPI REQUIRED: OPERATING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional	N262	MISSING/INCOMPLETE/INVALID OPERATING PROVIDER PRIMARY IDENTIFIER.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	(HEALTHCARE)		information is supplied using remittance advice remarks codes whenever appropriate		
1962	NPI REQUIRED: REFERRING PROVIDER (HEALTHCARE)	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
1974	TAXONOMY IS INVALID: DTL PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1975	TAXONOMY IS INVALID: DTL REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.
1976	TAXONOMY IS INVALID: DTL OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1977	TAXONOMY IS NOT VALID FOR DTL OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1978	TAXONOMY IS NOT VALID FOR DTL PERFORMING PROV	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1979	TAXONOMY IS NOT VALID FOR DTL REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.
1980	TAXONOMY IS NOT VALID FOR BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1981	TAXONOMY IS NOT VALID FOR PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1982	TAXONOMY IS NOT VALID FOR REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate		
1983	TAXONOMY IS NOT VALID FOR FACILITY PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1984	TAXONOMY IS NOT VALID FOR OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1985	TAXONOMY IS INVALID: BILLING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N255	MISSING/INCOMPLETE/INVALID BILLING PROVIDER TAXONOMY.
1986	TAXONOMY IS INVALID: PERFORMING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
1987	TAXONOMY IS INVALID: REFERRING PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N284	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER TAXONOMY.
1988	TAXONOMY IS INVALID: FACILITY PROVIDER	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
1989	TAXONOMY IS INVALID: OTHER PROVIDER 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.
2003	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	Expenses incurred prior to coverage.	N30	Recipient ineligible for this service.
2045	ITEM NOT PAYABLE IN LONG TERM CARE FACILITY	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
2053	ITEMIZED SERVICE DATE NOT IN ELIGIBILITY SPAN	26	Expenses incurred prior to coverage.	N30	Recipient ineligible for this service.
2057	RECIPIENT PARTIALLY ELIGIBILE - HEADER	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.
2077	RECIPIENT IS NOT ELIGIBLE ALL DATES OF	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	SERVICES				
2504	FILE SHOWS OTHER INSURANCE, SUBMIT TO OTHER CARRIER	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2505	RECIPIENT COVERED BY PRIVATE INSURANC(W/ATT ACHMNT)	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2507	THIS PATIENT HAS TWO COVERAGE TYPES	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	N4	Missing/incomplete/invalid prior insurance carrier EOB.
2800	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2801	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2802	ABORTION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMENTS.	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2804	DETAILS COVERED BY MORE THAN ONE PLAN CODE	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	N61	Rebill services on separate claims.
2807	COBA-NO MEDICAID ID FOR MEDICARE ID	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.
2808	COBA - MEDICARE ID NOT ON FILE	31	Claim denied as patient cannot be identified as our insured.	N382	Missing/incomplete/invalid patient identifier.
2850	STERILIZATION DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREME	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2851	HYSTERECTOMY DENIED BECAUSE DOCUMENTATION DOES NOT MEET HHS/MEDICAID REQUIREMEN	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete.	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.
2852	ABORTION DENIED BECAUSE DOCUMENTATION	226	Information requested from the Billing/Rendering Provider was not provided or was	N288	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER TAXONOMY.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	DOES NOT MEET HHS/MEDICAID REQUIREMENTS.		insufficient/incomplete.		
3019	PA CUTBACK PERFORMED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N123	This is a split service and represents a portion of the units from the originally submitted service.
3100	CLAIM AND PA PRESCRIBING PROV DON'T MATCH	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
3104	PA REQUIRED FOR CERTAIN TRANSPORTATION SERVICES	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.
3300	NEONATAL REVENUE - DIAGNOSIS CODE MISMATCH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M76	Missing/incomplete/invalid diagnosis or condition.
3302	PROCEDURE AND REVENUE CODE COMBINATION NOT VALID	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	M50	Missing/incomplete/invalid revenue code(s).
3307	FQHC/PBRHC FFS/ENCOUNTER PROCEDURE CONFLICT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
3309	PROCEDURE CODE - TYPE OF BILL RESTRICTION	5	The procedure code/bill type is inconsistent with the place of service.	MA30	Missing/incomplete/invalid type of bill.
3313	NDC DRUG, PRODUCT IS NOT PREFERRED	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M62	Missing/incomplete/invalid treatment authorization code.
3314	PHARMACY ONLY - OTC DRUG NOT COVERED FOR LTC RECIP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
3315	NURSERY DAYS EXCEED LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.
3316	PHARMACY ONLY - NDC IS NOT PAYABLE BY ALABAMA MEDICAID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
3351	PRIMARY DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
3352	SECOND	16	Claim/service lacks information	M64	Missing/incomplete/invalid other

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR		which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		diagnosis.
3353	THIRD DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3354	FOURTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3355	FIFTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3356	SIXTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3357	SEVENTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3358	EIGHTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3359	NINTH DIAGNOSIS REQUIRES PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3998	BPA-RR-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
3999	BPA-RR-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4001	BPA-RP-DIAG - BILL PROV	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	PRIMARY PT/PS RESTRICTION				
4002	BPA-RP-NDC - NO COVERAGE	96	Non-covered charge(s).	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4004	NDC IS NOT ON FILE	96	Non-covered charge(s).	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4013	PROCEDURE CODE IS NO LONGER VALID	96	Non-covered charge(s).	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4014	NO PRICING SEGMENT IS ON FILE.	133	The disposition of this claim/service is pending further review.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4016	BPA-RP-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	12	The diagnosis is inconsistent with the provider type.	M76	Missing/incomplete/invalid diagnosis or condition.
4021	BPA-RP-PROC - NO COVERAGE	96	Non-covered charge(s).	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4029	BPA-RP-DIAG - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4032	PROCEDURE CODE IS MISSING/NOT ON FILE	96	Non-covered charge(s).	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4046	DATE OF SERVICE BEFORE PROCEDURE IS PAYABLE	96	Non-covered charge(s).	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		service/provider.
4059	REVENUE CODE NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4061	BPA-RR - NO RULE FOR CLAIM TYPE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4062	BPA-RR - NO RULE FOR COND CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4064	BPA-RP-ICD9 - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4073	BPA-RP-DIAG - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4075	BPA-RP-ICD9 - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4077	NON-COVERED REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4093	BPA-RP-DIAG - DIAG ROLE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4104	BPA-RP-PROC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4106	BPA-RP-REV - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using	M50	Missing/incomplete/invalid revenue code(s).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate		
4109	BPA-PC-DIAG - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4112	BPA-PC-ICD9 - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4117	BPA-PC-NDC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4118	BPA-PC-PROC - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4120	ORAL CAVITY DESIGNATION CODE INVALID	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N346	Missing/incomplete/invalid oral cavity designation code.
4130	PAYER HIERARCHY NOT FOUND	A1	Claim/Service denied.	M56	Missing/incomplete/invalid payer identifier.
4136	BPA-RP-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4138	BPA-RP-NDC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4140	BPA-RP-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4141	BPA-RP-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4142	BPA-RP-REV - BILL PROV PRIMARY PT/PS	16	Claim/service lacks information which is needed for adjudication. Additional	M50	Missing/incomplete/invalid revenue code(s).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	RESTRICTION		information is supplied using remittance advice remarks codes whenever appropriate		
4143	BPA-RP-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4144	BPA-PC-DIAG - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4149	BPA-PC-PROC - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4150	BPA-PC-PROC - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4151	BPA-PC-REV - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4152	BPA-PC-REV - PERF PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4154	BPA-PC-REV - FAMILY PLANNING IND RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4155	BPA-RR-PROC - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4157	BPA-PC-DIAG - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M76	Missing/incomplete/invalid diagnosis or condition.
4159	BPA-PC-ICD9 - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4160	BPA-PC-NDC - CURR PROV	B7	This provider was not certified/eligible to be paid for	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	CONTRACT RESTRICTION		this procedure/service on this date of service.		DRUG CODE (NDC).
4161	BPA-PC-PROC - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4162	BPA-PC-REV - CURR PROV CONTRACT RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M50	Missing/incomplete/invalid revenue code(s).
4166	BPA-RR-NDC - NO RULE FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4167	BPA-RR-REV - NO RULE FOR BENEFIT PLAN	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4177	BPA-PC-ICD9 - BILL PROV PRIMARY PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N95	This provider type/provider specialty may not bill this service.
4194	BPA-RP-PROC - OTHER DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.
4208	CLIA NUMBER NOT EFFECTIVE FOR ENTIRE SVC PERIOD	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.
4210	BPA-RR-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4211	INVALID TOOTH NUMBER FOR THIS PROCEDURE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N37	Missing/incomplete/invalid tooth number/letter.
4212	BILLING OUT OF CLIA CERTIFICATE TYPE	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	MA120	Missing/incomplete/invalid CLIA certification number.
4219	BPA-RR-REV - NO RULE FOR TYPE OF BILL	16	Claim/service lacks information which is needed for adjudication. Additional	MA30	Missing/incomplete/invalid type of bill.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		
4224	BPA-RP-PROC - QUANTITY RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.
4225	INVALID INPATIENT REVENUE CODE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4226	DIAGNOSIS MUST BE BILLED AT THE HIGHEST SUBDIVISION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M81	YOU ARE REQUIRED TO CODE TO THE HIGHEST LEVEL OF SPECIFICITY.
4227	BPA-RP-REV - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4244	BPA-RP-DIAG - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4246	ADJUSTMENT NET PAID AMOUNT EXCEEDS THE CASH RECEIPT BALANCE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	M78	Missing/incomplete/invalid HCPCS modifier.
4250	BPA-RR - NO RULE FOR PRIMARY PT/PS BILL/PERF	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N95	This provider type/provider specialty may not bill this service.
4251	DECIMAL UNITS NOT BILLABLE FOR PROCEDURE.	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
4252	DIAGNOSIS CODE 10-24 NOT ON FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4254	BPA-RP-REV - AGE RESTRICTION	6	The procedure code is inconsistent with the patient's age.	M50	Missing/incomplete/invalid revenue code(s).
4260	NDC REQUIRED FOR PROCEDURE	16	Claim/service lacks information which is needed for	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		DRUG CODE (NDC).
4264	NDC NOT ON THE DRUG FILE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4265	INVALID HCPCS/NDC COMBINATION FOR PRIMARY NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4266	NDC NOT COVERED - PRIMARY NDC NOT ACTIVE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4267	NDC NOT COVERED - SECONDARY NDC NOT ACTIVE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4268	NDC NOT COVERED - NDC NOT REBATABLE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4269	NDC NOT COVERED - SECOND NDC NOT REBATABLE ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4270	NDC NOT COVERED - NDC RATED LESS THAN EFFECTIVE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4271	DUPLICATE NDC FOR CLAIM DETAIL	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4272	NDC NOT COVERED - OBSOLETE OR TERMINATED ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4273	INVALID NDC QUALIFIER CODE, MUST EQUAL N4	16	Claim/service lacks information which is needed for adjudication. Additional	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			information is supplied using remittance advice remarks codes whenever appropriate		
4278	NDC NOT COVERED - NDC NOT EFFECTIVE ON THE DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4279	NDC NOT COVERED - NDC INACTIVE ON THE DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4280	NDC NOT COVERED - NDC IN REJECT REGARDLESS ON DOS	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4281	NDC NOT COVERED - REPACKAGED NDC	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4310	BPA-PC-PROC - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4311	BPA-PC-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4312	BPA-PC-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4313	BPA-PC-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4314	BPA-RP-DIAG - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4315	BPA-PC-PROC - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using	M76	Missing/incomplete/invalid diagnosis or condition.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate		
4316	BPA-PC -ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4317	BPA-PC-ICD9 - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4318	BPA-PC-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4319	BPA-PC-ICD9 - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4320	BPA-PC-REV - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4321	BPA-PC-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4322	BPA-PC-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4362	BPA-PC-DIAG - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4364	BPA-PC-ICD9 - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4371	BPA-RP-PROC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			codes whenever appropriate		
4372	BPA-PC-PROC - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4373	BPA-RP-NDC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4374	BPA-RP-REV - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4376	BPA-RP-ICD9 - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4519	BPA-PC-PROC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4520	BPA-PC-REV - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4521	BPA-RP-DIAG - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4522	BPA-RP-NDC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4523	BPA-RP-ICD9 - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4524	BPA-RP-PROC - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4525	BPA-RP-REV - BILL PROV ALL PT/PS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4529	BPA-RP-REV - PROV COUNTY RESTRICTION	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	M50	Missing/incomplete/invalid revenue code(s).
4530	BPA-RR-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4532	BPA-RR-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4533	BPA-RP-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4535	BPA-RP-ICD9 - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4536	BPA-RP-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4538	BPA-RP-REV - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4539	BPA-PC-PROC - EMERGENCY DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4540	BPA-PC-PROC - MIN UNIT RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M53	Missing/incomplete/invalid days or units of service.
4560	BPA-RP-ICD9 - SECONDARY HDR DIAG	16	Claim/service lacks information which is needed for adjudication. Additional	M64	Missing/incomplete/invalid other diagnosis.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	RESTRICTION		information is supplied using remittance advice remarks codes whenever appropriate		
4561	BPA-RP-REV - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4562	BPA-RP-REV - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4564	BPA-RR-PROC - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4565	BPA-RR-ICD9 - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4566	BPA-RR-REV - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4580	BPA-RP-PROC - DIAGNOSIS RESTRICTION - GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4581	BPA-PC-PROC - DIAGNOSIS RESTRICTION - GROUP	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4716	BPA-PC-ICD9 - AGE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4723	BPA-RP-ICD9 - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA36	Missing/incomplete/invalid patient name.
4724	BPA-RP-ICD9 - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using	M64	Missing/incomplete/invalid other diagnosis.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate		
4726	BPA-RP-ICD9 - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4731	BPA-RP-PROC - ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4732	BPA-RP-REV - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4733	BPA-RP-REV - ANY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4736	BPA-RP-REV - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4741	BPA-RP-PROC - ADMIT DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA65	Missing/incomplete/invalid admitting diagnosis.
4742	BPA-RP-PROC - PRIMARY HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4743	BPA-RP-PROC - SECONDARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4744	BPA-RP-PROC - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4745	BPA-RP-PROC - DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	M64	Missing/incomplete/invalid other diagnosis.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			codes whenever appropriate		
4746	BPA-RP-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA63	Missing/incomplete/invalid principal diagnosis.
4747	BPA-PC-ICD9 - HDR SECONDARY DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4748	BPA-PC-REV - SECONDARY HDR DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4751	BPA-PC-REV - TYPE OF BILL RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA30	Missing/incomplete/invalid type of bill.
4756	BPA-PC-DIAG - CURRENT BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4757	BPA-PC-REV - CURRENT BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4762	BPA-PC-ICD9 - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4765	BPA-RP-ICD9 - NO COVERAGE	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4767	BPA-RP-ICD9 - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4801	BPA-PC-PROC - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
4802	BPA-PC-DIAG - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4804	BPA-PC-REV - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4806	BPA-PC-ICD9 - NO CONTRACT	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4821	BPA-PC-PROC - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4822	BPA-PC-DIAG - PLACE OF SERVICE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M77	Missing/incomplete/invalid place of service.
4835	BPA-PC-PROC - OTHER DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4871	BPA-PC-PROC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4872	BPA-PC-DIAG - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4873	BPA-PC-NDC - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4874	BPA-PC-REV - CLAIM TYPE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.
4876	BPA-PC-ICD9 -	16	Claim/service lacks information	N34	INCORRECT CLAIM FORM/FORMAT

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	CLAIM TYPE RESTRICTION		which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		FOR THIS SERVICE.
4900	BPA-RP-DIAG - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4901	BPA-RP-DIAG - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4902	BPA-RP-DIAG - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4905	BPA-RP-ICD9 - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4906	BPA-RP-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4910	BPA-PC-DIAG - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4911	BPA-PC-DIAG - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4912	BPA-PC-DIAG - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4913	BPA-XX-DIAG - DIAG ROLE RESTRICTION -PC and RR	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4923	BPA-PC-ICD9 - OTHER HDR	16	Claim/service lacks information which is needed for	M64	Missing/incomplete/invalid other diagnosis.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	DIAGNOSIS RESTRICTION		adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate		
4927	BPA-RP-DIAG - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4928	BPA-RP-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4929	BPA-RP-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4933	BPA-PC-PROC - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4937	BPA-PC-DIAG - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4938	BPA-PC-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4939	BPA-PC-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4940	BPA-RP-ICD9 - BENE PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4941	BPA-RP-ICD9 - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4942	BPA-RP-ICD9 - OCCURRENCE CODE	16	Claim/service lacks information which is needed for adjudication. Additional	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	RESTRICTION		information is supplied using remittance advice remarks codes whenever appropriate		
4943	BPA-PC-REV - OTHER HDR DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4944	BPA-PC-ICD9 - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4947	BPA-RR-NDC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4948	BPA-RR-PROC - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).
4949	BPA-RR-REV - ASSIGNMENT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4950	BPA-PC-ICD9 - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4951	BPA-PC-ICD9 - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4952	BPA-PC-ICD9 - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4960	BPA-RP-NDC - BENE PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4961	BPA-RP-PROC - PROV COUNTY RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			remittance advice remarks codes whenever appropriate		
4962	BPA-PC-NDC - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4963	BPA-PC-PROC - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4964	BPA-PC-REV - GENDER RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	MA39	Missing/incomplete/invalid gender.
4965	BPA-PC-NDC - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M119	MISSING/INCOMPLETE/INVALID/DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
4966	BPA-RR - DIAGNOSIS RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4970	BPA-RP-REV - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).
4971	BPA-RP-REV - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4972	BPA-RP-REV - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4973	BPA-RR-PROC - ANY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M64	Missing/incomplete/invalid other diagnosis.
4975	BPA-PC-REV - BENEFIT PLAN RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	M50	Missing/incomplete/invalid revenue code(s).

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			codes whenever appropriate		
4976	BPA-PC-REV - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4977	BPA-PC-REV - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4981	BPA-RP-PROC - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4982	BPA-RP-PROC - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4991	BPA-PC-PROC - CONDITION CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M44	Missing/incomplete/invalid condition code.
4992	BPA-PC-PROC - OCCURRENCE CODE RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M45	MISSING/INCOMPLETE/INVALID OCCURRENCE CODE(S).
4993	BPA-RR-PROC - PRIMARY DTL DIAG RESTRICTION	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.
4999	RECIPIENT IS PART D ELIGIBLE - CLAIM NOT COVERED. IF A RECIPIENT HAS MEDICAREP	96	Non-covered charge(s).	N30	Recipient ineligible for this service.
5200	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5201	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS AN OFFICE VISIT AND/OR	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5202	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5203	CHEMOTHERAPY ADMINISTRATION FEE MAY NOT BE BILLED ON THES AME DAY AS THIS PROCE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5204	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5205	VENIPUNCTURE AND LAB CODES ARE NOT ALLOWED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5206	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5207	THIS SERVICE IS INCLUDED IN THE FACILITY FEE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5208	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5209	ADMINISTRATION FEE MAY NOT BE BILLED ON THE SAME DAY AS THIS PROCEDURE CODE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5210	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5211	OUTPATIENT CHEMOTHERAPY AND EMERGENCY DEPARTMENT SERVICE CODES MAY NOT BE BILLE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5213	PROCEDURE CODE CANNOT BE BILLED ON THE SAME DAY WITH PROCEDURE CODES Z5181-Z518	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5214	PROCEDURE CODE NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	ON THE SAME DAY		were not met or were exceeded.		
5218	SUPPLY CODE CANNOT BE BILLED WITH LAB OR OFFICE VISIT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5219	SUPPLY CODE HAS BEEN PAID IN HISTORY, CANNOT BILL A LAB OR OFFICE VISIT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5230	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5231	SUBSEQUENT PROCEDURE INCLUDED IN PRIMARY ANESTHESIA CHARGE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5232	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5233	DAILY MANAGEMENT OF AN EPIDURAL OR SUBARACHNOID CATHETER MAYNOT BE BILLED ON TH	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5234	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N59	Please refer to your provider manual for additional program and provider information.
5235	ADDITIONAL PAIN CONTROL PROCEDURES PAID AT 50% OF MEDICAID ALLOWED.	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	N59	Please refer to your provider manual for additional program and provider information.
5236	QUALIFYING PROCEDURE LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5238	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	3 DAYS				
5239	PHYSICIAN VISIT CODES/PRIMARY ANESTHESIA CODES MAY NOT BE BILLED WITHIN 3 DAYS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5240	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5241	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5262	PROCEDURE CODES 92553, 92556 AND 92557 CANNOT BE BILLED ON THE SAME DAY BY THE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5270	CLINIC CODES Z5145-Z5149 CANNOT BE BILLED ON THE SAME DAY WITH SAME UNIQUE NUMB	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5271	CLINIC CODES AND E&M CODES CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5280	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5281	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5282	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5283	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5284	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5285	DME HUMIDIFIER OR CPAP/CPAP CONTRA	A1	Claim/Service denied.	N59	Please refer to your provider manual for additional program and provider information.
5286	DME CPAP OR	A1	Claim/Service denied.	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	HUMIDIFIER/CPAP CONTRA				for additional program and provider information.
5300	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5301	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5302	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5303	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5304	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5305	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5306	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5307	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5308	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5309	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5310	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5311	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5312	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5313	PULP THERAPY COMBINATION NOT ALLOWED IN THIS CASE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5314	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5315	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5316	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5317	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5318	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5319	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5320	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5321	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5322	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5323	PULP THERAPY COMBINATION NOT ALLOWED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5324	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5325	WHEN PROPHYLAXIS AND FLUORIDE ARE PERFORMED ON THE SAME DAY,THE COMBINED CODE M	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5326	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.
5327	CORE BUILDUP NOT COVERED WITH OTHER RESTORATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.
5328	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.
5329	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N39	Procedure code is not compatible with tooth number/letter.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5330	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5331	TWO RESTORATIONS NOT COVERED FOR THE SAME TOOTH NUMBER SAME DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5332	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5333	THIS X-RAY PROCEDURE MAY NOT BE BILLED WITHIN 30 (THIRTY) DAYS OF A ROOT CANAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5334	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5335	PALLIATIVE (EMERGENCY)TREATMENT MAY NOT BE BILLED WITH DEFINITIVE TREATMENT OR	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5336	DENTAL RECEMENT OF CROWNS NOT ALLOWED WITHIN 180 DAYS OF CROWN.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5338	ORAL EXAM EVALUATIONS ARE LIMITED TO ONE PER DAY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5350	NO EXTRACTION CODE IN HISTORY IN 180 TIME FRAME.	107	The related or qualifying claim/service was not identified on this claim.	N59	Please refer to your provider manual for additional program and provider information.
5351	PULP CAP NOT ALLOWED FOR THIS TOOTH/DATE OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5352	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			appropriate.		
5353	CLAIMS HISTORY SHOWS TOOTH HAS BEEN EXTRACTED.	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.
5354	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5355	TEMPORARY FILLING NOT PAYABLE ON SAME DATE OF SERVICE AS DEFINITIVE FILLING	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5400	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5401	PROCEDURE CANNOT BE BILLED ON THE SAME DAY BY THE PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5402	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5403	SCREENING PROVIDER MAY NOT BILL FOR SCREENING EXAM AND INCLUSIVE MEDICAL SERVIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5410	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5411	MORE THAN ONE CONTACT LENS FITTING CANNOT BE BILLED FOR THE SAME DATE OF SERVIC	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5412	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5413	PROCEDURE CODE V2020 AND V2025 CANNOT BE BILLED ON THE SAME DAY OF SERVICE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5414	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5415	EPSDT VISION SCREEN AND EXTERNAL OCULAR PHOTOGRAPHY NOT COVERED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5430	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5431	AN INITIAL VISIT WILL NOT BE PAID ON SAME DATE OF SERVICE ASAN ANNUAL, PERIODIC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5432	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5433	PRENATAL VISIT NOT COVERED FOR THE SAME DATE OF SERVICE OF FAMILY PLANNING.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5436	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5437	SALPINGECTOMY WILL NOT BE PAID ON THE SAME DAY AS A TUBAL LIGATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5438	COMPREHENSIVE EPSDT SCREENING AND FP VISIT MAY NOT BE BILLED ON THE SAME DAY.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5439	COMPREHENSIVE EPSDT SCREENING	B5	Payment adjusted because coverage/program guidelines	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	AND FP VISIT MAY NOT BE BILLEDON THE SAME DAY.		were not met or were exceeded.		
5440	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5441	FAMILY PLANNING VISIT NOT PAYABLE AFTER STERILIZATION	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5451	HOME HEALTH PROVIDERS CANNOT BILL INPATIENT AND OUTPATIENT SERVICES ON THE SAME	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5460	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5461	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5462	THIS SERVICE IS INCLUDED IN THE FACILITY FEE (REVENUE CODE 450).	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5464	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5465	PROCEDURE CODE IS PART OF THE OUTPATIENT SURGICAL PROCEDURE REIMBURSEMENT.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5470	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5471	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5472	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5473	CHEMISTRY PROFILE AND CHEMICAL PANEL CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5474	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5475	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5476	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5477	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5478	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5479	COMPONENTS OF A URINALYSIS MAY NOT BE BILLED ON THE SAME DAY AS URINALYSIS	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5480	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5481	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5482	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5483	COMPONENTS OF A CBC MAY NOT	B5	Payment adjusted because coverage/program guidelines	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	BE BILLED ON THE SAME DAY AS A COMPLETE CBC		were not met or were exceeded.		
5484	LAB SERVICES MUST BE BILLED WITH COMBINATION CODE. SEE CPT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5486	CHEMISTRY PROFILES MUST BE BILLED USING ONE MULTICHANNEL TEST CODE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5488	COMPONENTS OF A CBC MAY NOT BE BILLED ON THE SAME DAY AS A COMPLETE CBC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5490	LAB-CHLAMYDIA/GONORRHEA CONTRA	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5500	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5501	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5502	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5503	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5504	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5505	POSTPARTUM VISIT WILL NOT BE PAID ON THE SAME DAY AS PRENATAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5506	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M83	Service is not covered unless the patient is classified as at high risk.
5507	SERVICE NOT PAYABLE WITH OTHER SERVICE ON SAME DAY	125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	M83	Service is not covered unless the patient is classified as at high risk.
5508	SECONDARY	59	Processed based on multiple or	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A		concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)		for additional program and provider information.
5509	SECONDARY SURGICAL PROCEDURE WITHIN THE SAME INCISION PAID AT 50% OF MEDICAID A	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.
5510	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN SIXTY DAYS OF DELIVERY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5511	PROCEDURE CODE IS LIMITED TO ONE PER RECIPIENT WITHIN 60 DAYS OF DELIVERY.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
5512	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
5513	PRENATAL VISIT NOT BE COVERED ON THE SAME DAY AS POSTPARTUM VISIT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5514	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5515	THIS PROCEDURE CANNOT BE BILLED IN ADDITION TO THE DELIVERY CODE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5516	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED WITH GLOBAL OB C	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5517	ANTEPARTUM, POSTPARTUM CARE/VAGINAL DELIVERY MAY NOT BE BILLED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	WITH GLOBAL OB C				
5518	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5519	LOCAL ANESTHESIA PROCEDURES ARE COVERED IN THE TOTAL OB COST AND MAY NOT BE BIL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5520	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.
5521	REGIONAL ANESTHESIA PAYMENT IS 50% OF LEVEL III PRICE	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N59	Please refer to your provider manual for additional program and provider information.
5522	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5523	ROUTINE PRENATAL LAB, OFFICE/HOSPITAL VISITS MAY NOT BE BILLED WITH GLOBAL OB P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5524	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5525	POSTPARTUM SERVICES MAY NOT BE BILLED WITH GLOBAL OB ON OR WITHIN 62 DAYS OF DE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5600	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5601	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5602	PROCEDURE CODE	B5	Payment adjusted because	N20	Service not payable with other service

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	NOT COVERED WHEN BILLED ON THE SAME DAY		coverage/program guidelines were not met or were exceeded.		rendered on the same date.
5603	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5604	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.
5605	PROCEDURE IS INCLUSIVE IN PRIMARY PROCEDURE.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.
5606	PAYMENT MADE FOR SIMILAR PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5607	PAYMENT MADE FOR SIMILAR PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5608	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5609	SAME PROVIDER CANNOT BILL APPLICATION/REMOVAL/REPAIR OF CAST FOR THE SAME RECIP	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5610	PROCEDURE CODES 95115, 95117 OR Z4998 SHALL NOT BE PAID ON THE SAME DAY AS PROC	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5611	PROFESSIONAL SERVICES ARE INCLUDED IN THE PROVISION OF THE EXTRACT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5612	PROCEDURE CODES 95120-95134 WILL NOT BE PAID ON THE SAME DAY AS PROCEDURE CODES	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5613	PROCEDURE CODES 95120-95134 WILL NOT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	BE PAID ON THE SAME DAY AS PROCEDURE CODES				
5614	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5615	PROCEDURE NOT COVERED WHEN BILLED WITH PROCEDURE CODES 90918-90947	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5616	CRITICAL CARE CANNOT BE BILLED ON THE SAME DAY AS PROCEDURE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5617	PROCEDURE CANNOT BE BILLED ON THE SAME DAY AS CRITICAL CARE	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5618	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5619	THE SAME PHYSICIAN MAY NOT BILL INTUBATION AND NEWBORN RESUSCITATION ON THE SAM	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5620	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLEDTOGETHER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5621	STANDBY/RESUCITATION/ATTENDANCE AT DELIVERY CANNOT BE BILLED TOGETHER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5622	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5623	ELECTROSHOCK THERAPY MAY NOT BE ON THE SAME DAY AS A HOSPITAL VISIT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
5624	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5625	EMERGENCY ROOM VISIT/INITIAL HOSPITAL VISIT MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5626	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5627	PROFESSIONAL COMPONENTS AND HOSPITAL VISITS MAY NOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5628	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5629	THE PAYMENT FOR THIS SERVICE WAS PREVIOUSLY MADE TO ANOTHER PROVIDER OR TO ANOT	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5630	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5631	INCIDENTAL SURGERY MAY NOT BE BILLED WITH DEFINITIVE SURGERY ON THE SAME DAY.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5632	EXPLORATORY LAP/LYSIS OF ADHESIONS MAY NOT BE BILLED ON THE SAME DAY WITH OTHER	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5633	INCIDENTAL SURGERY NOT COVERED WITH	97	The benefit for this service is included in the payment/allowance for another	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	DEFINITIVE SURGERY ON THE SAME DAY		service/procedure that has already been adjudicated.		
5634	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5635	THE SAME PHYSICAIN MAY NOT BILL HOSPITAL VISIT AND DISCHARGE VISIT ON THE SAME	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5636	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5637	HYSTERECTOMY ANCILLARY CODES MAY NOT BE PAID IN ADDITION TO THE HYSTERECTOMY P	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5638	HOSPITAL ADMISSION/VISIT S MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5639	HOSPITAL ADMISSION/VISIT S MAY NOT BE BILLED ON OR AFTER OB GLOBAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5640	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5641	SUBSEQUENT HOSPITAL CARE MAY NOT BE BILLED ON SAME DAY AS INITIAL HOSPITAL CARE	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5642	ROUTINE ANCILLARY SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5643	ROUTINE ANCILLARY	97	The benefit for this service is included in the	N59	Please refer to your provider manual for additional program and provider

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	SERVICES ASSOCIATED WITH AN ABORTION ARE COVERED IN THE TOTAL		payment/allowance for another service/procedure that has already been adjudicated.		information.
5644	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5645	HOSPITAL VISITS AND SUBSEQUENT CRITICAL CARE MAY NOT BE BILLED ON THE SAME DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5646	POST-OPERATIVE CARE IS INCLUDED IN THE SURGERY FEE AND CANNOT BE BILLED SEPARAT	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5647	POST-OPERATIVE PHYSICIAN SERVICES FOR THE SAME DIAGNOSIS MAY NOT BE BILLED WITH	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5648	PROCEDURE CODES NOT ALLOWED ON THE SAME DAY (95130- 95134)	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5650	ONLY ONE OUTPATIENT OBSERVATION VISIT MAY BE BILLED PER DAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
5656	THIS PROCEDURE IS PART OF ANOTHER PROCEDURE PERFORMED ON THE SAME DAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
5660	ONLY ONE HOSPITAL ADMISSION MAY BE BILLED PER HOSPITAL STAY	B14	Payment denied because only one visit or consultation per physician per day is covered.	N59	Please refer to your provider manual for additional program and provider information.
5661	SUBSEQUENT CRITICAL CARE NOT VALID WITHOUT INITAL CARE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.
5664	INITIAL OFFICE VISIT CANNOT BE BILLED ANYTIME	B8	Claim/service not covered/reduced because alternative services were	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	WITHIN 3 YEARS OF A PRIOR VISIT		available, and should have been utilized.		
5665	PRIOR VISIT CANNOT BE BILLED WITHIN 3 YEARS PRIOR TO AN INITIAL OFFICE VISIT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.
5666	NEW PATIENT/EXISTING PATIENT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.
5667	EXISTING PATIENT/NEW PATIENT	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	N59	Please refer to your provider manual for additional program and provider information.
5710	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5711	SERVICE CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5712	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5713	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5714	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5715	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5716	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5717	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5718	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5719	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	RECIPENT				
5720	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5721	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5722	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5723	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5726	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5727	THIS SERVICE IS NOT ALLOWED ON THE SAME DAY AS DAY TREATMENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5728	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5729	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5730	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
5731	THIS PROCEDURE CODE IS NOT COVERED WHEN BILLED WITH MEDICAL PSYCHOTHERAPY CODES	96	Non-covered charge(s).	N20	Service not payable with other service rendered on the same date.
5732	THE SAME PROVIDER MAY NOT BILL HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5733	THE SAME PROVIDER MAY NOT BILL	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	HOSPITAL VISITS/PSYCHOTHERAPY ON THE SAME DAY				
5734	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/ OFFICE VISITS ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5735	THE SAME PROVIDER MAY NOT BILL PSYCHOTHERAPY/ OFFICE VISITS ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5736	SERVICES CANNOT BE BILLED ON THE SAME DAY BY THE SAME PROVIDER	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5738	SERVICES CANNOT BE BILLED ON THE SAME DAY FOR THE SAME RECIPIENT	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5750	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5751	PROCEDURE NOT COVERED WHEN BILLED WITH 76805, 76810 OR 76816 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5752	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5753	PROCEDURE NOT COVERED WHEN BILLED WITH 76805 ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5754	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5755	OUR RECORDS INDICATE THAT THIS SERVICE HAS ALREADY BEEN PERFORMED ON THIS PATIE	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
5760	ESWL PRICING	45	Charge exceeds fee schedule/maximum allowable or	N59	Please refer to your provider manual for additional program and provider

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
			contracted/legislated fee arrangement.		information.
5790	PHYSICAL THERAPY ELECTRIC STIMULATION CONTRA	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
5791	PROCEDURE CODE NOT COVERED WHEN BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5792	PHYSICAL THERAPY APPLIANCES CONTRA	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
5800	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANIO N CARE NOT ALLOWED FOR	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
5801	RESIDENTIAL SERVICES AND RESPITE ,PERSONAL CARE/COMPANIO N CARE NOT ALLOWED FOR	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
5802	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5803	PREVOCATIONAL SERVICES AND SUPPORTED EMPLOYMENT SHALL NOT BE PAID ON THE SAME D	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
5804	ONLY ONE TYPE OF RESPITE CARE IS ALLOWED FOR A GIVEN DATE OF SERVICE.	18	Duplicate claim/service.	N20	Service not payable with other service rendered on the same date.
5814	PROCEDURE NOT COVERED WITH SPECIFIC CODES.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.
5815	VISION AND HEARING SCREENING MUST BE BILLED WITH A REGULAR SCREENING AND ARE LI	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.
5816	HIV CODES MUST	B5	Payment adjusted because	N390	This service/report cannot be billed

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	BE BILLED IN CONJUNCTION WITH FAMILY PLANNING CODES.		coverage/program guidelines were not met or were exceeded.		separately.
5817	REVENUE CODES 170 -171 MUST NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.
5818	THERAPY CODE PAYABLE ONLY WITH THERAPEUTIC TREATMENT.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.
5819	OBSERVATION MUST BE BILLED IN CONJUNCTION WITH FACILITY FEE.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N390	This service/report cannot be billed separately.
5820	LTC VENT CANNOT BE BILLED WITHOUT LTC STAY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N59	Please refer to your provider manual for additional program and provider information.
5821	ADD - ON CODE CANNOT BE PAID WITHOUT PAID PRIMARY CODE	A1	Claim/Service denied.	N59	Please refer to your provider manual for additional program and provider information.
5822	AVASTIN J9035 NEGATIVE CONTRA	204	This service/equipment/drug is not covered under the patients current benefit plan.	N59	Please refer to your provider manual for additional program and provider information.
5823	PACE NH DEPENDENT ON PACE NON-NH BILLING	168	PAYMENT DENIED AS SERVICE(S) HAVE BEEN CONSIDERED UNDER THE PATIENT'S MEDICAL PLAN. BENEFITS ARE NOT AVAILABLE UNDER THIS DENTAL PLAN	N59	Please refer to your provider manual for additional program and provider information.
5830	PROCEDURE IS NOT PAYABLE WHEN BILLED WITHOUT A PAID ROOT CANAL FOR THE SAME TOO	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5831	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
5832	MEDICAID'S RECORD DO NOT SHOW A ROOT CANAL PAYMENT THEREFORE THIS PROCEDURE COD	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6001	THIS AMBULANCE SERVICE PROCEDURE CODE IS LIMITED TO FOUR UNITS PER CALENDAR MON	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6010	INPATIENT/OUTPATIENT/ASC VISITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6020	HEARING AID REPAIR IS LIMITED TO TWO EVERY SIX MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6021	MONAURAL HEARING AID BATTERIES ARE LIMITED TO ONE PACKAGE EVERY TWO MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6022	MONAURAL EARMOLDS ARE LIMITED TO ONE EVERY FOUR MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6023	HEARING AID REPAIR IS LIMITED TO ONCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6024	THE PURCHASE OF A HEARING AID STETHOSCOPE IS LIMITED TO ONE EVERY TWO YEARS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6025	EARMOLDS ARE LIMITED TO TWO EVERY FOUR MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6026	BINAURAL HEARING AID BATTERIES ARE LIMITED TO TWO PACKAGES EVERY TWO MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6030	NEW PATIENT CODE Z5147 MAY ONLY BE BILLED ONCE PER LIFETIME PER RECIPIENT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6041	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6042	PROCEDURE LIMITED TO ONCE EVERY 30 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6043	THE CALENDAR YEAR LIMIT HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6044	EMERGENCY	119	Benefit maximum for this time	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	ORAL EXAM (D0140) LIMITED TO ONCE PER CALENDAR YEAR.		period or occurrence has been reached.		for additional program and provider information.
6045	DENTAL SERVICE LIMITED TO ONCE PER TOOTH/PER LIFETIME.	119	Benefit maximum for this time period or occurrence has been reached.	N117	THIS SERVICE IS PAID ONLY ONCE IN A LIFETIME.
6046	PROCEDURE CODE LIMITED TO ONCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6047	PROPHYLAXIS IS LIMITED TO ONCE EVERY 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6048	FLUORIDE IS LIMITED TO ONCE EVERY 6 MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6049	PROCEDURE LIMITED TO TWO PER LIFETIME PER TOOTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6050	PROCEDURE CODE IS LIMITED TO ONE OCCURANCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6051	FULL SERIES/PANORAMIC X-RAYS ARE LIMITED TO ONE EVERY THREE CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6052	CODE, SERVICE, PROCEDURE, NDC OR STAY REQUIRES PRIOR AUTHORIZATION	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.
6053	COMPREHENSIVE DENTAL EXAM MAY ONLY BE BILLED ONCE PER LIFETIME PER PROVIDER.	119	Benefit maximum for this time period or occurrence has been reached.	N117	THIS SERVICE IS PAID ONLY ONCE IN A LIFETIME.
6100	DME PROCEDURE LIMITED TO 60 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6101	DME PROCEDURE LIMIT TO 20 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6102	DME PROCEDURE LIMITED TO 1 PER 5 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6103	PROCEDURE IS LIMITED TO THIRTY (30) PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6104	DME PROCEDURE	119	Benefit maximum for this time	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	LIMITED TO 700 PER CALENDAR MONTH		period or occurrence has been reached.		for additional program and provider information.
6105	DME CLOSED POUCH TOTAL LIMIT OF 60 PER CAL MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6106	PROCEDURE IS LIMITED TO 30 (THIRTY) PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6107	DME PROCEDURE LIMITED TO 40 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6108	DME WC PRESSURE PAD TOTAL LIMIT OF 1 PER CAL YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6109	PROCEDURE CODE IS LIMTED TO 100 PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6110	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6111	THE LIMIT OF THREE UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6112	THE LIMIT OF TWO UNITS PER MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6113	DME CODES LIMITED TO THIRTY-ONE UNITS PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6114	DME PROCEDURE LIMITED TO 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6115	MEDICAL SUPPLIES LIMIT IS $1,800.00 PER WAIVER YEAR, 02/22-02/21. THE LIMIT HA	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6116	DME PROCEDURE LIMITED TO 1 PER 4 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6117	DME PROCEDURE LIMITED TO 3 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6118	THE LIMIT OF TWO UNITS PER	119	Benefit maximum for this time period or occurrence has been	N59	Please refer to your provider manual for additional program and provider

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	MONTH HAS BEEN EXCEEDED FOR THIS PROCEDURE		reached.		information.
6120	THIS PROCEDURE CODE IS LIMITED TO ONE PER MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6121	DME PROCEDURE LIMITED TO 1 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6122	LEG BAGS ARE LIMITED TO TWO PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6123	DME PROCEDURE LIMITED TO 8 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6124	DME PROCEDURE LIMITED TO 1 PER 3 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6125	DME PROCEDURE LIMITED TO 2 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6126	DME PROCEDURE LIMITED TO 120 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6128	DME PROCEDURE LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6129	DME PROCEDURE LIMITED TO 4 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6130	DME PROCEDURE LIMITED TO 5 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6131	DME PROCEDURE LIMITED TO 10 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6132	DME PROCEDURE LIMITED TO 12 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6133	DME PROCEDURE LIMITED TO 50 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6134	DME PROCEDURE LIMITED TO 90 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6135	DME PROCEDURE LIMITED TO 100 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6136	DME PROCEDURE	119	Benefit maximum for this time	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	LIMITED TO 500 PER CALENDAR MONTH		period or occurrence has been reached.		for additional program and provider information.
6137	DME PROCEDURE LIMITED TO 1000 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6138	DME PROCEDURE LIMITED TO 1 PER 2 CALENDAR YEARS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6139	DME PROCEDURE LIMITED TO 4 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6140	DME PROCEDURE RENTAL LIMITED TO 1 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6141	DME PROCEDURE RENTAL LIMITED TO 2 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6142	DME PROCEDURE RENTAL LIMITED TO 31 PER CALENDAR MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6143	DME BATTERY CHARGER TOTAL LIMIT OF 1 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6144	DME BATTERY TOTAL LIMIT OF 2 PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6150	VISION AND HEARING SCREENING ONE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6151	INITIAL SCREENING IS LIMITED TO ONCE PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6152	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6153	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6154	MAXIMUN UNIT LIMIT HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6155	EPSDT SCREENING LIMIT HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6179	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6180	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6181	THE ALLOWED LENS LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6182	THE ALLOWED FRAMES LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6183	THE ALLOWED EYE EXAM LIMITATION HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6184	THE ALLOWED FITTING LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6185	EYE LENS LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6186	EYE FRAME LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6187	EYE EXAM LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6188	EYE FITTING LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6189	EYE EXAM LIMIT 1 PER 3 YR (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6190	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6191	EYE REFRACTION LIMIT LESS THAN 21	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6192	EYE REFRACTION LIMIT 1 PER 2 YEARS (21 AND OLDER)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6193	EYE EXAM LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6194	EYE REFRACTION LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6195	EYE FRAME LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6196	EYE LENS LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6197	EYE FITTING LIMIT 1 PER 3 YR (21 AND >)	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6200	THIS PROCEDURE	119	Benefit maximum for this time	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	IS LIMITED TO SIXTEEN (16) UNITS PER CALENDAR YEAR.		period or occurrence has been reached.		for additional program and provider information.
6201	FAMILY PLANNING PERIODIC FOLLOW-UP IS LIMITED TO FOUR (4) VISITS PER YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6202	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6203	THIS PROCEDURE IS LIMITED TO ONE PER POSTPARTUM PERIOD.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6204	INITIAL VISIT IS LIMITED TO ONE PER RECIPIENT, PER PROVIDER, PER LIFETIME	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6205	THIS PROCEDURE CODE IS LIMITED TO ONE EVERY CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6206	PROCEDURE CODE 11795 IS LIMITED TO ONE EVERY 365 DAYS AND PROCEDURE CODE 11977	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6207	THESE NORPLANT SERVICES MUST BE BILLED USING THE APPROPRIATE COMBINATION CODE O	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6208	PROCEDURE IS LIMITED TO ONE SERVICE EVERY 70 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6209	PROCEDURE LIMITED TO ONE SERVICE DURING 60 (SIXTY) DAY POSTPARTUM PERIOD.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6211	DEPO-PROVERA INJECTION LIMITED TO ONE PER EVERY 70 DAYS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6230	MORE THAN ONE MEDICAL ENCOUNTER (Z5298) CANNOT BE PAID ON THE	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	SAME DATE OF SERV				
6231	MORE THAN ONE DENTAL ENCOUNTER (D9430)CANNOT BE PAID ON THE SAME DATE OF SERVIC	B14	Payment denied because only one visit or consultation per physician per day is covered.	N20	Service not payable with other service rendered on the same date.
6240	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6241	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6242	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6243	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6244	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6245	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6246	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6247	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6248	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6249	HBO LIMIT HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6260	NUMBER OF HOME HEALTH VISITS EXCEED LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6280	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6281	OUTPATIENT VISITS HAVE BEEN EXCEEDED FOR THIS CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6282	INPATIENT DAYS HAVE BEEN EXEEDED FOR THIS CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6283	REVENUE CODES 170 -171 MUST	B5	Payment adjusted because coverage/program guidelines	N59	Please refer to your provider manual for additional program and provider

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	NOT EXCEED 10 UNITS UNDER MOTHER'S NUMBER.		were not met or were exceeded.		information.
6284	MEPD FISCAL YEAR DOLLAR LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.
6290	MULTIPLE URINALYSIS TESTS CANNOT BE BILLED ON THE SAME DAY	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
6291	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6292	LAB DRUG SCREENING LIMIT OF 1 PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6293	LAB ?DRUG SCREENING LIMIT OF 1 EVERY 7 DAYS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6300	THIS PROCEDURE IS LIMITED TO 12 UNITS EVERY 24 MONTHS.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6301	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED W ITHIN SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6302	MORE THAN THREE OFFICE VISITS MAY NOT BE BILLED WITH PREGNANCY DIAGNOSIS.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6303	MORE THAN ONE OBSTETRICAL DELIVERY CODE MAY NOT BE BILLED WITHIN SIX MONTHS.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N59	Please refer to your provider manual for additional program and provider information.
6305	ES - VAGINAL DELIVERY LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6306	ES - C-SECTION LIMIT LIMIT	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6311	QTY DISPENSED EXCEEDS MAX QTY BASED ON PA	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
6350	DME GESTATIONAL INSULIN LIMIT 4 BOXES PER	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	MONTH				
6351	DME GESTATIONAL INSULIN LIMIT 2 BOXES PER MONTH	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6400	SPECIMEN COLLECTION FEE IS LIMITED TO ONE PER DAY	119	Benefit maximum for this time period or occurrence has been reached.	N20	Service not payable with other service rendered on the same date.
6401	OB ULTRASOUND LIMIT HAS BEEN REACHED FOR THIS RECIPIENT. ANY FURTHER WILL REQUI	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6402	SCREENING MAMMOGRAPHY IS LIMITED TO ONE PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6403	THE LIMIT FOR THESE SERVICES HAS BEEN REACHED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6404	PROCEDURE IS LIMITED TO ONCE EVERY THIRTY(30) DAYS BY THE SAME BILLING PROVIDER	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6405	PROCEDURE CODE IS LIMITED TO ONE OCCURENCE EVERY SIX MONTHS	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6406	NEWBORN CODE MAY NOT BE BILLED MORE THAN ONCE	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6407	THE SAME PROVIDER MAY NOT BILL MORE THAN ONE NEW PATIENT OFFICE VISIT PER RECIP	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6408	PHYSICIAN IS LIMITED TO ONE VISIT PER DAY PER RECIPIENT	B14	Payment denied because only one visit or consultation per physician per day is covered.	N59	Please refer to your provider manual for additional program and provider information.
6409	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6410	PHYSICIAN OFFICE VISIT LIMITATION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6411	INITIAL CRITICAL	119	Benefit maximum for this time	N59	Please refer to your provider manual

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	CARE LIMITED TO ONE PER DAY		period or occurrence has been reached.		for additional program and provider information.
6412	ER AND CRITICAL CARE CODE ONE PER CLAIM.	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	N20	Service not payable with other service rendered on the same date.
6413	REQUESTED INPATIENT HOSPITAL SERVICES EXCEED LIMIT OF 16	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6416	EMG PROCEDURE LIMIT TO 4 PER CAL YR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6510	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6511	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6512	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6513	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6514	THIS PROCEDURE IS LIMITED TO 5 UNITS PER YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6515	THIS PROCEDURE IS LIMITED TO ONE EPISODE A YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6516	THIS PROCEDURE IS LIMITED TO 52 UNITS PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6517	THIS PROCEDURE IS LIMITED TO 10 (TEN) UNITS PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6518	PROCEDURE CODE IS LIMITED TO 104 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6519	PROCEDURE CODE IS LIMITED TO 104 TIMES PER YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6520	PROCEDURE CODE IS LIMITED TO 104 TIMES A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6521	THIS PROCEDURE IS LIMITED TO 365 EPISODES A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6522	THIS PROCEDURE IS LIMITED TO 52 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6523	BENEFITS HAVE BEEN EXCEEDED FOR THE CALDEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
	YEAR.				
6524	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6525	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6526	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6527	BENEFITS HAVE BEEN EXCEEDEF FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6528	BENEFITS HAVE BEEN EXCEEDED FOR THE CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6529	PROCEDURE IS LIMITED TO 260 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6530	PROCEDURE IS LIMITED TO 8 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6531	PROCEDURE CODE IS LIMITED TO 312 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6532	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6533	PROCEDURE IS LIMITED TO 1040 UNITS A YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6534	PROCEDURE IS LIMITED TO 2016 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6535	PROCEDURE IS LIMITED TO 130 UNITS A CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6536	PROCEDURE IS LIMITED TO 104 TIMES A CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6537	PROCEDURE IS LIMITED TO 365 TIMES A CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6538	YEARLY LIMIT FOR CRISIS INTERVENTION HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6539	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

EOB CODE	EOB DESCRIPTION	HIPAA ADJUSTMENT REASON CODE	HIPAA ARC DESCRIPTION	HIPAA REMARK CODE	HIPAA RRC DESCRIPTION
6540	PSYCHOTHERAPY SERVICES ARE LIMITED TO 12 (TWELVE) PER CALENDAR YEAR AT PLACE OF	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6541	DIAGNOSTIC ASSESSMENTS ARE LIMITED TO ONE ENCOUNTER PER CALENDAR YEAR	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6542	PROCEDURE IS LIMITED TO 4160 UNITS A YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6610	DIALYSIS ULTRAFILTRATION CODES Z5256 AND Z5266 ARE LIMITED TO A TOTAL OF 3 PER	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6611	PROCEDURE CODE IS LIMITED TO 156 UNITS PER CALENDAR YEAR.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6612	PROCEDURE CODE IS LIMITED TO ONE UNIT PER CALENDAR MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6613	PROCEDURE CODE IS LIMITED TO 12 UNITS PER LIFETIME.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6630	THIS PROCEDURE CODE IS LIMITED TO ONE PER CALENDAR MONTH.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6640	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6641	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6642	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6643	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.
6644	THE YEARLY LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.	119	Benefit maximum for this time period or occurrence has been reached.	N59	Please refer to your provider manual for additional program and provider information.

K Top 200 Third Party Carrier Codes

This appendix lists the top 200 insurance companies that may be a third-party resource for payment of claims. The company name and carrier codes are listed numerically in Section K.1, Numerical Listing by Company Code, and alphabetically in Section K.2, Alphabetical Listing by Company Name.

Because federal Medicaid regulations require that any resources currently available to a recipient, be considered in determining liability for payments of medical services, providers have an obligation to investigate and report the existence of other insurance or liability to Medicaid. When you identify a third party resource, you should submit the claim to that resource.

Refer to Section 3.3.6, Third Party Liability, for more information about how to file a claim when another insurance company may be responsible for all or part of the cost of the medical care.

K.1 Numerical Listing by Company Code

Company Code	***Company Name***	***City, State***
00002	AARP Insurance Plan	Philadelphia, PA
00007	Aetna Life and Casualty Company	Tampa, FL
00020	Amalgamated Life Insurance Company	New York, NY
00031	American Family Life Insurance	Columbus, GA
00039	American Heritage Life	Jacksonville, FL
00067	Assoc Doctors Health and Life	Longhorne, PA
00073	Atlantic American Life	Atlanta, GA
00081	Bankers Life and Casualty Company	Chicago, IL
00128	Colonial Life and Accident	Columbia, SC
00143	Connecticut General Life Insurance Company	Atlanta, GA
00231	Globe Life and Accident	Oklahoma City, OK
00253	American General Gulf Life	Mobile, AL
00272	Independent Life and Accident	Nashville, TN
00291	John Hancock Mutual Life	Greensboro, NC
00306	Liberty National	Birmingham, AL
00310	Life Insurance Company of Alabama	Gadsden, AL
00314	Life Insurance Company of Georgia	Atlanta, GA
00337	Unicare	Springfield, MA
00341	Metropolitan Life	Tampa, FL
00358	Mutual of Omaha Insurance	Omaha, NE
00360	Mutual Savings Life	Decatur, AL
00366	National Home Life Assurance	Valley Forge, PA
00370	American General Life	Nashville, TN
00376	National Security	Elba, AL
00388	New Southland National	Tuscaloosa, AL
00439	Physicians Mutual	Omaha, NE
00445	Pioneer Life Insurance Company	Rockford, IL
00453	Professional Insurance Corporation	Raleigh, NC
00454	Protective Industrial	Birmingham, AL
00455	Protective Life Insurance Company	Birmingham, AL

Company Code	***Company Name***	***City, State***
00461	Prudential Insurance Company	Jacksonville, FL
00474	Ret/Wholesale O Store International	Birmingham, AL
00514	State Farm Insurance Company	Birmingham, AL
00531	Time Insurance Company	Milwaukee, WI
00544	Union Bakers Insurance Company	Dallas, TX
00546	Union Fidelity Life Insurance	Trevose, PA
00550	Union National Life Insurance Company	Baton Rouge, LA
00553	United American Insurance Company	McKinney, TX
00606	New York Life Insurance Company	Atlanta, GA
00614	Boilermakers National	Kansas City, KS
00624	Goodyear	Gadsden, AL
00626	Great West Life Assurance	Atlanta, GA
00633	Life Investors Insurance Company	Cedar Rapids, IA
00640	National Association of Letter Carriers	Ashburn, VA
00706	Provident Life and Accident	Chattanooga, TN
00779	Unicare	Fort Scott, KS
00881	Provident Life Insurance	Greenville, SC
00906	AETNA Life and Casualty	Arlington, TX
00929	Prudential Ins Co.	Jacksonville, FL
01002	United of Omaha	Omaha, NE
01045	KANWHA Ins Co.	Lancaster, SC
01046	Wausau Ins. Co.	Wausau, WI
01085	Provident Life & ACC	Bristol, TN
01110	Combined Ins. Co. of America	Chicago, IL
01114	Mail Handlers Benefit Plan	Rockville, MD
01119	Aetna Life & Casualty	Minneapolis, MN
01158	Aetna Life & Casualty	Memphis, TN
01165	Aetna Life & Casualty	Greensboro, SC
01174	John Alden Life Ins. Co.	Miami, FL
01200	Golden Rule Ins. Co.	Indianapolis, IN
01234	Aetna Insurance Co.	Peoria, IL
01248	Aetna Life & Casualty	Allentown, PA
01264	United Ins. Of America	Baton Rouge, LA
01303	Metropolitan	Utica, NY
01395	Aetna Insurance Co.	Tyler, TX
01427	Metrahealth Travellers	Salt Lake City, UT
01460	Grp Resource Inc.	Duluth, GA
01476	Prime Health	Mobile, AL
01523	Southeast Health Plan Ins.	Birmingham, AL
01582	United Health Care	Birmingham, AL
01613	Prime Health ADM	Mobile, AL
01626	Hilb, Rogal, & Hamilton	Birmingham, AL
01650	Metropolitan Life Insurance	Pittsburgh, PA
01676	National Foundation Life	Ft. Worth, TX
01718	Principal Financial Group	Springfield, MO
01723	Metropolitan Life	Greenville, SC
01740	United Food and Com Workers	Atlanta, GA
01828	Capitol American Life	Cleveland, OH
01894	Delta Dental Plan of Ohio	Columbus, OH
01924	PCS Drug Plan	Phoenix, AZ
01928	Employers Health Insurance	Green Bay, WI
01930	Paid Prescription Plan	Fair Lawn, NJ
01934	Wal-Mart Group Health Plan	Bentonville, AR
01954	Cigna Health Care/Provident	Houston, TX

Company Code	*Company Name*	*City, State*
02001	Federal Employee Program, BCA/BSA	Birmingham, AL
02005	BC/BS of Florida, Incorporated	Jacksonville, AL
02010	BC/BS of Georgia/Columbus	Columbus, GA
02091	BC/BS of Alabama	Birmingham, AL
02092	BC/BS of Georgia/Atlanta	Atlanta, GA
02094	BC/BS of Michigan	Detroit, MI
02095	BC/BS of Mississippi	Jackson, MS
02097	BC/BS of Tennessee	Chattanooga, TN
02106	BC/BS of Virginia	Richmond, VA
02118	BC of Illinois	Chicago, IL
02123	BC/BS of Kentucky, Inc.	Louisville, KY
02137	BC/BS of Greater New York	New York, NY
02171	BC/BS of W PA	Pittsburgh, PA
02198	BC/BS of Alabama	Birmingham, AL
02201	BellSouth D E D Service Center	Birmingham, AL
03035	Health Partners A D M Services	Birmingham, AL
03036	Partners National Health Plans	Birmingham, AL
03256	Guardian Life	Appleton, WI
03261	Eldercare Plus	Fairfield, AL
03308	Freedom Life	Louisville, KY
03382	Southern Administrative Services	Columbus, GA
03427	SIMA	Chattanooga, TN
03478	United Medical Resources	Cincinnati, OH
03485	W H Shepherd Company	Birmingham, AL
03576	AL Hospitals Association Employee Benefit Trust.	Jackson, MS
03584	Principal Mutual Life	Overland Park, KS
03591	Prudential Insurance	High Point, NC
03628	Group Administrators	Birmingham, AL
03712	Senior Partners	Birmingham, AL
03718	Tennessee Laborers Health & Welfare Trust Fund	Goodlettsville, TN
03737	Alabama Health Network	Birmingham, AL
03745	Amer Med Security	Green Bay, WI
03798	Delta Dental Plan	N. Little Rock, AR
03996	Corporate Benefit Service	Minnetonka, MN
04011	Palmetto G B A	Camden, SC
04012	BC/BS of South Carolina	Florence, SC
05001	United Mine Workers	Van Nuys, CA
05018	United Mine Workers	Duluth, MN
10014	Central Reserve Life Insurance	Arlington, TX
10040	United Insurance Co. Of Amer.	Baton Rouge, LA
10049	Prime Care/Prime Health	Mobile, AL
10158	Jefferson Pilot	Lake City, FL
10170	Insurance Claims Service	Birmingham, AL
10172	Employers Health Insurance	Madison, WI
10196	S R C Service I N C C	Columbia, SC
10275	Great West Life	Atlanta, GA
10292	Southern Benefits Service	Birmingham, AL
10349	Great West Life insurance	Detroit, MI
10377	Corporate Benefit Service	Hopkins, MN
10397	Commercial Travelers	Utica, NY
10465	Insurance Benefit Service	Houston, TX
10501	U S A Health Plan	Mobile, AL

Company Code	***Company Name***	***City, State***
10571	Travelers	Charlotte, NC
10579	Great West Life	Atlanta, GA
10655	New E R A	Houston, TX
10689	Health Strategies Insurance	Birmingham, AL
10716	Administrative Enterprise	Phoenix, AR
10730	Advantage Health	Montgomery, AL
10763	Third Party Claims Mgt.	Youngstown, OH
10794	John Hancock Mutual	Greensboro, NC
10807	Premier Health Plans	Huntsville, AL
10878	First Health	Houston, TX
10879	Employee Benefit Consultants	Birmingham, AL
10880	AETNA	Greensboro, NC
10932	Health Partners of Alabama	Birmingham, AL
10942	Value RX	Bloomfield Hills, MI
10950	Prudential Insurance Company	Matteson, IL
11103	First Health	Maitland, FL
11232	NAMCI	Huntsville, AL
11363	CIGNA	Pittsburgh, PA
12389	National RX	Dallas, TX
12431	Benefit Support	Gainesville, GA
12439	Caremark	San Antonio, TX
12452	CACH Administrative Services	Birmingham, AL
12474	Express Scripts	St. Louis, MO
12482	Alascript	Northport, AL
12492	Strategic Resource Company	Columbia, SC
12494	Seniors First	Birmingham, AL
12517	Med. Net	Huntsville, AL
12526	Health Network	Birmingham, AL
12594	Diversified Pharmaceuticals	International Falls, MN
12843	First Health	London, KY
12847	Fountainhead Administrative	Austin, TX
12885	Health Risk Management	Minneapolis, MN
12886	PCA Health Plans	Birmingham, AL
12960	New E R A	Houston, TX
13237	First Community Health	Huntsville, AL
13286	Paid Prescriptions	Fairlawn, NJ
13297	Viva Health	Birmingham, AL
13301	Third Party Management	Oklahoma City, OK
13451	Merit Health	Birmingham, AL
97220	Webb Wheel Products	Cullman, AL
97288	Sunshine Homes	Red Bay, AL
97446	Sanders Employee Benefits	Troy, AL
97460	Tyson Foods	Boaz, AL
97501	Shaw Industries	Dalton, GA
97896	City of Montgomery	Montgomery, AL
97985	Southern Alum Castings	Bay Minette, AL
98142	Phifer Wire Products, Inc.	Tuscaloosa, AL
98174	Goodyear Tire and Rubber Company	Akron, OH
98403	ITPE - NMU Health & Welfare	Savannah, GA
98485	Columbus Mills	Eufaula, AL
98756	Tyson Foods	Gadsden, AL
98790	Tyson Foods	Oxford, AL
98876	Utility Trailer Corporation	Enterprise, AL
98907	Tyson Foods	Ashland, AL

Company Code	Company Name	City, State
98928	Tyson Foods	Heflin, AL
98929	Tyson Foods	Blountsville, AL
98930	Tyson Foods	Ashland, AL
99225	Bush Hog	Selma, AL
99362	Fieldcrest Mills Inc.	Charlotte, NC
99601	Scotch Lumber Co.	Fulton, AL
99684	Wayne Poultry Co.	Decatur, AL
99685	Wayne Poultry Co.	Union Springs, AL
99844	Goldkist Inc.	Trussville, AL
99998	Martin Industries	Florence, AL

K.2 Alphabetical Listing by Company Name

Company Code	Company Name	City, State
00002	A A R P Insurance Plan	Philadelphia, PA
10716	Administrative Enterprise	Phoenix, AR
10730	Advantage Health	Montgomery, AL
10880	AETNA	Greensboro, NC
01234	Aetna Insurance Co.	Peoria, IL
01395	Aetna Insurance Co.	Tyler, TX
01119	Aetna Life & Casualty	Minneapolis, MN
01158	Aetna Life & Casualty	Memphis, TN
01165	Aetna Life & Casualty	Greensboro, SC
01248	Aetna Life & Casualty	Allentown, PA
00906	AETNA Life and Casualty	Arlington, TX
00007	Aetna Life and Casualty Company	Tampa, FL
03576	AL Hospitals Association Employee Benefit Trust.	Jackson, MS
03737	Alabama Health Network	Birmingham, AL
12482	Alascript	Northport, AL
00020	Amalgamated Life Insurance Company	New York, NY
03745	Amer Med Security	Green Bay, WI
00031	American Family Life Insurance	Columbus, GA
00253	American General Gulf Life	Mobile, AL
00370	American General Life	Nashville, TN
00039	American Heritage Life	Jacksonville, FL
00067	Assoc Doctors Health and Life	Longhorne, PA
00073	Atlantic American Life	Atlanta, GA
00081	Bankers Life and Casualty Company	Chicago, IL
02118	BC of Illinois	Chicago, IL
02091	BC/BS of Alabama	Birmingham, AL
02198	BC/BS of Alabama	Birmingham, AL
02005	BC/BS of Florida, Incorporated	Jacksonville, AL
02092	BC/BS of Georgia/Atlanta	Atlanta, GA
02010	BC/BS of Georgia/Columbus	Columbus, GA
02137	BC/BS of Greater New York	New York, NY
02123	BC/BS of Kentucky, Inc.	Louisville, KY
02094	BC/BS of Michigan	Detroit, MI
02095	BC/BS of Mississippi	Jackson, MS
04012	BC/BS of South Carolina	Florence, SC
02097	BC/BS of Tennessee	Chattanooga, TN
02106	BC/BS of Virginia	Richmond, VA
02171	BC/BS of W PA	Pittsburgh, PA

Company Code	***Company Name***	***City, State***
02201	BellSouth D E D Service Center	Birmingham, AL
12431	Benefit Support	Gainesville, GA
00614	Boilermakers National	Kansas City, KS
99225	Bush Hog	Selma, AL
12452	CACH Administrative Services	Birmingham, AL
01828	Capitol American Life	Cleveland, OH
12439	Caremark	San Antonio, TX
10014	Central Reserve Life Insurance	Arlington, TX
11363	CIGNA	Pittsburgh, PA
01954	Cigna Health Care/Provident	Houston, TX
97896	City of Montgomery	Montgomery, AL
00128	Colonial Life and Accident	Columbia, SC
98485	Columbus Mills	Eufaula, AL
01110	Combined Ins. Co. of America	Chicago, IL
10397	Commercial Travelers	Utica, NY
00143	Connecticut General Life Insurance Company	Atlanta, GA
03996	Corporate Benefit Service	Minnetonka, MN
10377	Corporate Benefit Service	Hopkins, MN
03798	Delta Dental Plan	N. Little Rock, AR
01894	Delta Dental Plan of Ohio	Columbus, OH
12594	Diversified Pharmaceuticals	International Falls, MN
03261	Eldercare Plus	Fairfield, AL
10879	Employee Benefit Consultants	Birmingham, AL
01928	Employers Health Insurance	Green Bay, WI
10172	Employers Health Insurance	Madison, WI
12474	Express Scripts	St. Louis, MO
02001	Federal Employee Program, BCA/BSA	Birmingham, AL
99362	Fieldcrest Mills Inc.	Charlotte, NC
13237	First Community Health	Huntsville, AL
10878	First Health	Houston, TX
11103	First Health	Maitland, FL
12843	First Health	London, KY
12847	Fountainhead Administrative	Austin, TX
03308	Freedom Life	Louisville, KY
00231	Globe Life and Accident	Oklahoma City, OK
01200	Golden Rule Ins. Co.	Indianapolis, IN
99844	Goldkist Inc.	Trussville, AL
00624	Goodyear	Gadsden, AL
98174	Goodyear Tire and Rubber Company	Akron, OH
10275	Great West Life	Atlanta, GA
10579	Great West Life	Atlanta, GA
00626	Great West Life Assurance	Atlanta, GA
10349	Great West Life insurance	Detroit, MI
03628	Group Administrators	Birmingham, AL
01460	Grp Resource Inc.	Duluth, GA
03256	Guardian Life	Appleton, WI
12526	Health Network	Birmingham, AL
03035	Health Partners A D M Services	Birmingham, AL
10932	Health Partners of Alabama	Birmingham, AL
12885	Health Risk Management	Minneapolis, MN
10689	Health Strategies Insurance	Birmingham, AL
01626	Hilb, Rogal, & Hamilton	Birmingham, AL

Company Code	*Company Name*	*City, State*
00272	Independent Life and Accident	Nashville, TN
10465	Insurance Benefit Service	Houston, TX
10170	Insurance Claims Service	Birmingham, AL
98403	ITPE - NMU Health & Welfare	Savannah, GA
10158	Jefferson Pilot	Lake City, FL
01174	John Alden Life Ins. Co.	Miami, FL
10794	John Hancock Mutual	Greensboro, NC
00291	John Hancock Mutual Life	Greensboro, NC
01045	KANWHA Ins Co.	Lancaster, SC
00306	Liberty National	Birmingham, AL
00310	Life Insurance Company of Alabama	Gadsden, AL
00314	Life Insurance Company of Georgia	Atlanta, GA
00633	Life Investors Insurance Company	Cedar Rapids, IA
01114	Mail Handlers Benefit Plan	Rockville, MD
99998	Martin Industries	Florence, AL
12517	Med. Net	Huntsville, AL
13451	Merit Health	Birmingham, AL
01427	Metrahealth Travellers	Salt Lake City, UT
01303	Metropolitan	Utica, NY
00341	Metropolitan Life	Tampa, FL
01723	Metropolitan Life	Greenville, SC
01650	Metropolitan Life Insurance	Pittsburgh, PA
00358	Mutual of Omaha Insurance	Omaha, NE
00360	Mutual Savings Life	Decatur, AL
11232	NAMCI	Huntsville, AL
00640	National Association of Letter Carriers	Ashburn, VA
01676	National Foundation Life	Ft. Worth, TX
00366	National Home Life Assurance	Valley Forge, PA
12389	National RX	Dallas, TX
00376	National Security	Elba, AL
10655	New E R A	Houston, TX
12960	New E R A	Houston, TX
00388	New Southland National	Tuscaloosa, AL
00606	New York Life Insurance Company	Atlanta, GA
01930	Paid Prescription Plan	Fair Lawn, NJ
13286	Paid Prescriptions	Fairlawn, NJ
04011	Palmetto G B A	Camden, SC
03036	Partners National Health Plans	Birmingham, AL
12886	PCA Health Plans	Birmingham, AL
01924	PCS Drug Plan	Phoenix, AZ
98142	Phifer Wire Products, Inc.	Tuscaloosa, AL
00439	Physicians Mutual	Omaha, NE
00445	Pioneer Life Insurance Company	Rockford, IL
10807	Premier Health Plans	Huntsville, AL
10049	Prime Care/Prime Health	Mobile, AL
01476	Prime Health	Mobile, AL
01613	Prime Health ADM	Mobile, AL
01718	Principal Financial Group	Springfield, MO
03584	Principal Mutual Life	Overland Park, KS
00453	Professional Insurance Corporation	Raleigh, NC
00454	Protective Industrial	Birmingham, AL
00455	Protective Life Insurance Company	Birmingham, AL
01085	Provident Life & ACC	Bristol, TN

Company Code	***Company Name***	***City, State***
00706	Provident Life and Accident	Chattanooga, TN
00881	Provident Life Insurance	Greenville, SC
00929	Prudential Ins Co.	Jacksonville, FL
03591	Prudential Insurance	High Point, NC
00461	Prudential Insurance Company	Jacksonville, FL
10950	Prudential Insurance Company	Matteson, IL
00474	Ret/Wholesale O Store International	Birmingham, AL
10196	S R C Service I N C C	Columbia, SC
97446	Sanders Employee Benefits	Troy, AL
99601	Scotch Lumber Co.	Fulton, AL
03712	Senior Partners	Birmingham, AL
12494	Seniors First	Birmingham, AL
97501	Shaw Industries	Dalton, GA
03427	SIMA	Chattanooga, TN
01523	Southeast Health Plan Ins.	Birmingham, AL
03382	Southern Administrative Services	Columbus, GA
97985	Southern Alum Castings	Bay Minette, AL
10292	Southern Benefits Service	Birmingham, AL
00514	State Farm Insurance Company	Birmingham, AL
12492	Strategic Resource Company	Columbia, SC
97288	Sunshine Homes	Red Bay, AL
03718	Tennessee Laborers Health & Welfare Trust Fund	Goodlettsville, TN
10763	Third Party Claims Mgt.	Youngstown, OH
13301	Third Party Management	Oklahoma City, OK
00531	Time Insurance Company	Milwaukee, WI
10571	Travelers	Charlotte, NC
97460	Tyson Foods	Boaz, AL
98756	Tyson Foods	Gadsden, AL
98790	Tyson Foods	Oxford, AL
98907	Tyson Foods	Ashland, AL
98928	Tyson Foods	Heflin, AL
98929	Tyson Foods	Blountsville, AL
98930	Tyson Foods	Ashland, AL
10501	U S A Health Plan	Mobile, AL
00337	Unicare	Springfield, MA
00779	Unicare	Fort Scott, KS
00544	Union Bakers Insurance Company	Dallas, TX
00546	Union Fidelity Life Insurance	Trevose, PA
00550	Union National Life Insurance Company	Baton Rouge, LA
00553	United American Insurance Company	McKinney, TX
01740	United Food and Com Workers	Atlanta, GA
01582	United Health Care	Birmingham, AL
01264	United Ins. Of America	Baton Rouge, LA
10040	United Insurance Co. Of Amer.	Baton Rouge, LA
03478	United Medical Resources	Cincinnati, OH
05001	United Mine Workers	Van Nuys, CA
05018	United Mine Workers	Duluth, MN
01002	United of Omaha	Omaha, NE
98876	Utility Trailer Corporation	Enterprise, AL
10942	Value RX	Bloomfield Hills, MI
13297	Viva Health	Birmingham, AL

Company Code	***Company Name***	***City, State***
03485	W H Shepherd Company	Birmingham, AL
01934	Wal-Mart Group Health Plan	Bentonville, AR
01046	Wausau Ins. Co.	Wausau, WI
99684	Wayne Poultry Co.	Decatur, AL
99685	Wayne Poultry Co.	Union Springs, AL
97220	Webb Wheel Products	Cullman, AL

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L AVRS Quick Reference Guide

The Alabama Medicaid Automated Voice Response System (AVRS) enables providers to access information regarding check amount, claim status, recipient eligibility and third party resources, drug and procedure code pricing, prior authorization requirements, and recipient household information. When you dial 1 (800) 727-7848, you can access this information 18-20 hours per day, seven days a week. This guide is intended to help you use AVRS quickly, accurately, and efficiently.

This quick reference guide consists of the following sections:

In This Section	***You Can Find Out About***
AVRS Basics	General information, such as hours of operations and the type of information available on AVRS; AVRS spoken requests and responses; function keys; and time-outs, invalid data, and errors. **Please note the alphabetic table in Section L.1.3, Special Function Keys, which provides a number combination for each letter of the alphabet. Providers who must enter alphabetic characters in AVRS should refer to this section for instructions.**
Accessing AVRS	Using the main menu and entering a valid provider number. **You must enter a valid provider number to access any AVRS information. Only Option 0, the Provider Assistance Center, will be available to callers who do not enter a valid provider number.**
Verifying Check Amount	Selecting the appropriate main menu option and entering valid data to verify check amounts.
Accessing Claims Status	Selecting the appropriate main menu option and entering valid data to verify claims status.
Verifying Recipient Eligibility	Selecting the appropriate main menu option and entering valid data to verify recipient eligibility. **Providers have the option of receiving the eligibility response via fax. The instructions are included in this section.**
Accessing Pricing Information	Selecting the appropriate menu options and entering valid data to access pricing information for NDCs or procedure codes.
Accessing Prior Authorization Information	Selecting the appropriate menu option and entering valid data to access information about approved prior authorizations.
Accessing Household Information	Selecting the appropriate menu options and entering valid data to access information for recipient household members. **Providers have the option of receiving the household information response via fax. The instructions are included in this section.**

NOTE:

All AVRS responses are based on the information entered by the caller. Data is provided for informational purposes and is current only as of the inquiry date. This information is not a guarantee of payment. Claims submitted for payment are subject to system audits (medical policy), edits, and applicable limitations.

L.1 AVRS Basics

This section provides general information about AVRS that will help you use AVRS more efficiently and effectively. It provides general information on how to access AVRS and what information is provided and describes AVRS spoken requests and responses, special function keys, and global messages. Of particular importance is the alphabetic table, described in Section L.1.3, Special Function Keys, providing number combinations corresponding to the letters of the alphabet. Providers who must enter data that contains both numbers and letters should read this section.

L.1.1 General Information

AVRS is available approximately 18-20 hours per day, 7 days per week. Scheduled down times usually occur during off-peak hours, such as late at night or very early in the morning.

To access AVRS, you must use a touch tone phone. Providers with rotary dial phones should contact the HP Provider Assistance Center, from 8:00 a.m. until 5:00 p.m., Monday through Friday. For Pharmacy Providers only, the Pharmacy Help Desk is also available from 7:00 a.m. until 8:00 p.m. Monday through Friday, and on Saturdays from 9:00 a.m. to 5:00 p.m., and can be accessed by dialing 1 (800) 456-1242. Please refer to the Alabama Medicaid Provider Insider, a quarterly bulletin sent to Alabama Medicaid providers, for holiday schedules.

NOTE:

It is important to have all necessary information on hand prior to calling AVRS. AVRS is designed to give callers several chances to enter or correct data; however, the system will terminate the call if you fail to enter correct data within the allowed number of attempts, or if you cause the system to time-out. Please refer to Section L.1.4, Time-outs, Invalid Data, and Errors, for more information.

AVRS enables callers to access the following data:

Press Menu Option	***To Retrieve Information About***
1	Check amount for the current checkwrite.
2	Claim status, including the following information for pharmacy, Medicare-related, and non-Medicare related claims: • Paid amount and checkwrite date for paid claims • Message that the claim is in process for suspended claims • EOB codes and RA date for claim denials • Procedure or revenue code that denied or partially paid (for non-Medicare related claims, as appropriate) • ICN for fully or partially refunded claims

Press Menu Option	*To Retrieve Information About*
3	**Recipient eligibility verification** (option 1 on the sub-menu), including the following eligibility information: • Check digit for recipient number entered • Recipient last and first names • Current recipient number and check digit • Issue number for recipient ID card • Recipient date of birth and sex • Eligibility start and stop dates corresponding to the month of eligibility entered • Screening information, if selected • City • State • ZIP code • County code • Maternity waiver information, if applicable • Recipient aid category • Lock-in, lock-out, Long Term Care, and waiver information • Medicare HMO information and HIC number • Managed care information, including plan, PMP name, phone number, and 24-hour phone number At the end of the verification response, you may also retrieve the following recipient information using the recipient sub-menu: • **Benefit limits** (option 2 on the sub-menu), including inpatient, outpatient, and physician counts; eyeglass limitation counts; dental limits; and other counts • **Other insurance** (option 3 on the sub-menu), including the following third party policy information (for up to three policies): – Policy number – Company code and group number – Subscriber name and SSN – Coverage dates – Policy coverage information – Coverage limitation – Health Insurance Premium (HIP) information
4	Drug pricing information for the dispensed date entered, including prior authorization requirements
5	Procedure code pricing information, including prior authorization requirements and procedure coverage information, if applicable
6	Prior authorization verification for procedure code or NDC, including prior authorization number, status, start date, stop date, units or dollars authorized, and units or dollars used
7	Recipient household members. Allows the user to find a recipient Medicaid number for a member of the recipient's household. Information returned includes the following: - member number - name - date of birth - race - sex - certifying program

L.1.2 AVRS Spoken Requests and Responses

AVRS provides a spoken response to queries entered using a touch tone phone. Based on the information you enter, or the menu options you select, AVRS will provide a custom response. AVRS does this by translating responses to the data you enter into speech patterns.

Messages are spoken as recorded, because these do not change. However, other words, such as names, are spelled out. For instance, AVRS translates the last name “Doe” as D-O-E.

Likewise, AVRS speaks number values one number at a time. For example, the number ‘155’ is spoken as ‘one-five-five’, rather than ‘one hundred fifty-five’.

If the response represents a dollar amount, AVRS provides the response in a monetary format. For example, the dollar value ‘128432’ is represented as ‘one thousand, two hundred eighty-four dollars and thirty-two cents’.

AVRS translates date responses in a Gregorian format (the manner in which most of us express dates). For instance, the date ‘05/14/1999’ is spoken as ‘May fourteenth, nineteen ninety-nine’.

L.1.3 Special Function Keys

You will receive better, faster results using AVRS if you understand how to use the following special function keys.

End of Data

Because the length of data you enter may vary (for instance, while most Alabama Medicaid provider numbers have nine-digit numbers, some have eight-digit numbers, and all National Provider Identifier (NPI) numbers have ten digits), you must signal AVRS when you have finished entering data. The pound sign (#) is the symbol you use to do this. You should always enter the pound sign key to mark the end of the data you have just entered. The following examples illustrate how to use the pound sign (#) to mark the end of data:

To enter provider number 123456789	Press 123456789#
To enter procedure code 11111	Press 11111#

Repeat Response or Prompt

AVRS is designed to provide you the information you need by using a series of prompts and responses. The system ‘speaks’ requests to you, such as available menu options, or a request to enter data. If you want AVRS to repeat the message, press the asterisk (*) key on your touch tone phone.

Alphabetic Data

AVRS uses information keyed on a touch tone phone, which does not provide a key for each letter of the alphabet. Sometimes, you will have to enter data that contains letters as well as numbers (for instance, some Alabama Medicaid provider numbers contain letters and numbers). To do this, you must use a combination of the asterisk (*) key and **two** numbers to represent a particular letter.

The table below describes the number combinations that represent the letters of the alphabet:

A - *21	G - *41	M - *61	S - *73	Y - *93
B - *22	H - *42	N - *62	T - *81	Z - *12
C - *23	I - *43	O - *63	U - *82	
D - *31	J - *51	P - *71	V- *83	
E - *32	K - *52	Q - *11	W - *91	
F - *33	L - *53	R - *72	X - *92	

Using this table as a guide, enter data with a combination of letters and number in the following way:

Actual Provider Number	ABC0099D
Enter the following in AVRS	*21 *22 *23 0099 *31
AVRS reads back this number	ABC0099D

L.1.4 Time-outs, Invalid Data, and Errors

AVRS can respond only to what is entered by you, the caller. To receive information from AVRS, you must enter valid data in the correct format. When you make an error or fail to enter information when prompted, AVRS gives you another chance to correct the mistake. If you do not correct the error or respond in a timely fashion, AVRS will end the call.

Maximum Errors Exceeded

You have three chances to enter correct data when prompted. If you exceed the limit, AVRS plays the following message:

> *We're sorry – the data you entered is invalid. If you would like assistance from the Provider Assistance Center, press 0.*

If you press 0, AVRS transfers you to the Provider Assistance Center, which will assist you during normal business hours. If you do not press 0 within 10 seconds, AVRS ends the call.

Maximum Time-outs Exceeded

You have ten seconds to enter requested data. The first time you exceed this limit, AVRS prompts you to enter the data. If you exceed the limit a second time, AVRS plays the following message:

> *You have not responded with the requested information. If you would like assistance from the Provider Assistance Center, press 0.*

If you press 0, AVRS transfers you to the Provider Assistance Center, which will assist you during normal business hours. If you do not press 0 within 10 seconds, AVRS ends the call.

Invalid Data

If you enter a value that is not described as a menu option (for instance, if you press '9' after listening to the main menu, when '9' is not a valid option), AVRS plays the following:

Invalid option. Please re-enter.

AVRS then replays the menu options.

Maximum Transactions Exceeded

To ensure AVRS is available to all providers, you are limited to ten (10) transactions per phone call. For each main menu item, AVRS counts **one** transaction using the following criteria:

- For 'Check Amount,' (Option 1), each time you enter a different provider number
- For 'Claims Status' (Option 2), each time you check another claim for the same recipient, or each time you check a claim for a different recipient
- For 'Recipient Eligibility Verification' (Option 3), each time you verify eligibility for a recipient
- For 'Drug Pricing Information' (Option 4), each time you enter an NDC
- For 'Procedure Code Pricing Information' (Option 5), each time you enter a procedure code
- For 'Prior Authorization Verification' (Option 6), each time you enter a procedure code or NDC
- For 'Household Inquiry' (Option 7), each time you request an inquiry for recipient household information

When you exceed the ten transaction limit, AVRS ends the call after playing the following message:

In order to serve as many callers as possible, we must limit the number of inquiries per call. Please call again for any additional inquiries you may have.

L.2 Accessing the AVRS Main Menu

When you dial 1 (800) 727-7848 to access AVRS, the system supplies the following greeting:

Good morning (good afternoon, or good evening). Welcome to the Alabama Medicaid Voice Response Inquiry System.

If the system is unavailable, the following message plays:

The Alabama Medicaid Voice Response Inquiry System is currently unavailable. Please call back later or call the Provider Assistance Center at 1 (800) 392-5741 between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

If you wish to have confirmation after entering required information, press 1 when prompted. For the remainder of the call data entered will be repeated back to you and then ask you to confirm before continuing. Press 2 if you do not wish to have confirmation.

You must enter a valid NPI or Alabama Medicaid provider number to access any AVRS information. If your NPI is shared by multiple provider location ZIP codes and / or taxonomy numbers, you may be prompted to enter your nine-digit ZIP+4 code and, if necessary, your ten-digit taxonomy number.

If AVRS is available, the system provides the Main Menu. Callers may choose from the following menu options:

- Check amount (press 1)
- Claims status (press 2)
- Recipient eligibility verification (press 3)
- Drug pricing information (press 4)
- Procedure code pricing information (press 5)
- Prior authorization verification (press 6)
- Recipient household information (press 7)
- Provider Assistance Center (press 0)

Providers calling from a rotary phone are instructed to hold for the provider unit during normal business hours, or to call back during normal business hours to speak with a representative of the Provider Assistance Center.

L.3 Verifying a Check Amount

To verify a check amount, press 1 (the number one) from the Main Menu. AVRS prompts you to enter your National Provider Identifier (NPI) or Alabama Medicaid provider number. After AVRS verifies your NPI, the system returns the following information:

- Check amount for the current checkwrite

Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the checkwrite response
- Press 2 to obtain checkwrite information for another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

NOTE:
AVRS returns check amount information based on the payee, or billing provider number. You must have a valid payee provider number in order to complete a successful query. For group practices where several providers receive a single check, the check amount given will be for the entire group.

L.4 Accessing Claims Status

To access claims status, press 2 (the number two) from the Main Menu. AVRS prompts you for your NPI or billing provider number and the Alabama Medicaid recipient ID number entered on the claim form. Once you have entered this data, you may choose from the following options, as prompted by AVRS:

- Press 1 for pharmacy claims
- Press 2 for non-Medicare related claims
- Press 3 for Medicare related claims
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

L.4.1 Pharmacy Claim Status

To access claims status for pharmacy claims, you must enter the following data:

- Eleven-digit NDC, followed by the pound sign
- Dispensed date in MMDDCCYY format, followed by the pound sign
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and RA date for claim denials

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.2 Non-Medicare Claim Status

To access claims status for non-Medicare claims, you must enter the following data:

- From date of service in MMDDCCYY format, followed by the pound sign
- Through date of service in MMDDCCYY format, followed by the pound sign

- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one or more of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and RA date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Paid amount, checkwrite date, and ICN for partially paid claims
- Line item, procedure or revenue code, and paid amount for each paid detail on a partially paid claim
- Line item, procedure or revenue code, and EOB code for each denied detail on a partially paid claim

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.3 Medicare Claim Status

To access claims status for Medicare claims, you must enter the following data:

- From date of service in MMDDCCYY format, followed by the pound sign
- Through date of service in MMDDCCYY format, followed by the pound sign
- Billed amount, including dollars and cents, followed by the pound sign. **Do not include a decimal point. You may enter a maximum of nine digits.**

AVRS has now collected the required input data, and can perform a query to retrieve the requested information. If AVRS cannot find a match for the provider or recipient, the system prompts you to re-enter the data. If the provider and recipient data are valid, AVRS returns one or more of the following responses:

- System could not find a claim that matches the search criteria
- Paid amount, checkwrite date, and ICN for paid claims
- Message that the claim is in process for suspended claims
- EOB codes and RA date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Message that claim has been partially refunded and ICN for partially refunded claim
- Message that claim has been fully refunded, and ICN for fully refunded claim

The system also returns similar messages if more than one claim matches the search criteria. Once you have listened to the response, you may choose from the following options, as prompted by AVRS:

- Press 1 to repeat the claim status response
- Press 2 to check another claim for the same recipient
- Press 3 to check a claim for another recipient
- Press 4 to enter another NPI
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.4.4 Verifying Recipient Eligibility

To verify recipient eligibility, press 3 (the number three) from the Main Menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- A valid Alabama Medicaid recipient number, or the recipient's Social Security Number and Date of Birth, each followed by the pound sign
- Eligibility date, either for the current month (simply press the pound (#) sign) or for a previous month for which you must enter the date in MMCCYY format, followed by the pound sign
- Press 1 to hear all screening types; otherwise press 2
- Patient account number, if applicable (to bypass this, simply press the pound (#) sign)

NOTE:

The patient account number is an optional field. It reflects your internal patient account number. You may find it helpful to enter this number if you wish to receive a fax response and would like the number to display on the response. You may enter a maximum of 15 digits.

AVRS verifies the data you entered (except for the patient account number) and returns a message if the recipient is not eligible for the eligibility dates entered. If the recipient is eligible, you may choose from the following sub-menu options, as prompted by AVRS:

- Press 1 for eligibility information
- Press 2 for benefit limits
- Press 3 for other insurance
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

L.4.5 General Eligibility Information

You can receive a faxed copy of the eligibility response. Instructions are provided below.

Prior to playing the response, you may choose from the following options, prompted by AVRS:

- Press 1 to receive a fax only response of the eligibility information
- Press 2 to receive a voice only response
- Press 3 if you want both a fax and voice response

Receiving a Fax

When you select Option 1 or 3, AVRS prompts you to enter your ten-digit fax number (three-digit area code plus the seven-digit number), followed by the pound (#) sign. The system will send a fax transmission to the number you entered.

AVRS provides the following eligibility information for the recipient number entered:

- Check digit for recipient number entered
- Recipient last and first names
- Current recipient number and check digit
- Issue number for recipient ID card
- Recipient date of birth and sex
- Eligibility start and stop dates corresponding to the month of eligibility entered
- Screening information, if selected
- City
- State
- ZIP code

-
- County code
- Maternity waiver information, if applicable
- Recipient aid category
- Lock-in, lock-out, Long Term Care, and waiver information
- Medicare HMO information and HIC number
- Managed care information, including plan name, PMP name, phone number, and 24-hour phone number

Once the response has played, you may choose from the following options, prompted by AVRS:

- Press 1 to repeat the message
- Press 2 to continue

Selecting Option 2 to Continue

Option 2 accesses a menu that enables you to do the following:

- Press 1 to continue researching eligibility, such as benefit limits or other insurance, for the same recipient
- Press 2 to verify eligibility for another recipient
- Press 3 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

If you select Option 1, AVRS allows you to check benefit limits or other insurance for the recipient number you entered.

L.4.6 Benefit Limits

To access benefit limits (option 2 on the sub-menu) for the recipient number you entered, choose from the following options:

- Press 1 for inpatient, outpatient, and physician counts
- Press 2 for eyeglass limitation counts
- Press 3 for dental limits
- Press 4 for other counts
- Press 5 to repeat the message
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

If you choose options 1-4, AVRS responds with the applicable limitation information, then prompts you to select from the following:

- Press 1 to repeat the response
- Press 2 to inquire on other limits for the recipient you entered
- Press 3 to continue

If you select Option 3 (to continue), AVRS allows you to request another type of recipient information for the same recipient; check eligibility for another recipient; enter another provider number; return to the Main Menu; speak with a Provider Assistance Center representative; or end the call.

Inpatient, Outpatient, and Physician Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Inpatient hospital days
- Outpatient hospital days
- Physician office visits

Eyeglass Limitation Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Eyeglass frames
- Eyeglass lenses
- Eyeglass fitting exams
- Eyeglass exams

Dental Limitation Counts

When available, AVRS provides the paid and suspended counts for the following limits:

- Space maintainers
- Fluoride
- Prophylaxis
- Full or panoramic X-rays
- Oral exams

Other Counts

AVRS provides the effective date of the limitation counts and the paid and suspended counts for the following limits:

- Home health visits
- Ambulatory surgery center visits
- Dialysis services

Screening Information

AVRS provides the last EPSDT screening date for the following screening types:

- Medical screening
- Dental screening
- Vision screening
- Hearing screening

Please note that EPSDT screenings for recipients under three years of age occur more frequently than yearly. Please refer to Appendix A, EPSDT, for screening schedules.

L.4.7 Other Insurance

AVRS indicates the number of third party policies (option 3 on the sub-menu) on file for the recipient. AVRS will provide the following information for up to three (3) third party policies:

- Policy number
- Company code and group number
- Subscriber name and SSN
- Coverage dates
- Policy coverage information
- Coverage limitation
- Health Insurance Premium (HIP) information

When the response concludes, AVRS provides you with the following options:

- Press 1 to continue researching eligibility, such as benefit limits or other insurance, for the same recipient
- Press 2 to verify eligibility for another recipient
- Press 3 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.5 Accessing Pricing Information

AVRS allows you to verify pricing information for NDCs and procedure codes.

L.5.1 Drug Pricing

To verify pricing information for drugs, press 4 (the number 4) from the Main Menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- A valid, 11-digit NDC, followed by the pound sign
- The dispensed date in MMDDCCYY format, followed by the pound sign

AVRS performs a query and responds with the Reimbursement Rate Per Unit (RPU) price on file and whether the NDC requires a prior authorization. The system then allows you to choose from the following options:

- Press 1 to repeat the message
- Press 2 to check another NDC for the same provider
- Press 3 to verify the prior authorization number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.5.2 Procedure Code Pricing

To verify pricing information for procedure codes, press 5 (the number 5) from the Main Menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- A valid, five-digit procedure code, followed by the pound sign
- Up to four modifiers, each followed by the pound sign, if applicable (to bypass this, simply press the pound (#) sign)
- The date of service in MMDDCCYY format, followed by the pound sign

AVRS performs a query and responds with the price on file, whether the procedure code requires a prior authorization, and procedure coverage information, if applicable. The system then allows you to choose from the following options:

- Press 1 to repeat the message
- Press 2 to check another procedure code for the same provider
- Press 3 to check another modifier for the same procedure
- Press 4 to enter another provider number
- Press 5 to verify the prior authorization number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)

- Hang up to end the call

L.6 Inquiring About Prior Authorization Information

To inquire about approved prior authorizations (PAs), press 6 (the number 6) from the main menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- The five-digit procedure code or 11-digit NDC, followed by the pound sign
- Up to four modifiers, if inquiring on a PA for a procedure code, each followed by the pound sign, if applicable (to bypass this, simply press the pound (#) sign)

AVRS performs a query and responds with the following information for the PA:

- Multiple PAs found message, if multiple PAs found that match the input criteria
- PA number
- PA status
- Start and stop dates, for approved PAs only
- Units or dollars authorized, for approved PAs only
- Units or dollars used, for approved PAs only

If multiple PAs are found, AVRS states *More PAs exist. To hear the next PA, press 1. To continue, press 2. To repeat the message you just heard, press *.*

- Press 1 to continue to the next PA information
- Press 2 to skip the next PA information and conclude the response
- Press * to repeat the subsystem message options

When the response concludes, AVRS provides you with the following options:

- Press 1 to repeat the message
- Press 2 to check another procedure code or NDC for the same provider
- Press 3 to enter another provider number
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

L.7 Recipient Household Inquiry

To request information about recipient household members, press 7 (the number 7) from the main menu. AVRS prompts you for the following:

- Your NPI or Alabama Medicaid provider number, followed by the pound sign
- The parent/guardian's 12-digit recipient Medicaid number, or the parent/guardian's 9-digit Social Security Number, followed by the pound sign
- The household member's date of birth

You can receive a faxed copy of the household information. Instructions are provided below.

Prior to playing the response, you may choose from the following options, prompted by AVRS:

- Press 1 to receive a fax only response of the household information
- Press 2 to receive a voice only response
- Press 3 if you want both a fax and voice response

Receiving a Fax

When you select Option 1 or 3, AVRS prompts you to enter your ten-digit fax number (three-digit area code plus the seven-digit number), followed by the pound (#) sign. The system will send a fax transmission to the number you entered.

AVRS performs a query and responds with the following information for the household inquiry:

- Member Number
- Member Name
- Member Date of Birth
- Member Race
- Member Sex
- Certifying Program

When the response concludes, AVRS provides you with the following options:

- Press 1 to continue
- Press 2 to repeat the message just heard
- Press 3 to hear the previous member's information
- Press 4 to repeat this member's information
- Press 5 to enter another provider number
- Press 6 to perform another transaction with a different recipient
- Press 7 to enter another Date of Birth for the same parent/guardian
- Press 9 to return to the Main Menu
- Press 0 to speak with a Provider Assistance Center representative (please note that the Provider Assistance Center is available during normal business hours only)
- Hang up to end the call

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M Reserved for future use

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N Alabama Medicaid Contact Information

N.1 Important Telephone Numbers for the Alabama Medicaid Agency

Dental Services 1-800-688-7989

Durable Medical Equipment

Administration 1-800-688-7989

Hospital, psychiatric, admission

Children/Adolescent 1-800-688-7989

Geriatric Inpatient 1-800-688-7989

Long Term Care 1-800-688-7989

- Home Health Services
- Hospice Services
- Personal Care (for children under 21 only)
- Private Duty Nursing (for children under 21 only)
- Program of All Inclusive Care for the Elderly (PACE)
- Alabama Community Transition (ACT) Waiver

Medical Services Customer Service 1-800-688-7989

- Adolescent Pregnancy Prevention
- Ambulatory Surgical Centers
- EPSDT (Early and periodic screening, diagnosis, and treatment/Child Health Checkups)
- Eye Care
- Family Planning
- Federally Qualified Health Centers
- Hearing Services
- Hospital Program
- Laboratory Services

- Maternity Care Program
- Mental Health Services
- Patient 1st
- Pharmacy Program
- Physician's Program
- Prenatal Care
- Prenatal Education
- Radiology Services
- Renal Dialysis
- Residential Treatment Facilities
- Rural Health Clinics
- Therapist, in home (for children under 21 only)
- Transplants
- Transportation, air (for children under 21 only)

Nursing Home Care

Admissions/Program Administration 1-800-688-7989

Prior Authorization

For providers..…… 1-800-688-7989

For recipients……..1-800-362-1504

- Durable Medical Equipment
- Eye Care
- Home Health, additional visits (for children under 21 only)
- Inpatient Psychiatric Admissions (for children under 21 only)
- Private Duty Nursing (for children under 21 only)
- Therapies, in home (for children under 21 only)

Pharmacy Services (prior approval of drugs)..... 1-800-748-0130

Radiology Services (prior approval of MRI's, CT and PET scans)...1-888-693-3211

Third Party Division

Health Insurance Updates for last names A-F……334-242-5249

Health Insurance Updates for last names G-K……334-242-5280

Health Insurance Updates for last names L-Q……334-242-5254

Health Insurance Updates for last names R-Z……. 334-242-5253

N.2 General Information

For anyone to call 334-242-5000

For Medicaid recipients only 1-800-362-1504

For Medicaid providers regarding policies, procedures and/or administrative reviews 1-800-362-1504 for all other information 1-800-688-7989

N.3 Important Telephone Numbers for HP

Automated Voice Response System (AVRS) 1-800-727-7848

Electronic Media Claims (EMC) 1-800-456-1242

Provider Assistance Center 1-800-688-7989

Provider Enrollment 1-888-223-3630

Provider Relations Representatives 1-855-523-9170

HP Operator 334-215-0111

N.4 Mailing Addresses

Alabama Medicaid Agency ..... 501 Dexter Avenue
Post Office Box 5624
Montgomery, AL 36103-5624

For mailing claims which require attachments:

Pharmacy, Dental, and UB-04 Claims ..... HP
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

CMS-1500 Claims ..... HP
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

Inquiries, Provider Enrollment Information, Provider Relations
..... HP
..... Post Office Box 241685
..... Montgomery, AL 36124-1685

Medicare-related Claims ..... HP
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

Medical Prior Authorization ..... HP
..... Post Office Box 244032
..... Montgomery, AL 36124-4032

Pharmacy Prior Authorization ..... HID
..... Post Office Box 3210
..... Auburn, AL 36823-3210
..... FAX: 1-800-748-0116

N.5 Web Site Address

Refer to the Alabama Medicaid Agency's web site at http://www.medicaid.alabama.gov for the following resources:

- Forms
- Manuals
- Bulletins
- Provider Notices
- Schedule of Events
- Billing and Eligibility Software

O CRNP and PA Services

CRNP and PA services are **limited** to the injectable drug codes referenced in Appendix H, Alabama Medicaid Physician Administered Drugs, all laboratory services, which are CLIA certified, and the following CPT codes or HCPCS codes.

The Evaluation and Management codes that Nurse Practitioners/Physician Assistants may bill have been expanded. The following list does not include all procedure codes covered for CRNP's and PA's. For more specific information on coverage, you may call the Provider Assistance Center at 1 (800) 688-7989.

Procedure Codes	Description
96110	Developmental testing; limited (eg. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report.
99201-99205	Office/Outpatient visit for E & M of a new patient
99211-99215	Office/Outpatient visit for E & M of an established patient
99241-99245	Office consultation for a new or established patient
99281-99285	Emergency department visit for E & M
99305-99318	E & M of a new or established patient-nursing facility assessment
99311-99316	Subsequent nursing facility care-E & M of new/established patient
99324-99337	Domiciliary or rest home visit for E & M of a new patient
99341-99345	Home visit for E & M of a new patient
99347-99350	Home visit for E & M of established patient
99354-99357	Prolonged physician service in the office or outpatient setting
99360	Physician standby service
99377	Physician supervision of a hospice patient
99461	Normal newborn care-other than hospital or birthing room
99381-99385-EP	EPSDT periodic screening (with EP modifier), new patient
99381-99385	EPSDT interperiodic screening (w/o EP modifier) new patient
99391-99395-EP	EPSDT periodic screening (w/EP modifier), established patient

Nurse Practitioners may be reimbursed at 100% for lab and injectable drugs. Lab codes allowed are based on CLIA certification.

In order to bill for the administration fee for vaccines for children, providers must be enrolled as a VFC provider.

Refer to Chapter 13, section 13.2 for instructions on administering and billing dental varnishing procedures.

O.1 First Assistant CPT Codes for Physician Employed CRNP/PAs

CRNP's and Physician Assistants who perform as 1st assistant at surgery, must bill modifier AS (Physician Assistant, nurse practitioner, or clinical nurse specialist service for assistant at surgery) along with the appropriate procedure code. The surgical codes are not an all-inclusive list. For more specific information on coverage, you may call the Provider Assistance Center at 1-800-688-7989.

20930	23470	24545	25526	27181	27397	27524	27745	28755
20936	23480	24546	25545	27185	27400	27525	27758	28760
20937	23485	24575	25574	27187	27403	27535	27759	28800
22612	23490	24579	25575	27215	27405	27536	27766	28805
22614	23491	24586	25628	27217	27407	27540	27784	28810
22800	23515	24587	25645	27218	27409	27556	27792	28820
22802	23530	24615	25670	27226	27418	27557	27814	28825
22804	23532	24635	25676	27227	27420	27558	27822	32900
22808	23550	24665	25685	27228	27422	27566	27823	
22810	23552	24666	25695	27236	27424	27590	27826	
22812	23585	24685	25800	27244	27425	27610	27827	
22830	23615	24802	25805	27245	27427	27612	27828	
22840	23616	25135	25810	27248	27428	27620	27829	
22841	23630	25136	25820	27253	27429	27625	27832	
22842	23660	25170	25825	27254	27438	27626	27846	
22843	23670	25210	25830	27258	27440	27637	27848	
22844	23680	25215	26165	27259	27441	27638	27870	
22845	23800	25230	26992	27280	27442	27640	27871	
22846	23802	25240	27036	27282	27445	27641	27880	
22847	23935	25274	27050	27284	27446	27645	27881	
22849	24006	25320	27052	27286	27446	27646	27882	
22850	24130	25332	27054	27290	27447	27647	27886	
22852	24134	25370	27067	27295	27448	27650	27888	
22855	24136	25375	27070	27303	27450	27652	28420	
23101	24138	25390	27071	27310	27454	27654	28445	
23130	24140	25391	27075	27329	27455	27676	28465	
23140	24145	25393	27076	27331	27457	27695	28485	
23145	24147	25405	27077	27332	27465	27696	28487	
23150	24149	25420	27078	27333	27466	27698	28505	
23155	24150	25425	27090	27334	27468	27702	28515	
23170	24152	25426	27091	27335	27470	27703	28525	
23172	24155	25440	27122	27340	27472	27705	28531	
23174	24341	25441	27125	27345	27475	27707	28555	
23180	24361	25442	27130	27347	27477	27709	28585	
23182	24362	25443	27132	27350	27479	27712	28615	
23184	24363	25444	27134	27356	27485	27715	28645	
23410	24366	25445	27137	27357	27486	27720	28675	
23412	24400	25446	27138	27358	27488	27722	28705	
23420	24410	25447	27140	27360	27495	27724	28715	
23440	24420	25455	27146	27365	27506	27725	28725	
23450	24430	25490	27151	27380	27507	27730	28730	
23455	24435	25491	27156	27381	27511	27732	28735	
23460	24470	25492	27158	27385	27513	27734	28737	
23462	24498	25515	27161	27386	27514	27740	28740	
23465	24516	25525	27170	27396	27519	27742	28750	

P

P Durable Medical Equipment (DME) Procedure Codes and Modifiers

The following procedure codes apply when filing claims for DME services. Call Automated Voice Response System (AVRS) at 1-800- 727-7848 to verify current coverage and reimbursement for each procedure code. Submit requests to add procedure codes to this list in writing to the Alabama Medicaid Agency, 501 Dexter Avenue, P. O. Box 5624, Montgomery, AL 36103-5624, Attention: DME Program.

The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

EPSDT Referred Services

The procedure codes identified with an asterisk (*) are available for all Medicaid recipients. However, if these procedure codes exceed Medicaid established limits or program guidelines, a current EPSDT screening, Patient 1st referral (if applicable) and prior authorization would be required. A prior authorization may be required before Medicaid would make reimbursement for service provided beyond the limitations.

RR Modifier

Rental equipment codes must be billed with the appropriate procedure code with modifier RR. These codes are denoted with the appropriate modifier. IF RR modifier is not indicated on the prior authorization request do not use the RR modifier when billing the claim.

NOTE:

The following procedure codes for the ambulation devices may not be billed at the same time: E0100, E0110, E0112, E0130, E0135, E0135 (RR), E0140, E0143, E0148, E0148 (RR) and E0149.

NOTE:

Include a copy of the Oxygen Certification Form (Form 360) with oxygen requests. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form must be filled out, signed and dated by the ordering physician.

Supplies used with BI-PAP and CPAP Machines

A7030	Full mask fused with positive airway pressure device
A7031	Face mask interface, replacement for full facemask, each
A7032	Replacement cushion for nasal application device, each
A7033	Replacement pillows for nasal application device, pair
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, without head strap
A7035	Headgear used positive airway pressure device
A7036	Chinstrap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, non disposable, used with positive airway pressure device
A7044	Oral interface used with positive airway pressure device, each
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement each

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A4414 or A4415. Procedure code A5063 may not be billed on the same date of service as A5052.

External Breast Prosthesis

NOTE:

* Evaluated External Breast Prosthesis on a case-by-case basis with submission of pricing information and medical documentation for procedure codes L8035 and L8039.

Complex Rehabilitation Technology (CRT) Category Procedure Codes

The related HCPCS billing codes include, but are not limited to:

a. Pure CRT Codes: *These HCPCS codes contain 100% CRT products:*

E0637, E0638, E0986, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1011, E1014, E1037, E1161, E1228, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, E2209, E2293, E2294, E2300, E2301, E2310, E2311, E2312, E2313, E2321, E2322, E2323, E2324, E2325, E2326, E2327, E2328, E2329, E2330, E2331, E2351, E2373, E2374, E2376, E2377, E2609, E2617, E8000, E8001, E8002, K0005, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859,K0860,K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, and K0898.

b. Mixed CRT Codes: *These HCPCS codes contain a mix of CRT products and standard mobility and accessory products: E0143, E0950, E0951, E0952, E0955, E0956, E0957, E0960, E0967, E0978, E0990, E1015, E1016, E1028, E01029, E1030, E2205, E2208, E2231, E2368, E2369, E2370, E2605, E2606, E2607, E2608, E2613, E2614, E2615, E2616, E2620, E2621, E2624, E2625, K0009, K0040, and K0108.*

NOTE:

To file a claim for procedure codes E1399 or E1399 (EP):

1. The procedure code must be entered on the claim as one line item.

2. The units billed must be entered as “1” unit.

3. The dollar amount billed must be the “total” dollar amount for all items approved on the prior authorization for the date of service on the claim.

In other words, the money amounts for multiple items approved on a prior authorization request for E1399 or E1399 (EP) must be combined and the total money amount must be billed as one lump sum. The total units for all items must be billed as “one” unit.

If each approved item for E1399 or E1399 (EP) is billed on separate lines or if more than one unit is billed, for the same dates of service, the claim will be denied.

Prosthetics, Orthotics and Pedorthics

All orthotics and prosthetics (L Codes) are covered for children up to the age of 21 through the EPSDT Program with a current screening and referral. Most of prosthetic, orthotic and pedorthic codes in this section are covered through the EPSDT Program and do not require prior authorization. The L codes that require an EPSDT Screening and a prior authorization are denoted with two asterisks (**)..

Certain Prosthetic, Orthotic and Pedorthic codes are covered for the adult population ages 21-64. These L codes are denoted with three asterisks (***).. Information regarding medical policy and coverage of these codes for adults can be found in Chapter 14 of the DME Provider Manual.

An" X" in the Requires PA column indicates that the procedure requires prior authorization.

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
A4206		Syringe With Needle, Sterile 1cc, Each		100/mo
A4208*		Syringe With Needle, Sterile 3cc, Each		100/mo
A4209		Syringe With Needle, Sterile 5cc Or Greater, Each		100/mo
A4210		Needle-Free Injection Device, Each		100/mo
A4213*		Syringe, Sterile, 20cc Or Greater, Each		120/mo
A4215*		Needle, Sterile, Any Size, Each (Home Iv)		100/mo
A4216		Sterile Water, Saline and/or Dextrose (Diluent), 10 ml		31/mo
A4217		Sterile Water/Saline, 500 ml		31/mo
A4212		Noncoring Needle Or Stylet With Or Without Catheter (Huber Needle)		1/mo
A4221		Supplies For Maintenance Of Drug Infusion Catheter, Per Week (List Drug Separately)		1/ wk
A4222		Infusion Supplies For External Drug Infusion Pump, Per Cassette Or Bag (List Drugs Separately		31/mo
A4230		Infusion Set For External Insulin Pump, Nonneedle Cannula Type		15/mo
A4232		Syringe With Needle For External Insulin Pump, Sterile, 3cc		15/mo
A4233*		Replacement Battery, Alkaline (Other Than J Cell), For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each		1/yr
A4234*		Replacement Battery, Alkaline, J Cell, For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each		1/yr
A4235*		Replacement Battery, Lithium, For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each		1/yr
A4236*		Replacement Batter, Silver Oxide, For Use With Medically Necessary Home Blood Glucose Monitor Owned By Patient, Each		1/yr
A4244		Alcohol Or Peroxide, Per Pint		3/mo
A4245*		Alcohol Wipes, Per Box		3/mo
A4246		Betadine Or Phisohex Solution, Per Pint		4/mo
A4247*		Betadine Or Iodine Swabs/Wipes, Per Box		2/mo
A4250*		Urine Test Or Reagent Strips Or Tablets (100 Tablets Or Strips)		2/mo
A4253*		Blood Glucose Test Or Reagent Strips For Home Blood Glucose Monitor, Per 50 Strips		2 boxes every 3 months for diabetics not using insulin
A4253*	U6	Blood Glucose Test Or Reagent Strips For Home Blood Glucose Monitor, Per 50 Strips		3 boxes per month for diabetics using insulin age 21 and above
A4253*	U6	Blood Glucose Test Or Reagent Strips For Home Blood Glucose Monitor, Per 50 Strips		4 boxes per month for diabetics using insulin age 0 - 21
A4256*		Normal, Low And High Calibrator Solution/Chips		3/yr
A4258*		Spring-Powered Device For Lancet, Each		1/yr

Added: A4212

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
A4259*		Lancets, Per Box Of 100		1 box every three months for diabetics not using insulin
A4259	U6	Lancets, Per Box Of 100		2 boxes per month for diabetics using insulin
A4259	SC	Lancets, Per Box Of 25		1 box per yr for age group 0-20 requiring special PKU finger sticks.
A4335		Incontinence Supply; Miscellaneous		31/mo
A4338*		Indwelling Catheter; Foley Type, Two-Way Latex With Coating (Teflon, Silicone, Silicone Elastomer, Or Hydrophilic, Etc.), Each		2/mo
A4340		Indwelling Catheter; Specialty Type, (e.g., Coude, mushroom, wing, etc.), Each		5/mo
A4344*		Indwelling Catheter, Foley Type, Two-Way, All Silicone, Each		2/mo
A4349*		Male External Catheter, With Or Without Adhesive, Disposable, Each		150/mo (EPSDT)
A4349*		Male External Catheter, With Or Without Adhesive, Disposable, Each		31/mo
A4351*		Intermittent Urinary Catheter; Straight Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomer, Or Hydrophilic, Etc.), Each		150/mo (EPSDT)
A4351*		Intermittent Urinary Catheter; Straight Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomer, Or Hydrophilic, Etc.), Each		31/mo
A4352		Intermittent Urinary Catheter; Coude (Curved) Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomeric, Or Hydrophilic, Etc.), Each		150/mo (EPSDT)
A4352		Intermittent Urinary Catheter; Coude (Curved) Tip, With Or Without Coating (Teflon, Silicone, Silicone Elastomeric, Or Hydrophilic, Etc.), Each		31/mo
A4354*		Insertion Tray With Drainage Bag But Without Catheter		2/mo
A4357*		Bedside Drainage Bag, Day Or Night, With Or Without Anti-Reflux Device, With Or Without Tube, Each		2/mo
A4358*		Urinary Drainage Bag, Leg Or Abdomen, Vinyl, With Or Without Tube, With Straps, Each		2/mo
A4362*		Skin Barrier; Solid, 4 X 4 Or Equivalent; Each		20/mo
A4364*		Adhesive, Liquid Or Equal, Any Type, Per Oz		12/mo
A4367*		Ostomy Belt, Each		1/mo
A4400*		Ostomy Irrigation Set		5/mo
A4402*		Lubricant, Per Ounce		5/mo
A4404		Ostomy Ring, Each		31/mo
A4414*		Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion), Without Built-In Convexity, 4 X 4 Inches Or Smaller, Each		31/mo
A4415*		Ostomy Skin Barrier, With Flange (Solid, Flexible Or Accordion), Without Built-In Convexity, Larger Than 4x4 Inches, Each		20/mo
A4421	SC	Ostomy Supply, Miscellaneous	X	N/A
A4450*		Tape, Non-Waterproof, Per 18 Square Inches		60/mo
A4452*		Tape, Waterproof, Per 18 Square Inches		60/mo
A4456		Adhesive Remover, Wipes, Any Type, Each		150/mo

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit	
A4606		Oxygen Probe For Use With Oximeter Device, Replacement	X	2/mo	Added: A4606
A4605		Tracheal Suction Catheter, Closed System, Each		4/mo	
A4614		Peak Expiratory Flow Rate Meter, Hand Held		1/ 3yrs	
A4618		Breathing Circuits		4/mo	
A4623		Tracheostomy, Inner Cannula		20/mo	
A4624*		Tracheal Suction Catheter, Any Type Other Than Closed System, Each		500/mo	
A4625		Tracheostomy Care Kit For New Tracheostomy		90/mo	
A4628*		Oropharyngeal Suction Catheter, Each		50/mo	
A4629*		Tracheostomy Care Kit For Established Tracheostomy		31/mo	
A4640		Alternationg Pressure Pad	X	1/yr	
A4927*		Gloves, Non-Sterile, Per 100		2/mo	
A5052*		Ostomy Pouch, Closed; Without Barrier Attached (1 Piece), Each		60/mo	
A5054*		Ostomy Pouch, Closed; For Use On Barrier With Flange (2 Piece), Each		60/mo	
A5061*		Ostomy Pouch, Drainable; With Barrier Attached, (1 Piece), Each		31/mo	
A5063*		Ostomy Pouch, Drainable; For Use On Barrier With Flange (2 Piece System), Each		31/mo	
A5071*		Ostomy Pouch, Urinary; With Barrier Attached (1 Piece), Each		40/mo	
A5120		Skin Barrier, Wipes Or Swaps, Each		50/mo	
A5121*		Skin Barrier; Solid, 6 X 6 Or Equivalent, Each		20/mo	
A5500*		Diabetic Fitting (Including Follow-Up) Custom Off The Shelf Shoe (Per Shoe)		2/yr	Deleted: ~~A5500~~
A5500***		Diabetic Fitting (Including Follow-Up) Custom Off The Shelf Shoe (Per Shoe)		2/yr	Added: A5500***
A5501***		Diabetic Custom Molded Shoe, (Per Shoe)		2/yr	
A5501***		Diabetic Custom Molded Shoe, (Per Shoe)		2/yr	
A5513*		Diabetic Multiple Density Insert, Custom Molded From Patient's Foot, Each		6/yr	Deleted: ~~A5513~~
A5513***		Diabetic Multiple Density Insert, Custom Molded From Patient's Foot, Each		6/yr	Added: A5513***
A6216*		Gauze, Non-Impregnated, Non-Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing		1000/mo	
A6217*		Gauze, Non-Impregnated, Non-Sterile, Pad Size More Than 16 Sq. In. But Less Than Or Equal To 48 Sq. In., Without Adhesive Border, Each Dressing		700/mo	
A6402*		Gauze, Non-Impregnated, Sterile, Pad Size 16 Sq. In. Or Less, Without Adhesive Border, Each Dressing		400/mo	
A6403*		Gauze, Non-Impregnated, Sterile, Pad Size More Than 16 Sq. In. Less Than Or Equal To 48 Sq. In., Without Adhesive Border, Each Dressing		100/mo	
A6501		Compress Burn Garment, Bodysuit (Head To Foot), Custom Fabricated	X	2/ 3mos	
A6502		Compression Burn Garment, Chin Strap, Custom Fabricated	X	2/ 3mos	
A6503		Compression Burn Garment, Facial Hood, Custom Fabricated	X	2/ 3mos	
A6504		Compression Burn Garment, Glove To Wrist, Custom Fabricated	X	2/ 3mos	
A6505		Compression Burn Garment, Glove To Elbow, Custom Fabricated	X	2/ 3mos	
A6507		Compression Burn Garment, Foot To Knee Length, Custom Fabricated	X	2/ 3mos	
A6508		Compression Burn Garment, Foot To Thigh Length, Custom Fabricated	X	2/ 3mos	
A6509		Compression Burn Garment, Upper Trunk To Waist Including Arm Openings (Vest), Custom Fabricated	X	2/ 3mos	

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
A6511		Compression Burn Garment, Lower Trunk Including Leg Openings (Pantry), Custom Fabricated	X	2/ 3mos
A6512		Compression Burn Garment, Not Otherwise Classified	X	2/ 3mos
A6513		Compression Burn Mask, Face and/or Neck, Plastic Or Equal, Custom Fabricated	X	2/ 3mos
A6530*		Gradient Compression Stocking, Below Knee, 18-30 mm Hg, Each		8/yr
A6531*		Gradient Compression Stocking, Below Knee, 30-40, Each		8/yr
A6533*		Gradient Compression Stocking, Thigh Length, 18-30 mm Hg, Each		8/yr
A7000		Canister, Disposable, Used With Suction Pump, Each		4/mo
A7001		Canister, Non-Disposable, Used With Suction Pump, Each		1/yr
A7002		Tubing, Used With Suction Pump, Each		1/mo
A7003*		Administration Set, With Small Volume Nonfiltered Pneumatic Nebulizer, Disposable		3/mo
A7005*		Administration Set, With Small Volume Nonfiltered Pneumatic Nebulizer, Non-Disposable		2/yr
A7008		Large Volume Nebulizer, Disposable, Prefilled, Used With Aerosol Compressor		4/mo
A7010		Corrugated Tubing, Disposable, Used With Large Volume Nebulizer, 100 Ft. (Aerosol Tubing)		2/mo
A7012		Water Collection Device, Used With Large Volume Nebulizer (Drain Bag)		4/mo
A7015		Aerosol Mask, Used With DME Nebulizer		4/mo
A7030		Full Face Mask Used With Positive Airway Pressure Device	X	1/3yrs
A7031		Face Mask Interface, Replacement For Full Facemask, Each		2/yr
A7032		Replacement Cushion For Nasal Application Device, Each		2/yr
A7033		Replacement Pillows For Nasal Application Device, Pair		2/yr
A7034		Nasal Interface (Mask Or Cannula Type) Used With Positive Airway Pressure Device, Without Head Strap		2/yr
A7035		Headgear Used Positive Airway Pressure Device		2/yr
A7036		Chinstrap Used With Positive Airway Pressure Device		1/yr
A7037		Tubing Used With Positive Airway Pressure Device		1/mo
A7038		Filter, Disposable, Used With Positive Airway Pressure Device		1/mo
A7039		Filter, Non Disposable , Used With Positive Airway Pressure Device		1/yr
A7044		Oral Interface Used With Positive Airway Pressure Device, Each		2/yr
A7046		Water Chamber For Humidifier, Used With Positive Airway Pressure Device, Replacement Each		2/yr
A7509		Heat Moisture Exchange System Filter Housing, and Adhesive, For Use As A Tracheostomy Heat and Moisture Exchange System, Each	X	1/day
A7520		Tracheostomy/Laryngectomy Tube, Non-Cuffed, Polyvinylchloride (PVC), Silicone Or Equal, Each		5/mo
A7525		Tracheostomy Mask, Each		4/mo
A7526		Tracheostomy Tube Collar/Holder, Each		31/mo
A8000		Helmet, Protective, Soft, Prefabricated, Includes All Components And Accessories	X	1/yr
A8001		Helmet, Protective, Hard, Prefabricated, Includes All Components And Accessories	X	1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
A9900		Miscellaneous DME Supply, Accessory, and/or Service Component Of Another HCPC Code (Suction Bacteria Filters)		2/yr
B4034		Enteral Feeding Supply Kit; Syringe, Per Day	X	31/mo
B4035		Enteral Feeding Supply Kit; Pump Fed, Per Day (Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump.)	X	31/mo
B4035		Enteral Feeding Supply Kit; Pump Fed, Per Day	X	31/mo
B4036		Enteral Feeding Supply Kit; Gravity Fed, Per Day	X	31/mo
B4081*		Nasogastric Tubing With Stylet		31/mo
B4082*		Nasogastric Tubing Without Stylet		31/mo
B4087		Gastrostomy/Jejunostomy Tube, Standard, Any Material, Any Type, Each		4/mo
B4088		Gastrostomy/Jejunostomy Tube, Low Profile, Any Material, Any Type, Each (Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump.)	X	4/ yr
B4088		Gastrostomy/Jejunostomy Tube, Low Profile, Any Material, Any Type, Each	X	4/ yr
B4220		Parenteral Supply Kit, Premix, Per Day		1/day
B4222		Parenteral Supply Kit, Home Mix, Per Day,		1/day
B4224		Parenteral Nutrition Administration Kit, Per Day		1/day
B9002		Enteral Nutrition Infusion Pump - With Alarm (Per Day) (Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump	X	1/2 yr
B9002	RR	Enteral Nutrition Infusion Pump - With Alarm (Per Day)(Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump).	X	31/mo
B9004*	RR	Parenteral Nutrition Infusion Pump, Portable	X	1/day
B9006*	RR	Parenteral Nutrition Infusion Pump, Stationary	X	1/day
B9998	EP	NOC For Enteral Supplies(Covered For Recipients Over 21 Who Meets Medical Criteria, Cannot Tolerate Bolus Feeding And Must Have A Pump)	X	12/yr
E0100*		Cane, Includes Canes Of All Materials, Adjustable Or Fixed, With Tip		1/2yrs
E0105*		Cane, Quad Or Three Prong, Includes Canes Of All Materials, Adjustable Or Fixed, With Tips		1 2yrs
E0110*		Crutches, Forearm, Includes Crutches Of Various Materials, Adjustable Or Fixed, Pair, Complete With Tips And Handgrips		1/2yrs
E0112*		Crutches, Underarm, Wood, Adjustable Or Fixed, Pair, With Pads, Tips And Handgrips		1/2yrs
E0114		Crutches, Underarm Other Than Wood, Adjustable Or Fixed, Pair, With Pads, Tips And Handgrips		1/2yrs
E0130*	RR	Walker, Rigid (Pickup), Adjustable Or Fixed Height		1/ 2yrs
E0130*		Walker, Rigid (Pickup), Adjustable Or Fixed Height		1/ 2yrs
E0135*	RR	Walker, Folding (Pickup), Adjustable Or Fixed Height		1/mo
E0135*		Walker, Folding (Pickup), Adjustable Or Fixed Height		1/2yrs
E0140		Walker, With Trunk Support, Adjustable Or Fixed Height, Any Type	X	1/5yr (children only)
E0143		Walker, Folding, Wheeled, Adjustable Or Fixed Height		1/2yrs
E0148	RR	Walker, Heavy Duty, Without Wheels, Rigid Or Folding, Any Type, Each	X	1/mo
E0148		Walker, Heavy Duty, Without Wheels, Rigid Or Folding, Any Type, Each	X	1/ 2yrs
E0149		Walker, Heavy Duty, Wheeled, Rigid Or Folding, Any Type	X	1/2yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E0153		Platform Attachment, Forearm Crutch, Each	X	1/2yrs
E0163*	RR	Commode Chair, Stationary, With Fixed Arms		1/mo
E0163*		Commode Chair, Stationary, With Fixed Arms		1/2yrs
E0165*	RR	Commode Chair, Mobile Or Stationary, With Detachable Arms		1/mo
E0165*		Commode Chair, Mobile Or Stationary, With Detachable Arms		1/ 2yrs
E0168*		Commode Chair, Extra Wide and/or Heavy Duty, Stationary Or Mobile, With Or Without Arms, Any Type, Each	X	1/ 2yrs
E0181*	RR	Powered Pressure Reducing Mattress Overlay/Pad, Alternating With Pump Includes Heavy Duty	X	1/mo
E0181*		Powered Pressure Reducing Mattress Overlay/Pad, Alternating With Pump Includes Heavy Duty	X	1/ 3yrs
E0182		Pump For Alternating Pressure Pad, For Replacement Only	X	1/2 yr
E0184	RR	Dry Pressure Mattress		1/mo
E0184		Dry Pressure Mattress		1/ 2yrs
E0185*	RR	Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length and Width	X	1/mo
E0185*		Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length and Width	X	1/ 2yrs
E0188*	RR	Synthetic Sheepskin Pad		1/mo
E0188*		Synthetic Sheepskin Pad		1/yr
E0191*		Heel Or Elbow Protector, Each		4/yr
E0202	RR	Phototherapy (bilirubin) Light With Photometer		31/mo
E0210*	RR	Electric Heat Pad, Standard		1/mo
E0210*		Electric Heat Pad, Standard		1/yr
E0250*	RR	Hospital Bed, Fixed Height, With Any Type Side Rails, With Mattress	X	1/mo
E0250*		Hospital Bed, Fixed Height, With Any Type Side Rails, With Mattress	X	1/lifetime
E0255*	RR	Hospital Bed, Variable Height, Hi-Lo, With Any Type Side Rails, With Mattress	X	1/mo
E0255*		Hospital Bed, Variable Height, Hi-Lo, With Any Type Side Rails, With Mattress	X	1/lifetime
E0260*	RR	Hospital Bed, Semi-Electric (Head And Foot Adjustment), With Any Type Side Rails, With Mattress	X	1/mo
E0260*		Hospital Bed, Semi-Electric (Head And Foot Adjustment), With Any Type Side Rails, With Mattress	X	1/lifetime
E0271*	RR	Mattress, Innerspring	X	1/mo
E0271*		Mattress, Innerspring	X	1/ 3yrs
E0275*	RR	Bed Pan, Standard, Metal Or Plastic		1/mo
E0275*		Bed Pan, Standard, Metal Or Plastic		1/yr
E0276*		Bed Pan, Fracture, Metal Or Plastic		1/yr
E0277	RR	Powered Pressure-Reducing Air Mattress	X	1/mo
E0280	RR	Bed Cradle, Any Type	X	1/mo
E0280		Bed Cradle, Any Type	X	1/lifetime
E0303*		Hospital Bed, Heavy Duty, Extra Wide With Weight Capacity Greater Than 350 Pounds, But Less Than 600 Pounds With Any Type Side Rails With Mattress	X	1/lifetime
E0304*		Hospital Bed, Extra Heavy Duty, Extra Wide, With Weight Capacity Greater Than 600 Pounds With Any Type Side Rails With Mattress (Invoice)	X	1/lifetime
E0310*	RR	Bed Side Rails, Full Length	X	2/mo
E0310		Bed Side Rails, Full Length	X	1/3 yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E0424*	RR	Stationary Compressed Gaseous Oxygen System, Rental; Includes Container, Contents, Regulator, Flowmeter, Humidifier, Nebulizer, Cannula Or Mask, and Tubing	X	1/mo
E0431*	RR	Portable Gaseous Oxygen System, Rental; Includes Portable Container, Regulator, Flow Meter, Humidifier, Cannula Or Mask, And Tubing	X	1/mo
E0441*		Oxygen Contents, Gaseous (For Use With Owned Gaseous Stationary Systems Or When Both A Stationary And Portable Gaseous System Are Owned), 1 Month's Supply = 1	X	1/mo
E0443		Portable Oxygen Contents, Gaseous (For Use Only With Portable Gaseous Systems When No Stationary Gas Or Liquid System Is Used), 1 Month's Supply = 1 Unit	X	4/mo
E0445		Oximeter Device For Measuring Blood Oxygen Levels Non-Invasively (Per Overnight Oximetry Encounter)	X	1/mo
E0445	RR	Oximeter Device For Measuring Blood Oxygen Levels Non-Invasively	X	1/mo
E0450	RR	Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used With Invasive Interface (E.G., Tracheostomy Tube)	X	1/mo
E0461	RR	Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used With Non-Invasive Interface (E.G. Mask)	X	1/mo
E0463	RR	Pressure Support Ventilator With Volume Control Mode, May Include Pressure Control Mode, Used With Invasive Interface (E.G. Tracheostomy Tube)	X	1/mo
E0464	RR	Pressure Support Ventilator With Volume Control Mode, May Include Pressure Control Mode, Used With Non-Invasive Interface (e.g.mask)		1/mo
E0470	RR	Respiratory Assist Device, Bi-Level Pressure Capability, Without Back-Up Rate Feature, Used With Noninvasive Interface, E.G., Nasal Or Facial Mask	X	1/mo
E0471	RR	Respiratory Assist Device, Bi-Level Pressure Capability, With Back-Up Rate Feature, Used With Noninvasive Interface, E.G., Nasal Or Facial Mask	X	1/mo
E0472	RR	Respiratory Assist Device, Bi-Level Pressure Capability, Without Back-Up Rate Feature, Used With Noninvasive Interface, E.G., Tracheostomy Tube (intermittent assist device with continuous positive airway pressure device)	X	1/mo
E0480		Percussor, Electric Or Pneumatic, Home Model	X	1/lifetime
E0482	RR	Cough Stimulating Device, Alternating Positive And Negative Airway Pressure	X	1/mo
E0483	RR	High Frequency Chest Wall Oscillation Air Pulse Generator System (Includes Hoses And Vest) (Rent To Purchase)	X	1/lifetime
E0550	RR	Humidifier, Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	X	1/mo
E0550		Humidifier, Durable For Extensive Supplemental Humidification During IPPB Treatments Or Oxygen Delivery	X	1 3yrs
E0561	RR	Humidifier, Non-Heated, Used With Positive Airway Pressure Device	X	1/mo
E0561		Humidifier, Non-Heated, Used With Positive Airway Pressure Device	X	1/ 3yrs
E0562	RR	Humidifier, Heated, Used With Positive Airway Pressure Device	X	1/mo
E0565	RR	Compressor, Air Power Source For Equipment Which Is Not Self- Contained Or Cylinder Driven	X	1/mo
E0570*	RR	Nebulizer, With Compressor		1/mo
E0570*		Nebulizer, With Compressor		1/ 4yrs
E0575	RR	Nebulizer, Ultrasonic, Large Volume	X	1/mo
E0585	RR	Nebulizer With Compressor And Heater	X	1/mo
E0600*	RR	Respiratory Suction Pump, Home Model, Portable Or Stationary, Electric	X	1/mo

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E0600*		Respiratory Suction Pump, Home Model, Portable Or Stationary, Electric	X	1/ 5yrs
E0601	RR	Continuous Airway Pressure (CPAP) Device	X	1/mo
E0601	LL	Continuous Airway Pressure (CPAP) Device	X	1/8yr
E0601	RA	Continuous Airway Pressure (CPAP) Device	X	1/8yr
E0607*	RR	Home Blood Glucose Monitor		1/mo
E0607*		Home Blood Glucose Monitor		1/ 5yrs
E0619	RR	Apnea Monitor, With Recording Feature	X	1/mo
E0621*		Sling Or Seat, Patient Lift, Canvas Or Nylon		1 per yr
E0630*		Patient Lift, Hydraulic, With Seat Or Sling	X	1/ 5yrs
E0630	RR	Patient Lift, Hydraulic, With Seat Or Sling	X	1/mo
E0635		Patient Lift, Electric, With Seat Or Sling	X	1/5yrs
E0650	RR	Pneumatic Compressor, Non-Segmental Home Model	X	1/mo
E0650		Pneumatic Compressor, Non-Segmental Home Model	X	1/ 5yrs
E0667	RR	Pneumatic Appliance For Use With Segmental Pneumatic Compressor, Leg	X	1/mo
E0667		Pneumatic Appliance For Use With Segmental Pneumatic Compressor, Leg	X	2/ 3yrs
E0668	RR	Arm Appliance For Linear Pump	X	1/mo
E0668		Arm Appliance For Linear Pump	X	2/ 3yrs
E0705*		Transfer Device, Any Type, Each		
E0776*	RR	Iv Pole		1/mo
E0776*		Iv Pole		1/ 3yrs
E0779		Ambulatory Infusion Pump, Mechanical, Reusable, For Infusion 8 Hours Or Greater	X	1/ 5yrs
E0781*	RR	Ambulatory Infusion Pump, Single Or Multiple Channels, Electric Or Battery Operated, With Administrative Equipment, Worn By Patient	X	1/day
E0784	RR	External Ambulatory Infusion Pump, Insulin (Rent To Purchase)	X	1/mo
E0791	RR	Parenteral Infusion Pump, Stationary, Single Or Multi-Channel	X	1/mo
E0850	RR	Traction Stand, Free Standing, Simple Cervical Traction	X	1/mo
E0850		Traction Stand, Free Standing, Simple Cervical Traction	X	1/mo
E0890	RR	Traction Frame, Attached To Footboard, Simple Pelvic Traction	X	1/mo
E0890		Traction Frame, Attached To Footboard, Simple Pelvic Traction	X	1/mo
E0910*	RR	Trapeze Bars, A/K/A Patient Helper, Attached To Bed, With Grab Bar	X	1/mo
E0910*		Trapeze Bars, A/K/A Patient Helper, Attached To Bed, With Grab Bar	X	1/5yrs
E0911*		Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 Pounds, Attached To Bed, With Grab Bar	X	1/yr
E0912*		Trapeze Bar, Heavy Duty, For Patient Weight Capacity Greater Than 250 Pounds, Free Standing, Complete With Grab Bar	X	1/5yrs
E0944		Pelvic Belt/Harness Boot	X	1/yr
E0950		Wheelchair Accessory, Tray, Each	X	1/yr
E0951*		Wheel Loop/Holder, Any Type, With Or Without Ankle Strap, Each	X	2/yr
E0952		Toe Loop/Holder, Any Type, Each	X	2/yr
E0955		Wheelchair Accessory, Headrest, Cushioned, Any Type, Including Fixed Mounting Hardware, Each	X	1/yr
E0956		Wheelchair Accessory, Lateral Trunk Or Hip Support, Any Type, Including Fixed Mounting Hardware, Each	X	4/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E0957		Wheelchair Accessory, Medial Thigh Support, Any Type, Including Fixed Mounting Hardware, Each	X	2/yr
E0958*		Manual Wheelchair Accessory, One-Arm Drive Attachment, Each	X	1/yr
E0959		Manual Wheelchair Accessory, Adapter For Amputee, Each	X	2/yr
E0959		Manual Wheelchair Accessory, Adapter For Amputee, Each	X	2/yr
E0960		Wheelchair Accessory, Shoulder Harness/Straps Or Chest Strap, Including Any Type Mounting Hardware	X	2/ 3yr
E0961		Manual Wheelchair Accessory, Wheel Lock Brake Extension (Handle), Each	X	1/yr
E0966		Manual Wheelchair Accessory, Headrest Extension, Each	X	1/yr
E0967		Manual Wheelchair Accessory, Hand Rim With Projections, Any Type, Replacement Only, Each	X	2/yr
E0971*	RR	Manual Wheelchair Accessory, Anti-Tipping Device, Each	X	2/mo
E0971*		Manual Wheelchair Accessory, Anti-Tipping Device, Each	X	2/yr
E0973		Wheelchair Accessory, Adjustable Height, Detachable Armrest, Complete Assembly, Each	X	2/yr
E0974		Manual Wheelchair Accessory, Anti-Rollback Device, Each	X	2/yr
E0978*		Wheelchair Accessory, Positioning Belt/Safety Belt/Pelvic Strap, Each	X	1/yr
E0980*		Safety Vest, Wheelchair	X	1yr
E0981		Wheelchair Accessory, Seat Upholstery, Replacement Only, Each	X	1/yr
E0982		Wheelchair Accessory, Back Upholstery, Replacement Only, Each	X	1/yr
E0983		Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair, Joystick Control	X	1/yr
E0984		Manual Wheelchair Accessory, Power Add-On To Convert Manual Wheelchair To Motorized Wheelchair, Tiller Control	X	1/yr
E0985		Wheelchair Accessory, Seat Lift Mechanism	X	1/yr
E0986		Manual Wheelchair Accessory, Push Activated Power Assist, Each	X	1/yr
E0990		Wheelchair Accessory, Elevating Leg Rest, Complete Assembly, Each	X	2/yr
E0992		Manual Wheelchair Accessory, Solid Seat Insert	X	1/yr
E0994		Arm Rest, Each	X	2/yr
E0995		Wheelchair Accessory, Calf Rest/Pad, Each	X	2/yr
E1002		Wheelchair Accessory, Power Seating System, Tilt Only	X	1/7yrs
E1003		Wheelchair Accessory, Power Seating System, Recline Only, Without Shear Reduction	X	1/7yrs
E1004		Wheelchair Accessory, Power Seating System, Recline Only, With Mechanical Shear Reduction	X	1/7yrs
E1005		Wheelchair Accessory, Power Seating System, Recline Only, With Power Shear Reduction	X	1/7yrs
E1006		Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, Without Shear Reduction	X	1/7yrs
E1007		Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Mechanical Shear Reduction	X	1/7yrs
E1008		Wheelchair Accessory, Power Seating System, Combination Tilt And Recline, With Power Shear Reduction	X	1/7yrs
E1009		Wheelchair Accessory, Addition To Power Seating System Mechanically Linked Leg Elevation System, Including Pushrod And Leg Rest, Each	X	2/7yrs
E1010		Wheelchair Accessory, Addition To Power Seating System, Power Leg Elevation System, Including Leg Rest, Pair	X	1/7yrs
E1011		Modification To Pediatric Size Wheelchair, Width Adjustment Package (Not To Be Dispensed With Initial Chair)	X	1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E1014		Reclining Back, Addition To Pediatric Size Wheelchair	X	1/2yrs
E1015		Shock Absorber For Manual Wheelchair, Each	X	2/yr
E1016		Shock Absorber For Power Wheelchair, Each	X	2/yr
E1017		Heavy Duty Shock Absorber For Heavy Duty Or Extra Heavy Duty Manual Weelchair, Each	X	2/yr
E1018		Heavy Duty Shock Absorber For Heavy Duty Or Extra Heavy Duty Power Wheelchair, Each	X	2/yr
E1020		Residual Limb Support System For Wheelchair	X	2/yr
E1028*		Wheelchair Accessory, Manual Swingaway, Retractable Or Removable Mounting Hardware For Joystick, Other Control Interface Or Positioning Accessory	X	4 units/yr
E1029		Wheelchair Accessory, Ventilator Tray, Fixed	X	1/ 4yrs
E1030		Wheelchair Accessory, Ventilator Tray, Gimbaled	X	1/4yrs
E1031	RR	Rollabout Chair, Any And All Types With Castors 5" Or Greater	X	1/mo
E1031		Rollabout Chair, Any And All Types With Castors 5" Or Greater	X	1/ 7yrs
E1035		Multi-Positional Patient Transfer With Integrated Seat, Operated By Caregiver, Patient Weight Up To And Including 300 Lbs (This Code Is Used To Cover Adaptive Strollers, Equipment And Accessories)	X	1/7yrs
E1037*	RR	Transport Chair, Pediatric Size	X	1/mo
E1037*		Transport Chair, Pediatric Size	X	1/ 7yrs
E1050*	RR	Fully-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	X	1/mo
E1050*		Fully-Reclining Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Leg Rests	X	1/ 7yrs
E1060*	RR	Fully-Reclining Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Elevating Legrests	X	1/mo
E1060*		Fully-Reclining Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Elevating Legrests	X	1/ 7yrs
E1070*	RR	Fully-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X	1/mo
E1070*		Fully-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X	1/ 7yrs
E1088*	RR	High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length, Swing Away Detachable Elevating Leg Rests	X	1/mo
E1088*		High Strength Lightweight Wheelchair, Detachable Arms Desk Or Full Length, Swing Away Detachable Elevating Leg Rests	X	1/ 7yrs
E1092	RR	Wide Heavy Duty Wheel Chair, Detachable Arms (Desk Or Full Length), Swing Away Detachable Elevating Leg Rests	X	1/mo
E1092		Wide Heavy Duty Wheel Chair, Detachable Arms (Desk Or Full Length), Swing Away Detachable Elevating Leg Rests	X	1/ 7yrs
E1093*	RR	Wide Heavy Duty Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away Detachable Footrests	X	1/mo
E1093*		Wide Heavy Duty Wheelchair, Detachable Arms Desk Or Full Length Arms, Swing Away Detachable Footrests	X	1/ 7yrs
E1110*	RR	Semi-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X	1/mo
E1110*		Semi-Reclining Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X	1/ 7yrs
E1130*	RR	Standard Wheelchair, Fixed Full Length Arms, Fixed Or Swing Away Detachable Footrests	X	1/mo

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E1130*		Standard Wheelchair, Fixed Full Length Arms, Fixed Or Swing Away Detachable Footrests	X	1/ 7yrs
E1140*	RR	Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Footrests	X	1/mo
E1140*		Wheelchair, Detachable Arms, Desk Or Full Length, Swing Away Detachable Footrests	X	1/ 7yrs
E1150*	RR	Wheelchair, Detachable Arms, Desk Or Full Length Swing Away Detachable Elevating Legrests	X	1/mo
E1150*		Wheelchair, Detachable Arms, Desk Or Full Length Swing Away Detachable Elevating Legrests	X	1/ 7yrs
E1160*	RR	Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	X	1/mo
E1160*		Wheelchair, Fixed Full Length Arms, Swing Away Detachable Elevating Legrests	X	1/ 7yrs
E1161		Manual Adult Wheelchair With Tilt N And Space	X	1/ 7yrs
E1180*	RR	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrests	X	1/ mo; up to 6 mos
E1180*		Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrests	X	1/ 7yrs
E1190*	RR	Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	X	1/mo
E1190*		Amputee Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Elevating Leg Rests	X	1/ 7yrs
E1200*	RR	Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	X	1/ mo; up to 6 mos
E1200*		Amputee Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	X	1/ 7yrs
E1225		Wheelchair Accessory, Manual Semi-Reclining Back, (Recline Greater Than 15 Degrees, But Less Than 80 Degrees), Each	X	1/yr
E1226	RR	Wheelchair Accessory, Manual Fully Reclining Back, (Recline Greater Than 80 Degrees), Each	X	1/mo
E1226		Wheelchair Accessory, Manual Fully Reclining Back, (Recline Greater Than 80 Degrees), Each	X	1/yr
E1227		Special Height Arms For Wheelchair	X	2/yr
E1228		Special Back Height For Wheelchair	X	1/ 7yrs
E1229		Wheelchair, Pediatric Size, Not Otherwise Specified	X	1/ 7yrs
E1231		Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, With Seating System	X	1/ 7yrs
E1232		Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, With Seating System	X	1/ 7yrs
E1233		Wheelchair, Pediatric Size, Tilt-In-Space, Rigid, Adjustable, Without Seating System	X	1/ 7yrs
E1234		Wheelchair, Pediatric Size, Tilt-In-Space, Folding, Adjustable, Without Seating System	X	1/ 7yrs
E1235		Wheelchair, Pediatric Size, Rigid, Adjustable, With Seating System	X	1/ 7yrs
E1236		Wheelchair, Pediatric Size, Folding, Adjustable, With Seating System	X	1/ 7yrs
E1237	RR	Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating System	X	1/mo
E1237		Wheelchair, Pediatric Size, Rigid, Adjustable, Without Seating System	X	1/ 7yrs
E1238	RR	Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System	X	1/mo
E1238		Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System	X	1/ 7yrs
E1240*	RR	Lightweight Wheelchair, Detachable Arms, (Desk Or Full Length) Swing Away Detachable, Elevating Legrest	X	1/mo

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E1240*		Lightweight Wheelchair, Detachable Arms, (Desk Or Full Length) Swing Away Detachable, Elevating Legrest	X	1/ 7yrs
E1260*	RR	Wheelchair Lightweight, Detachable Arms (Desk Or Full Length), Swing Away Detachable Footrest	X	1/mo
E1260*		Wheelchair Lightweight, Detachable Arms (Desk Or Full Length), Swing Away Detachable Footrest	X	1/ 7yrs
E1280*	RR	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X	1/mo
E1280*		Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Elevating Legrests	X	1/ 7yrs
E1285*		Heavy Duty Wheelchair, Fixed Full Length Arms, Swing Away Detachable Footrest	X	1/ 7yrs
E1290*	RR	Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X	1/mo
E1290*		Heavy Duty Wheelchair, Detachable Arms (Desk Or Full Length) Swing Away Detachable Footrest	X	1/ 7yrs
E1296		Special Wheelchair Seat Height From Floor	X	1yr
E1297		Special Wheelchair Seat Depth, By Upholstery	X	1yr
E1298		Special Wheelchair Seat Depth and/or Width, By Construction	X	1/yr
E1372	RR	Immersion External Heater For Nebulizer	X	1/mo
E1390*	RR	Oxygen Concentrator, Single Delivery Port, Capable Of Delivering 85 Percent Or Greater Oxygen Concentration At The Prescribed Flow Rate	X	1/mo
E1399*		Durable Medical Equipment, Miscellaneous	X	N/A
E1811		Static Progressive Stretch Knee Device, Extension and/or Flexion, With Or Without Range Of Motion Adjustment, Includes All Components And Accessories		1/yr
E2000		Gastric Suction Pump, Home Model, Portable Or Stationary, Electric	X	1/5yrs
E2100		Blood Glucose Monitor With Integrated Voice Synthesizer	X	1/5yrs
E2201		Manual Wheelchair Accessory, Nonstandard Seat Frame, Width Greater Than Or Equal To 20 Inches And Less Than 24 Inches	X	1/yr
E2202		Manual Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	X	1/yr
E2203		Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 To Less Than 22 Inches	X	1/yr
E2204		Manual Wheelchair Accessory, Nonstandard Seat Frame Depth, 22 To 25 Inches	X	1/yr
E2205		Manual Wheelchair Accessory, Handrim Without Projections, Any Type, Replacement Only, Each	X	2/yr
E2206		Manual Wheelchair Accessory, Wheel Lock Assembly, Complete, Each	X	2/yr
E2208		Wheelchair Accessory, Cylinder Tank Carrier, Each	X	1/yr
E2209		Wheelchair Accessory, Arm Trough, Each	X	2/yr
E2210		Wheelchair Accessory, Bearings, Any Type, Replacement Only, Each	X	4/yr
E2211		Manual Wheelchair Accessory, Pneumatic Propulsion Tire, Any Size, Each	X	2/yr
E2212		Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	X	2/yr
E2213		Manual Wheelchair Accessory, Insert For Pneumatic Propulsion Tire (Removable), Any Type, Any Size, Each	X	2/yr
E2214		Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	X	2/yr
E2216		Manual Wheelchair Accessory, Foam Filled Propulsion Tire, Any Size, Each	X	2/yr
E2217		Manual Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Each	X	2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E2218		Manual Wheelchair Accessory, Foam Propulsion Tire, Any Size, Each	X	2/yr
E2219		Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	X	2/yr
E2220		Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size, Each	X	2/yr
E2221		Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	X	2/yr
E2222		Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	X	2/yr
E2223		Manual Wheelchair Accessory, Valve, Any Type, Replacement Only, Each	X	2/yr
E2224		Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	X	2/yr
E2225		Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	X	2/yr
E2226		Manual Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	X	2/yr
E2227		Manual Wheelchair Accessory, Gear Reduction Drive Wheel, Each	X	2/yr
E2228		Manual Wheelchair Accessory, Wheel Braking System And Lock, Each	X	4/yr
E2231		Manual Wheelchair Accessory, Solid Seat Support Base (Replaces Sling Seat), Includes Any Type Mounting Hardware	X	1/2yrs
E2291		Back, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X	1/2yrs
E2292		Seat, Planar, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X	1/2yrs
E2293		Back, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X	1/2yrs
E2294		Seat, Contoured, For Pediatric Size Wheelchair Including Fixed Attaching Hardware	X	1/2yrs
E2300		Power Wheelchair Accessory, Power Seat Elevation System	X	1/2yrs
E2301		Power Wheelchair Accessory, Power Standing System	X	1/2yrs
E2310		Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And One Power Seating System Motor, Including All Related Electronics	X	1/7yrs
E2311		Power Wheelchair Accessory, Electronic Connection Between Wheelchair Controller And Two Or More Power Seating System Motors, Including All Related Electronics,	X	1/7yrs
E2312		Power Wheelchair Accessory, Hand Or Chin Control Interface, Mini-Proportional Remote Joystick, Proportional, Including Fixed Mounting Hardware	X	1/7yrs
E2313		Power Wheelchair Accessory, Harness For Upgrade To Expandable Controller, Including All Fastners, Connectors And Mounting Hardware	X	1/7yrs
E2321		Power Wheelchair Accessory, Hand Control Interface, Remote Joystick, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And	X	1/7yrs
E2322		Power Wheelchair Accessory, Hand Control Interface, Multiple Mechanical Switches, Nonproportional, Including All Related Electronics, Mechanical Stop	X	1/4yrs
E2323		Power Wheelchair Accessory, Specialty Joystick Handle For Hand Control Interface, Prefabricated	X	1/4yrs
E2324		Power Wheelchair Accessory, Chin Cup For Chin Control Interface	X	1/3yrs

Added to E2291: X-requires PA

Added to E2292: X-requires PA, 1/2yrs –Benefit Limit

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E2325		Power Wheelchair Accessory, Sip And Puff Interface, Nonproportional, Including All Related Electronics, Mechanical Stop Switch, And Manual Swingaway Mounting	X	1/4yrs
E2326		Power Wheelchair Accessory, Breath Tube Kit For Sip And Puff Interface	X	1/2yrs
E2327		Power Wheelchair Accessory, Head Control Interface, Mechanical, Proportional, Including All Related Electronics, Mechanical Direction Change Switch, And	X	1/2yrs
E2328		Power Wheelchair Accessory, Head Control Or Extremity Control Interface, Electronic, Proportional, Including All Related Electronics And Fixed Mounting	X	1/3yrs
E2329		Power Wheelchair Accessory, Head Control Interface, Contact Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch,	X	1/3yrs
E2329		Power Wheelchair Accessory, Head Control Interface, Contact Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch,	X	1/3yrs
E2330		Power Wheelchair Accessory, Head Control Interface, Proximity Switch Mechanism, Nonproportional, Including All Related Electronics, Mechanical Stop Switch,	X	1/3yrs
E2331		Power Wheelchair Accessory, Attendant Control, Proportional, Including All Related Electronics And Fixed Mounting Hardware	X	1/3yrs
E2340		Power Wheelchair Accessory, Nonstandard Seat Frame Width, 20-23 Inches	X	1/yr
E2340		Power Wheelchair Accessory, Nonstandard Seat Frame Width, 20-23 Inches	X	1/yr
E2341		Power Wheelchair Accessory, Nonstandard Seat Frame Width, 24-27 Inches	X	1/yr
E2342		Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 20 Or 21 Inches	X	1/yr
E2343		Power Wheelchair Accessory, Nonstandard Seat Frame Depth, 22-25 Inches	X	1/yr
E2351		Power Wheelchair Accessory, Electronic Interface To Operate Speech Generating Device Using Power Wheelchair Control Interface	X	1/yr
E2359		Power Wheelchair Accessory, Group 34 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X	2/yr
E2360		Power Wheelchair Accessory, 22 Nf Non-Sealed Lead Acid Battery, Each	X	2/yr
E2361		Power Wheelchair Accessory, 22nf Sealed Lead Acid Battery, Each, (E.G. Gel Cell, Absorbed Glassmat)	X	2/yr
E2362		Power Wheelchair Accessory, Group 24 Non-Sealed Lead Acid Battery, Each	X	2/yr
E2363		Power Wheelchair Accessory, Group 24 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X	4/yr
E2364		Power Wheelchair Accessory, U-1 Non-Sealed Lead Acid Battery, Each	X	2/yr
E2365		Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X	2/yr
E2365	SC	Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E.G. Gel Cell, Absorbed Glassmat)	X	2/yr
E2366		Power Wheelchair Accessory, Battery Charger, Single Mode, For Use With Only One Battery Type, Sealed Or Non-Sealed, Each	X	1/yr
E2367		Power Wheelchair Accessory, Battery Charger, Dual Mode, For Use With Either Battery Type, Sealed Or Non-Sealed, Each	X	1/yr
E2368		Power Wheelchair Component, Motor, Replacement Only	X	2/yr
E2369		Power Wheelchair Component, Gear Box, Replacement Only	X	2/yr

Added: E2359

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E2370		Power Wheelchair Component, Motor And Gear Box Combination, Replacement Only	X	2/yr
E2371		Power Wheelchair Accessory, Group 27 Sealed Lead Acid Battery, (E.G. Gel Cell, Absorbed Glassmat), Each	X	2/yr
E2372		Power Wheelchair Accessory, Group 27 Non-Sealed Leaad Acid Battery, Each	X	2/yr
E2373		Power Wheelchair Accessory, Hand Or Chin Control Interface, Mini-Proportional, Compact, Or Short Throw Remote Joystick Or Touchpad, Proportional Including All Related Electronics And Fixed Mounting Hardware.	X	1/4yrs
E2374		Power Wheelchair Accessory, Hand Or Chin Control Interface, Standard Remote Joystick (Not Including Controller), Proportional, Including All Related	X	1/4yrs
E2375		Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	X	1/4yrs
E2376		Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	X	1/4yrs
E2377		Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics And Mounting Hardware, Upgrade Provided At Initial Issue	X	1/4yrs
E2381		Power Wheelchair Accessory, Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	X	4/yr
E2382		Power Wheelchair Accessory, Tube For Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each	X	2/yr
E2383		Power Wheelchair Accessory, Insert For Pneumatic Drive Wheel Tire, (Removable), Any Type, Any Size, Replacement Only, Each	X	2/yr
E2384		Power Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Replacement Only, Each	X	4/yr
E2385		Power Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Replacement Only, Each	X	4yr
E2386		Power Wheelchair Accessory, Foam Filled Drive Wheel Tire, Any Size, Replacement Only, Each	X	4/yr
E2387		Power Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Replacement Only, Each	X	4yr
E2388		Power Wheelchair Accessory, Foam Drive Wheel Tire, Any Size, Replacement Only, Each	X	4/yr
E2389		Power Wheelchair Accessory, Foam Caster Tire, Any Size, Replacement Only, Each	X	4yr
E2390		Power Wheelchair Accessory, Solid (Rubber/Plastic) Drive Wheel Tire, Any Size, Replacement Only, Each	X	4/yr
E2391		Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Replacement Only, Each	X	4yr
E2392		Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Replacement Only	X	4/yr
E2394		Power Wheelchair, Accessory, Drive Wheel, Excludes Tire, Any Size, Replacement Only, Each	X	4yr
E2395		Power Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	X	4/yr
E2396		Power Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	X	4yr
E2397		Power Wheelchair Accessory, Lithium-Based Battery,Each	X	1/yr
E2500		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Less Than Or Equal To 8 Minutes Recording Time	X	1/3yrs
E2502		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 8 Minutes But Less Than Or Equal To 20 Minutes Recording Time	X	1/3yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E2504		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 20 Minutes But Less Than Or Equal To 40 Minutes Recording Time	X	1/3yrs
E2506		Speech Generating Device, Digitized Speech, Using Pre-Recorded Messages, Greater Than 40 Minutes Recording Time	X	1/3yrs
E2508		Speech Generating Device, Synthesized Speech, Requiring Message Formulation By Spelling And Access By Physical Contact With The Device	X	1/3yrs
E2510	RR	Speech Generating Device, Synthesized Speech, Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	X	1/mo
E2510		Speech Generating Device, Synthesized Speech, Permitting Multiple Methods Of Message Formulation And Multiple Methods Of Device Access	X	1/3yrs
E2511		Speech Generating Software Program, For Personal Computer Or Personal Digital Assistant	X	1/yr
E2512		Accessory For Speech Generating Device, Mounting System	X	1/yr
E2599		Accessory For Speech Generating Device, Not Otherwise Classified	X	1/yr
E2601*		General Use Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	X	1/yr
E2602*		General Use Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	X	1/yr
E2603*		Skin Protection Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	X	1/2 yr
E2604*		Skin Protection Wheelchair Seat Cushion, Width Less Than 22 Inches Or Greater, Any Depth	X	1/2yr
E2605		Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth	X	1/2yrs
E2606		Positioning Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth	X	1/2yrs
E2607		Skin Protection And Positioning Wheelchair Seat Cushion, Width Less Than 22 Inches	X	1/2yr
E2608		Skin Protection And Positioning Wheelchair Seat Cushion, Width 22 Inches Or	X	1/2yr
E2609		Custom Fabricated Wheelchair Seat Cushion, An Size	X	1/2yrs
E2611		General Use Wheelchair Back Cushion, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2612		General Use Wheelchair Back Cushion, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2613		Positioning Wheelchair Back Cushion, Posterior, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2614		Positioning Wheelchair Back Cushion, Posterior, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2615		Positioning Wheelchair Back Cushion, Posterior-Lateral, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2616		Positioning Wheelchair Back Cushion, Posterior-Lateral, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2617		Custom Fabricated Wheelchair Back Cushion, Any Size, Including Any Type Mounting System	X	1/2yrs
E2619		Replacement Cover For Wheelchair Seat Cushion Or Back Cushion, Each	X	1/2yrs
E2620		Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware	X	1/2yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
E2621		Positioning Wheelchair Back Cushion, Planar Back With Lateral Supports, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware	X	1/2yrs
E2622		Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth	X	1/2yrs
E2623		Ski N Protection Wheelchair Seat Cushion, Adjustable, Width, 22 Inches Or Greater, Any Depth	X	1/2yrs
E2624		Ski N Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches , Any Depth	X	1/2yrs
E2625		Ski N Protection And Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches Or Greater, Any Depth	X	1/2yrs
E2626*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable, Prefabricated, Includes Fitting And Adjustment	X	2/yr
E2627*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable Rancho Type, Prefabricated, Includes Fitting And Adjustment	X	2/yr
E2628*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Reclining, Prefabricated, Includes Fitting And Adjustment	X	2/yr
E2629*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support Attached To Wheelchair, Balanced, Friction Arm Support (Friction Dampening To Proximal And Distal Joints),	X	2/yr
E2630*		Wheelchair Accessory, Shoulder Elbow Orthosis, Mobile Arm Support, Monosuspension Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type Suspension	X	2/yr
E2631*		Wheelchair Accessory, Seo, Addition To Mobile Arm Support, Elevating Proximal Arm	X	2/yr
E2632*		Wheelchair Accessory, Seo, Addition To Mobile Arm Support, Offset Or Lateral Rocker Arm With Elastic Balance Control	X	2/yr
E2633*		Wheelchair Accessory, Seo, Addition To Mobile Arm Support, Supinator	X	2/yr
E8000		Gait Trainer, Pediatric Size, Posterior Support, Includes All Accessories And Components	X	1/3yrs
E8001		Gait Trainer, Pediatric Size, Upright Support, Includes All Accessories And Components	X	1/3yrs
E8002		Gait Trainer, Pediatric Size, Anterior Support, Includes All Accessories And Components	X	1/3yrs
G0249		Provision Of Test Materials And Equipment For Home Inr Monitoring To Patient With Mechanical Heart Valves	X	1/yr
K0005		Ultralighweight Wheelchair	X	1/7yrs
K0005		Ultralighweight Wheelchair	X	1/7yrs
K0007*	RR	Extra Heavy Duty Wheelchair	X	1/mo
K0007*		Extra Heavy Duty Wheelchair	X	1/7yrs
K0009		Other Manual Wheelchair Base	X	1/7yrs
K0015*		Detachable, Non-Adjustable Height Armrest, Each	X	2/yr
K0017		Detachable, Adjustable Height Armrest, Base, Each	X	2/yr
K0018*		Detachable, Adjustable Height Armrest, Upper Portion, Each	X	2/yr
K0019*		Arm Pad, Each	X	2/yr
K0020*		Fixed, Adjustable Height Armrest, Pair	X	2/yr
K0037*		High Mount Flip-Up Footrest, Each	X	2/yr
K0038*		Leg Strap, Each	X	2/yr
K0039*		Leg Strap, H Style, Each	X	2/yr
K0040*		Adjustable Angle Footplate, Each	X	2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
K0041*		Large Size Footplate, Each	X	2/yr
K0042*		Standard Size Footplate, Each	X	2/yr
K0043*		Footrest, Lower Extension Tube, Each	X	2/yr
K0044*		Footrest, Upper Hanger Bracket, Each	X	2/yr
K0045*		Footrest, Complete Assembly	X	2/yr
K0046*		Elevating Legrest, Lower Extension Tube, Each	X	2/yr
K0047*		Elevating Legrest, Upper Hanger Bracket, Each	X	2/yr
K0050*		Ratchet Assembly	X	2/yr
K0051*		Cam Release Assembly, Footrest Or Legrest, Each	X	2/yr
K0052*		Swingaway, Detachable Footrests, Each	X	2/yr
K0053*		Elevating Footrests, Articulating (Telescoping), Each	X	2/yr
K0053*	RR	Elevating Footrests, Articulating (Telescoping), Each	X	2/yr
K0056*		Seat Height Less Than 17" Or Equal To Or Greater Than 21" For A High Strength, Lightweight, Or Ultra Lightweight Wheelchair	X	1/yr
K0065*		Spoke Protectors, Each	X	2/yr
K0068*		Pneumatic Tire Tube, Each	X	4/yr
K0069*		Rear Wheel Assembly, Complete, With Solid Tire, Spokes Or Molded, Each	X	2/yr
K0070*		Rear Wheel Assembly, Complete, With Pneumatic Tire, Spokes Or Molded, Each	X	2/yr
K0071*		Front Caster Assembly, Complete, With Pneumatic Tire, Each	X	2/yr
K0072*		Front Caster Assembly, Complete, With Semi-Pneumatic Tire, Each	X	2/yr
K0073*		Caster Pin Lock, Each	X	2/yr
K0077*		Front Caster Assembly, Complete, With Solid Tire, Each	X	2/yr
K0090		Rear Wheel Tire For Power Wheelchair, Any Size, Each	X	2/yr
K0098		Drive Belt For Power Wheelchair	X	1/yr
K0105*		Iv Hanger, Each	X	1/yr
K0108*		Wheelchair Component Or Accessory, Not Otherwise Specified	X	1 per item/per year
K0195*	RR	Elevating Leg Rests, Pair (For Use With Capped Rental Wheelchair Base)	X	1/yr
K0195*		Elevating Leg Rests, Pair (For Use With Capped Rental Wheelchair Base)	X	1/yr
K0462		Temporary Replacement For Patient Owned Equipment Being Repaired, Any Type	X	1/mo
K0601		Replacement Battery For External Infusion Pump Owned By Patient, Silver Oxide, 1.5 Volt Each	X	10/mo
K0606	RR	Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Agrment Type	X	1/mo
K0730		Controlled Dose Drug Delivery System		1/mo
K0733		Power Wheelchair Accessory, 12 To 24 Amp Hour Sealed Lead Acid Battery, Each (E.G., Gel Cell, Absorbed Glassmat)	X	2/yr
K0739*		Repair(Labor) Or Non Routine Service For Durable Medical Equipment Other Than Oxygen Equipment Requiring The Skill Of A Technician, Labor Component, Per 15 Minutes. Providers Must Continue To Submit Justification When Billing More Than 4 Units. Include All Units Over 4 On The PA Request With Justification For Repairs. The PA Letter Will State The Total Units Approved.		12/yr
K0813		Power Wheelchair, Group 1 Standard, Portable, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
K0814		Power Wheelchair, Group 1 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0815		Power Wheelchair, Group 1 Standard, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0815		Power Wheelchair, Group 1 Standard, Sling/Solid Seat And Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0816		Power Wheelchair, Group 1 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0820		Power Wheelchair, Group 2 Standard, Portable, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0821		Power Wheelchair, Group 2 Standard, Portable, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0822		Power Wheelchair, Group 2 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0823		Power Wheelchair, Group 2 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0824		Power Wheelchair, Group 2 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0825		Power Wheelchair, Group 2 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0826		Power Wheelchair, Group 2 Very Heavy Duty, Sling/Solid Seat Back, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0827		Power Wheelchair, Group 2 Very Heavy Duty, Captains Chair, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0828		Power Wheelchair, Group 2 Extra Heavy Duty, Sling/Solid Seat Back, Patient Weight Capacity 601 Pounds Or More	X	1/ 7yrs
K0829		Power Wheelchair, Group 2 Extra Heavy Duty, Captains Chair, Patient Weight Capacity 601 Pounds Or More	X	1/ 7yrs
K0830		Power Wheelchair, Group 2 Standard, Seat Elevator, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0831		Power Wheelchair, Group 2 Standard, Seat Elevator, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0835		Power Wheelchair, Group 2 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0836		Power Wheelchair, Group 2 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0837		Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0838		Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Captains Chair Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0839		Power Wheelchair, Group 2 Very Heavy Duty, Single Power Option, Sling/Back Seat/Solid Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0840		Power Wheelchair, Group 2 Heavy Duty, Single Power Option, Sling/Solid Seat Back Patient Weight Capacity 601 Pounds Or More	X	1/ 7yrs
K0841		Power Wheelchair, Group 2 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0842		Power Wheelchair, Group 2 Standard, Multiple Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0843		Power Wheelchair, Group 2 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0848		Power Wheelchair, Group 3 Standard, Sling/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0849		Power Wheelchair, Group 3 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
K0850		Power Wheelchair, Group 3 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0851		Power Wheelchair, Group 3 Heavy Duty, Captains Chair, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0852		Power Wheelchair, Group 3 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0853		Power Wheelchair, Group 3 Very Heavy Duty, Captains Chair Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0854		Power Wheelchair, Group 3 Extra Heavy Duty, Sling/Solid Seat Back, Patient Weight Capacity 601 Pounds Or More	X	1/ 7yrs
K0855		Power Wheelchair, Group 3 Extra Heavy Duty, Captains Chair Patient Weight Capacity 601 Pounds Or More	X	1/ 7yrs
K0856		Power Wheelchair, Group 3 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0857		Power Wheelchair, Group 3 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0858		Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0859		Power Wheelchair, Group 3 Heavy Duty, Single Power Option, Captains Chair Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0860		Power Wheelchair, Group 3 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back Patient Weight Capacity Pounds To 451 To 600 Pounds	X	1/ 7yrs
K0860		Power Wheelchair, Group 3 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back Patient Weight Capacity Pounds To 451 To 600 Pounds	X	1/ 7yrs
K0861		Power Wheelchair, Group 3 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0862		Power Wheelchair, Group 3 Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0863		Power Wheelchair, Group 3 Very Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0864		Power Wheelchair, Group 3 Extra Heavy Duty, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 601 Pounds Or More	X	1/ 7yrs
K0868		Power Wheelchair, Group 4 Standard, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0869		Power Wheelchair, Group 4 Standard, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0870		Power Wheelchair, Group 4 Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0871		Power Wheelchair, Group 4 Very Heavy Duty, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0877		Power Wheelchair, Group 4 Standard, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0878		Power Wheelchair, Group 4 Standard, Single Power Option, Captains Chair, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0879		Power Wheelchair, Group 4 Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0880		Power Wheelchair, Group 4 Very Heavy Duty, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity 451 To 600 Pounds	X	1/ 7yrs
K0884		Power Wheelchair, Group 4 Standard, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs
K0885		Power Wheelchair, Group 4 Standard, Multiple Power Option, Captains Chair Patient Weight Capacity Up To And Including 300 Pounds	X	1/ 7yrs

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
K0886		Power Wheelchair, Group 4 Heavy Duty Multiple Power Option, Sling/Solid Seat/Back Patient Weight Capacity 301 To 450 Pounds	X	1/ 7yrs
K0890		Power Wheelchair, Group 5 Pediatric, Single Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	X	1/ 7yrs
K0891		Power Wheelchair, Group 5 Pediatric, Multiple Power Option, Sling/Solid Seat/Back, Patient Weight Capacity Up To And Including 125 Pounds	X	1/ 7yrs
K0898		Power Wheelchair, Not Otherwise Classified	X	1/ 7yrs
L0112		Cranial Cervical Orthosis, Congenital Torticollis Type, With Or Without Soft Interface Material, Adjustable Range Of Motion Joint, Custom Fabricated		1/yr
L0120		Cervical, Flexible, Non-Adjustable (Foam Collar)		4/yr
L0130		Cervical, Flexible, Thermoplastic Collar, Molded To Patient		1/yr
L0140		Cervical,Semi-Rigid,Adjustable(Plastic Collar)		1/yr
L0150		Cervical, Semi-Rigid, Adjustable Molded Chin Cup (Plastic Collar With Mandibular/Occipital Piece)		1/yr
L0160		Cervical, Semi-Rigid, Wire Frame Occipital/Mandibular Support		1/yr
L0170		Cervical, Collar, Molded To Patient Model		1/yr
L0172***		Cervical, Collar, Semi-Rigid Thermoplastic Foam, Two Piece		1/yr
L0174		Cervical, Collar, Semi-Rigid, Thermoplastic Foam, Two Piece With Thoracic Extension		1/yr
L0180		Cervical, Multiple Post Collar, Occipital/Mandibular Supports, Adjustable		1/yr
L0190		Cervical, Multiple Post Collar, Occipital/Mandibular Supports, Adjustable Cervical Bars (Somi, Guilford, Taylor Types)		1/yr
L0200		Cervical, Multiple Post Collar, Occipital/Mandibular Supports, Adjustable Cervical Bars, And Thoracic Extension		1/yr
L0220		Thoracic, Rib Belt, Custom Fabricated		1/yr
L0430		Spinal Orthosis, Anterior-Posterior-Lateral Control, With Interface Material, Custom Fitted (Dewall Posture Protector Only)		1/yr
L0452		Tlso, Flexible, Provides Trunk Support, Upper Thoracic Region, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Disks With Rigid		1/yr
L0456		Tlso, Flexible, Provides Trunk Support, Thoracic Region, Rigid Posterior Panel And Soft Anterior Apron, Extends From The Sacrococcygeal Junction And		1/yr
L0458		Tlso, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just		1/yr
L0458***		Tlso, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just		1/yr
L0460		Tlso, Triplanar Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just		1/yr
L0462		Tlso, Triplanar Control, Modular Segmented Spinal System, Three Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And Terminates Just		1/yr
L0464		Tlso, Triplanar Control, Modular Segmented Spinal System, Four Rigid Plastic Shells, Posterior Extends From Sacrococcygeal Junction And Terminates Just		1/yr
L0466		Tlso,Sagittal Control, Rigid Posterior Frame		1/yr
L0468		Tlso, Sagittal-Coronal Control, Rigid Posterior Frame And Flexible Soft Anterior Apron With Straps, Closures And Padding, Extends From Sacrococcygeal		1/yr
L0470		Tlso,Triplanar Control, Rigid Posterior Frame		1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L0472		Tlso, Triplanar Control, Hyperextension, Rigid Anterior And Lateral Frame Extends From Symphysis Pubis To Sternal Notch With Two Anterior Components		1/yr
L0472***		Tlso, Triplanar Control, Hyperextension, Rigid Anterior And Lateral Frame Extends From Symphysis Pubis To Sternal Notch With Two Anterior Components		1/yr
L0480		Tlso, Triplanar Control, One Piece Rigid Plastic Shell Without Interface Liner, With Multiple Straps		1/yr
L0482		Tlso, Triplanar Control, One Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction		1/yr
L0484		Tlso, Triplanar Control, Two Piece Rigid Plastic Shell Without Interface Liner, With Multiple Straps And Closures, Posterior Extends From Sacrococcygeal		1/yr
L0486		Tlso, Triplanar Control, Two Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction		1/yr
L0486***		Tlso, Triplanar Control, Two Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction		1/yr
L0488		Tlso, Triplanar Control, One Piece Rigid Plastic Shell With Interface Liner, Multiple Straps And Closures, Posterior Extends From Sacrococcygeal Junction		1/yr
L0490		Tlso, Sagittal-Coronal Control, One Piece Rigid Plastic Shell, With Overlapping Reinforced Anterior, With Multiple Straps And Closures, Posterior Extends From		1/yr
L0491		Tlso, Sagittal-Coronal Control, Modular Segmented Spinal System, Two Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And		1/yr
L0492		Tlso, Sagittal-Coronal Control, Modular Segmented Spinal System, Three Rigid Plastic Shells, Posterior Extends From The Sacrococcygeal Junction And		1/yr
L5649		Addition To Lower Extremity, Ischial Containment/Narrow M-L socket		2/yr
L0622		Sacroiliac Orthosis, Flexible, Provides Pelvic-Sacral Support, Reduces Motion About The Sacroiliac Joint, Includes Straps, Closures, May Include Pendulous		1/yr
L0624		Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels placed over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated		1/yr
L0625		Lumber Orthotic, Sagittal Control, With Rigid Posteria Panel(S), Posteria Extends From L-1 To Below L-5 Vertebra, Produces Intracavity Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Pendulous Abdomen Design,		1/ yr
L0626		Lumbar Orthosis, Sagittal Control, With Rigid Posterior Panel(S), Posterior Extends From L-1 To Below L-5 Vertebra, Produces Intracavitary Pressure To		1/yr
L0627		Lumbar Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From L-1 To Below L-5 Vertebra, Produces Intracavitary		1/yr
L0628		Lumber-Sacral Orthosis, Flexible, Provides Lumbo-Sacral Support,Posterior Extends From Sacrococcygeal Junction To T-9 Vetebra, Produces Intracavitary Pressure To Reduce Load On Theintervertebral Disc, Includes Straps, Closures. May Include Stays, Shouldetr Straps, Pendulous Abdomen Design, Prefabricated, Includes Fitting And Adjustment		1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L0628***	CG modifier used for age 21-64	Lumber-Sacral Orthosis, Flexible, Provides Lumbo-Sacral Support,Posterior Extends From Sacrococcygeal Junction To T-9 Vetebra, Produces Intracavitary Pressure To Reduce Load On Theintervertebral Disc, Includes Straps, Closures. May Include Stays, Shouldetr Straps, Pendulous Abdomen Design, Prefabricated, Includes Fitting And Adjustment		1/yr
L0629		Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated		1/yr
L0630		Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Posterior Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces		1/yr
L0630***		Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Posterior Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Produces		1/yr
L0631		Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior And Posterior Panels, Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra,		1/yr
L0632		Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated		1/yr
L0633		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Posterior Frame/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra,		1/yr
L0634		Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated		1/yr
L0635		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Lumbar Flexion, Rigid Posterior Frame/Panel(S), Lateral Articulating Design To Flex The Lumbar Spine,		1/yr
L0636		Lumbar Sacral Orthosis, Sagittal-Coronal Control, Lumbar Flexion, Rigid Posterior Frame/Panels, Lateral Articulating Design To Flex The Lumbar Spine,		1/yr
L0637		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panels, Posterior Extends From Sacrococcygeal Junction To T-9		1/yr
L0638		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior And Posterior Frame/Panels, Posterior Extends From Sacrococcygeal Junction To T-9		1/yr
L0639		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Anterior		1/yr
L0640		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Anterior		1/yr
L0640***		Lumbar-Sacral Orthosis, Sagittal-Coronal Control, Rigid Shell(S)/Panel(S), Posterior Extends From Sacrococcygeal Junction To T-9 Vertebra, Anterior		1/yr
L0700		Cervical-Thoracic-Lumbar-Sacral-Orthoses (Ctlso), Anterior-Posterior-Lateral Control, Molded To Patient Model, (Minerva Type)		1/yr
L0710		Ctlso, Anterior-Posterior-Lateral-Control, Molded To Patient Model, With Interface Material, (Minerva Type)		1/yr

Deleted:
~~L0628~~

Added:
L0628***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L0810		Halo procedure, cervical halo incorporated into jacket vest		1/yr
L0820		Halo procedure, cervical halo incorporated into plaster body jacket		1/yr
L0830		Halo procedure, cervical halo incorporated into Milwaukee type orthosis		1/yr
L0859		Addition To Halo Procedure, Magnetic Resonance Image Compatible Systems, Rings And Pins, Any Material		1/yr
L0861		Addition To Halo Procedure, Replacement Liner/Interface Material		1/yr
L0970		Tlso,Corset Front		1/yr
L0972		Lso, Corset Front		1/yr
L0974		Tlso, Full Corset		1/yr
L0976		Lso, Full Corset		1/yr
L0978		Axillary Crutch Extension		2/yr
L0980		Peroneal Straps, Pair		1/yr
L0982		Stocking Supporter Grips, Set Of Four (4)		1/yr
L0984		Protective Body Sock, Each		1/yr
L0984***		Protective Body Sock, Each		1/mo
L1000		Cervical-Thoracic-Lumbar-Sacral Orthosis (Ctlso) (Milwaukee), Inclusive Of Furnishing Initial Orthosis, Including Model		1/yr
L1001		Cervical thoracic lumbar sacral orthosis immobilizer, infant size, prefabricated, includes fitting and adjustments		1/yr
L1005		Tension Based Scoliosis Orthosis And Accessory Pads, Includes Fitting And Adjustment		1/yr
L1010		Addition To Cervical-Thoracic-Lumbar-Sacral Orthosis (Ctlso) Or Scoliosis Orthosis, Axilla Sling		2/yr
L1020		Addition To Ctlso Or Scoliosis Orthosis, Kyphosis Pad		2/yr
L1025		Addition To Ctlso Or Scoliosis Orthosis, Kyphosis Pad, Floating		1/yr
L1030		Addition To Ctlso Or Scoliosis Orthosis, Lumbar Bolster Pad		1/yr
L1040		Addition To Ctlso Or Scoliosis Orthosis, Lumbar Or Lumbar Rib Pad		1/yr
L1050		Addition To Ctlso Or Scoliosis Orthosis, Sternal Pad		1/yr
L1060		Addition To Ctlso Or Scoliosis Orthosis, Thoracic Pad		1/yr
L1070		Addition To Ctlso Or Scoliosis Orthosis, Trapezius Sling		2/yr
L1080		Addition To Ctlso Or Scoliosis Orthosis, Outrigger		2/yr
L1085		Addition To Ctlso Or Scoliosis Orthosis, Outrigger, Bilateral With Vertical Extensions		1/yr
L1090		Addition To Ctlso Or Scoliosis Orthosis, Lumbar Sling		1/yr
L1100		Addition To Ctlso Or Scoliosis Orthosis, Ring Flange, Plastic Or Leather		2/yr
L1110		Addition To Ctlso Or Scoliosis Orthosis, Ring Flange, Plastic Or Leather, Molded To Patient Model		2/yr
L1120		Addition To Ctlso, Scoliosis Orthosis, Cover For Upright, Each		3/yr
L1200		Thoracic-Lumbar-Sacral-Orthosis(Tlso), Inclusive Of Furnishing Initial Orthosis Only		1/yr
L1210		Addition To Tlso,(Low Profile), Lateral Thoracic Extension		2/yr
L1220		Addition To Tlso, (Low Profile), Anterior Thoracic Extension		1/yr
L1230		Addition To Tlso, (Low Profile), Milwaukee Type Superstructure		1/yr
L1240		Addition To Tlso,(Low Profile), Lumbar Derotation Pad		1/yr
L1250		Addition To Tlso, (Low Profile), Anterior Asis Pad		1/yr

Added to LO984: 1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L1260		Addition To Tlso, (Low Profile), Anterior Thoracic Derotation Pad		1/yr
L1270		Addition To Tlso, (Low Profile), Abdominal Pad		3/yr
L1280		Addition To Tlso, (Low Profile), Rib Gusset (Elastic), Each		2/yr
L1290		Addition To Tlso, (Low Profile), Lateral Trochanteric Pad		2/yr
L1300**		Other Scoliosis Procedure, Body Jacket Molded To Patient Model	X	1/yr
L1310**		Other Scoliosis Procedure, Post-Operative Body Jacket	X	1/yr
L1510		THKAO, standing frame		1/yr
L1520**		THKAO, swivel walker (REQUIRES PRIOR AUTHORIZATION)	X	1/yr
L1600		Hip Orthosis, Abduction Control Of Hip Joints, Flexible, Frejka Type With Cover, Prefabricated, Includes Fitting And Adjustment		1/yr
L1610		Hip Orthosis, Abduction Control Of Hip Joints, Flexible, (Frejka Cover Only), Prefabricated, Includes Fitting And Adjustment		1/yr
L1620		Hip Orthosis, Abduction Control Of Hip Joints, Flexible, (Pavlik Harness), Prefabricated, Includes Fitting And Adjustment		1/yr
L1630		Hip Orthosis, Abduction Control Of Hip Joints, Semi-Flexible (Von Rosen Type), Custom-Fabricated		1/yr
L1640		Hip Orthosis, Abduction Control Of Hip Joints, Static, Pelvic Band Or Spreader Bar, Thigh Cuffs, Custom-Fabricated		1/yr
L1650		Hip Orthosis, Abduction Control Of Hip Joints, Static, Adjustable, (Ilfled Type), Prefabricated, Includes Fitting And Adjustment		1/yr
L1652		Hip Orthosis, Bilateral Thigh Cuffs With Adjustable Abductor Spreader Bar, Adult Size, Prefabricated, Includes Fitting And Adjustment, Any Type		1/yr
L1660		Hip Orthosis, Abduction Control Of Hip Joints, Static, Plastic, Prefabricated, Includes Fitting And Adjustment		1/yr
L1680		Hip Orthosis, Abduction Control Of Hip Joints, Dynamic, Pelvic Control, Adjustable Hip Motion Control, Thigh Cuffs (Rancho Hip Action Type), Custom		1/yr
L1685		Hip Orthosis, Abduction Control Of Hip Joint, Postoperative Hip Abduction Type, Custom Fabricated		1/yr
L1686		Hip Orthosis, Abduction Control Of Hip Joint, Postoperative Hip Abduction Type, Prefabricated, Includes Fitting And Adjustment		1/yr
L1690		Combination, Bilateral, Lumbo-Sacral, Hip, Femur Orthosis Providing Adduction And Internal Rotation Control, Prefabricated, Includes Fitting And Adjustment		1/yr
L1700		Legg Perthes Orthosis, (Toronto Type), Custom-Fabricated		1/yr
L1710		Legg Perthes Orthosis, (Newington Type), Custom Fabricated		1/yr
L1720		Legg Perthes Orthosis, Trilateral, (Tachdijan Type), Custom-Fabricated		2/yr
L1730		Legg Perthes Orthosis, (Scottish Rite Type), Custom-Fabricated		1/yr
L1755		Legg Perthes Orthosis, (Patten Bottom Type), Custom-Fabricated		2/yr
L1810		Knee Orthosis, Elastic With Joints, Prefabricated, Includes Fitting And Adjustment		2/yr
L1820		Knee Orthosis, Elastic With Condylar Pads And Joints, With Or Without Patellar Control, Prefabricated, Includes Fitting And Adjustment		2/yr
L1830		Knee Orthosis, Immobilizer, Canvas Longitudinal, Prefabricated, Includes Fitting And Adjustment		2/yr
L1831		Knee Orthosis, Locking Knee Joint(S), Positional Orthosis, Prefabricated, Includes Fitting And Adjustment		2/yr
L1832		Knee Orthosis, Adjustable Knee Joints (Unicentric Or Polycentric), Positional Orthosis, Rigid Support, Prefabricated, Includes Fitting And Adjustment		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L1834		Knee Orthosis, Without Knee Joint, Rigid, Custom-Fabricated		2/yr
L1836		Knee Orthosis, Rigid, Without Joint(S), Includes Soft Interface Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L1840		KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated to patient model		2/yr
L1843		KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted		2/yr
L1844		Knee Orthosis, Single Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation		2/yr
L1845		Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation		2/yr
L1846		Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation		2/yr
L1850		KO, Swedish type		2/yr
L1860		KO, modification of supracondylar prosthetic socket, molded to patient model, (SK)		2/yr
L1900*		Ankle Foot Orthosis, Spring Wire, Dorsiflexion Assist Calf Band, Custom-Fabricated		2/yr
L1902		Ankle Foot Orthosis, Ankle Gauntlet, Prefabricated, Includes Fitting And Adjustment		2/yr
L1904		Ankle Foot Orthosis, Molded Ankle Gauntlet, Custom-Fabricated		2/yr
L1906		Ankle Foot Orthosis, Multiligamentus Ankle Support, Prefabricated, Includes Fitting And Adjustment		2/yr
L1907		Afo, Supramalleolar With Straps, With Or Without Interface/Pads, Custom Fabricated		2/yr
L1910		Ankle Foot Orthosis, Posterior, Single Bar, Clasp Attachment To Shoe Counter, Prefabricated, Includes Fitting And Adjustment		2/yr
L1920		Ankle Foot Orthosis, Single Upright With Static Or Adjustable Stop (Phelps Or Perlstein Type), Custom-Fabricated		2/yr
L1930		Ankle Foot Orthosis, Plastic Or Other Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L1930***		Ankle Foot Orthosis, Plastic Or Other Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L1932		Afo, Rigid Anterior Tibal Section, Total Carbon Fiber Or Equal Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L1940		Ankle Foot Orthosis, Plastic Or Other Material, Custom-Fabricated		2/yr
L1945		Ankle Foot Orthosis, Plastic, Rigid Anterior Tibial Section (Floor Reaction), Custom-Fabricated		2/yr
L1950		Ankle Foot Orthosis, Spiral, (Institute Of Rehabilitative Medicine Type), Plastic, Custom-Fabricated		2/yr
L1951		Ankle Foot Orthosis, Spiral, (Institute Of Rehabilitative Medicine Type), Plastic Or Other Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L1960		Ankle Foot Orthosis, Posterior Solid Ankle, Plastic, Custom-Fabricated		2/yr
L1960***		Ankle Foot Orthosis, Posterior Solid Ankle, Plastic, Custom-Fabricated		2/yr
L1970		Ankle Foot Orthosis, Plastic With Ankle Joint, Custom-Fabricated		2/yr
L1970***		Ankle Foot Orthosis, Plastic With Ankle Joint, Custom-Fabricated		2/yr
L1971		Ankle Foot Orthosis, Plastic Or Other Material With Ankle Joint, Prefabricated, Includes Fitting And Adjustment		2/yr
L1980		Ankle Foot Orthosis, Single Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Single Bar 'Bk' Orthosis), Custom-Fabricated		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L1990		Ankle Foot Orthosis, Double Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Double Bar 'Bk' Orthosis), Custom-Fabricated		2/yr
L1990***		Ankle Foot Orthosis, Double Upright Free Plantar Dorsiflexion, Solid Stirrup, Calf Band/Cuff (Double Bar 'Bk' Orthosis), Custom-Fabricated		2/yr
L2000		Knee Ankle Foot Orthosis, Single Upright, Free Knee, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Single Bar 'Ak' Orthosis), Custom-Fabricated		2/yr
L2005		Knee Ankle Foot Orthosis, Any Material, Single Or Double Upright, Stance Control, Automatic Lock And Swing Phase Release, Mechanical Activation,		2/yr
L2010		Knee Ankle Foot Orthosis, Single Upright, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Single Bar 'Ak' Orthosis), Without Knee Joint,		2/yr
L2020		Knee Ankle Foot Orthosis, Double Upright, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Double Bar 'Ak' Orthosis), Custom-Fabricated		2/yr
L2020***		Knee Ankle Foot Orthosis, Double Upright, Free Ankle, Solid Stirrup, Thigh And Calf Bands/Cuffs (Double Bar 'Ak' Orthosis), Custom-Fabricated		2/yr
L2030		KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis), without knee joint		2/yr
L2035		KAFO, full plastic, static, prefabricated (pediatric size)		2/yr
L2036		Knee Ankle Foot Orthosis, Full Plastic, Double Upright, With Or Without Free Motion Knee, With Or Without Free Motion Ankle, Custom Fabricated		2/yr
L2037		Knee Ankle Foot Orthosis, Full Plastic, Single Upright, With Or Without Free Motion Knee, With Or Without Free Motion Ankle, Custom Fabricated		2/yr
L2038		Knee Ankle Foot Orthosis, Full Plastic, With Or Without Free Motion Knee, Multi-Axis Ankle, Custom Fabricated		2/yr
L2039		Knee Ankle Foot Orthosis, Full Plastic, Single Upright, Poly-Axial Hinge, Medial Lateral Rotation Control, With Or Without Free Motion Ankle, Custom		2/yr
L2040		Hip Knee Ankle Foot Orthosis, Torsion Control, Bilateral Rotation Straps, Pelvic Band/Belt, Custom Fabricated		1/yr
L2050		Hip Knee Ankle Foot Orthosis, Torsion Control, Bilateral Torsion Cables, Hip Joint, Pelvic Band/Belt, Custom-Fabricated		1/yr
L2060		Hip Knee Ankle Foot Orthosis, Torsion Control, Bilateral Torsion Cables, Ball Bearing Hip Joint, Pelvic Band/ Belt, Custom-Fabricated		1/yr
L2070		HKAFO, torsion control, unilateral rotation straps, pelvic band/belt		1/yr
L2080		HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt		1/yr
L2090		HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt		2/yr
L2106		AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient		2/yr
L2108		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Cast Orthosis, Custom-Fabricated		2/yr
L2112		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis, Soft, Prefabricated, Includes Fitting And Adjustment		2/yr
L2114		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis, Semi-Rigid, Prefabricated, Includes Fitting And Adjustment		2/yr
L2116		Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis, Rigid, Prefabricated, Includes Fitting And Adjustment		2/yr
L2126		KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient		2/yr

Deleted: ~~L2020**~~
Added: L2020***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L2128		Knee Ankle Foot Orthosis, Fracture Orthosis, Femoral Fracture Cast Orthosis, Custom-Fabricated		2/yr
L2132		Kafo, Fracture Orthosis, Femoral Fracture Cast Orthosis, Soft, Prefabricated, Includes Fitting And Adjustment		2/yr
L2134		KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid		2/yr
L2136		KAFO, fracture orthosis, femoral fracture cast orthosis, rigid		2/yr
L2180		Addition To Lower Extremity Fracture Orthosis, Plastic Shoe Insert With Ankle Joints		2/yr
L2182		Addition to lower extremity fracture orthosis, drop lock knee joint		2/yr
L2184		Addition to lower extremity fracture orthosis, limited motion knee joint.		2/yr
L2186		Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman Type		2/yr
L2188		Addition to lower extremity fracture orthosis, quadrilateral brim		2/yr
L2190		Addition to lower extremity fracture orthosis, waist belt		2/yr
L2192		Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt		2/yr
L2200***		Addition To Lower Extremity, Limited Ankle Motion, Each Joint		8/yr
L2210		Addition To Lower Extremity,Dorsiflexion Assist(Plantar Flexion Resist), Each Joint		8/yr
L2220		Addition To Lower Extremity, Dorsiflexion And Plantar Flexion Assist/Resist, Each Joint		8/yr
L2220***		Addition To Lower Extremity, Dorsiflexion And Plantar Flexion Assist/Resist, Each Joint		8/yr
L2230		Addition to lower extremity, split flat caliper stirrups and plate attachment		2/yr
L2232		Addition To Lower Extremity Orthosis, Rocker Bottom For Total Contact Ankle Foot Orthosis, For Custom Fabricated Orthosis Only		2/yr
L2240		Addition to lower extremity, round caliper and plate attachment		2/yr
L2250		Addition To Lower Extremity, Foot Plate, Molded To Patient Model, Stirrup Attachment		2/yr
L2260		Addition To Lower Extremity, Reinforced Solid Stirrup (Scott-Craig Type)		2/yr
L2265		Addition To Lower Extremity, Long Tongue Stirrup		2/yr
L2270		Addition To Lower Extremity, Varus/Valgus Correction ('T') Strap, Padded/Lined Or Malleolus Pad		2/yr
L2275		Addition To Lower Extremity, Varus/Valgus Correction, Plastic Modification, Padded/Lined		2/yr
L2280		Addition To Lower Extremity, Molded Inner Boot		2/yr
L2300		Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable		2/yr
L2310		Addition to lower extremity, abduction bar, straight		2/yr
L2320		Addition To Lower Extremity, Non-Molded Lacer, For Custom Fabricated Orthosis Only		2/yr
L2330		Addition To Lower Extremity, Lacer Molded To Patient Model, For Custom Fabricated Orthosis Only		2/yr
L2335		Addition To Lower Extremity, Anterior Swing Band		2/yr
L2340		Addition To Lower Extremity, Pre-Tibial Shell, Molded To Patient Model		2/yr

Deleted:
~~L2220~~
Added:
L2220***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L2350		Addition To Lower Extremity, Prosthetic Type, (Bk) Socket, Molded To Patient Model, (Used For 'Ptb' 'Afo' Orthoses)		2/yr
L2360		Addition To Lower Extremity, Extended Steel Shank		2/yr
L2370		Addition to lower extremity, Patten bottom		2/yr
L2375		Addition to lower extremity, torsion control, ankle joint and half solid stirrup		2/yr
L2380		Addition to lower extremity, torsion control, straight knee joint, each joint		2/yr
L2385		Addition To Lower Extremity, Straight Knee Joint, Heavy Duty, Each Joint		2/yr
L2390		Addition To Lower Extremity, Offset Knee Joint, Each Joint		2/yr
L2395		Addition to lower extremity, offset knee joint, heavy duty, each joint		2/yr
L2397		Addition to lower extremity orthosis, suspension sleeve		2/yr
L2405		Addition To Knee Joint, Drop Lock, Each		8/yr
L2405***		Addition To Knee Joint, Drop Lock, Each		8/yr
L2415		Addition To Knee Lock With Integrated Release Mechanism (Bail, Cable, Or Equal), Any Material, Each Joint		8/yr
L2425		Addition To Knee Joint, Disc Or Dial Lock For Adjustable Knee Flexion, Each Joint		8/yr
L2430		Addition to knee joint, ratchet lock for active and progressive knee extension, each joint		2/yr
L2492		Addition To Knee Joint, Lift Loop For Drop Lock Ring		2/yr
L2500		Addition To Lower Extremity, Thigh/Weight Bearing, Gluteal/Ischial Weight Bearing, Ring		2/yr
L2510		Addition To Lower Extremity, Thigh/Weight Bearing, Quadri- Lateral Brim, Molded To Patient Model		2/yr
L2520		Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted		2/yr
L2525		Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model		2/yr
L2526		Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted		2/yr
L2530		Addition to lower extremity, thigh/weight bearing, lacer, non-molded		2/yr
L2540		Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model		2/yr
L2550		Addition To Lower Extremity, Thigh/Weight Bearing, High Roll Cuff		2/yr
L2570		Addition To Lower Extremity, Pelvic Control, Hip Joint, Clevis Type Two Position Joint, Each		2/yr
L2580		Addition To Lower Extremity, Pelvic Control, Pelvic Sling		2/yr
L2600		Addition to lower extremity, pelvic control, hip joint, Clevis type or thrust bearing, free, each		2/yr
L2610		Addition To Lower Extremity, Pelvic Control, Hip Joint, Clevis Or Thrust Bearing, Lock, Each		2/yr
L2620		Addition to lower extremity, pelvic control, hip joint, heavy duty, each		2/yr
L2622		Addition To Lower Extremity, Pelvic Control, Hip Joint, Adjustable Flexion, Each		2/yr
L2624		Addition To Lower Extremity, Pelvic Control, Hip Joint, Adjustable Flexion, Extension, Abduction Control, Each		2/yr
L2627		Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables.		2/yr
L2628		Addition To Lower Extremity, Pelvic Control, Metal Frame, Reciprocation Hip Joint And		2/yr
L2630		Addition to lower extremity, pelvic control, band and belt, unilateral		1/yr

Deleted: ~~L2405**~~
Added: L2405***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L2640		Addition To Lower Extremity, Pelvic Control, Band And Belt, Bilateral		1/yr
L2650		Addition To Lower Extremity, Thigh/Weight Bearing, High Roll Cuff		2/yr
L2660		Addition to lower extremity, thoracic control, thoracic band		2/yr
L2670		Addition to lower extremity, thoracic control, paraspinal uprights		2/yr
L2680		Addition To Lower Extremity, Thoracic Control, Lateral Support Uprights		2/yr
L2750		Addition to lower extremity orthosis, plating chrome or nickel, per bar		2/yr
L2755		Addition To Lower Extremity Orthosis, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Per Segment, For Custom Fabricated		2/yr
L2760		Addition To Lower Extremity Orthosis, Extension, Per Extension, Per Bar (For Lineal Adjustment For Growth)		2/yr
L2768		Orthotic Side Bar Disconnect Device, Per Bar		2/yr
L2770		Addition To Lower Extremity Orthosis, Any Material - Per Bar Or Joint		2/yr
L2780		Addition To Lower Extremity Orthosis, Non-Corrosive Finish, Per Bar		4/yr
L2785		Addition To Lower Extremity Orthosis, Drop Lock Retainer, Each		8/yr
L2795		Addition To Lower Extremity Orthosis, Knee Control, Full Kneecap		2/yr
L2795***		Addition To Lower Extremity Orthosis, Knee Control, Full Kneecap		2/yr
L2800		Addition To Lower Extremity Orthosis, Knee Control, Knee Cap, Medial Or Lateral Pull, For Use With Custom Fabricated Orthosis Only		2/yr
L2810		Addition To Lower Extremity Orthosis, Knee Control, Condylar Pad		2/yr
L2820		Addition To Lower Extremity Orthosis, Soft Interface For Molded Plastic, Below Knee Section		2/yr
L2830		Addition To Lower Extremity Orthosis, Soft Interface For Molded Plastic, Above Knee Section		2/yr
L2840		Addition To Lower Extremity Orthosis, Tibial Length Sock, Fracture Or Equal, Each		2/yr
L2850		Addition To Lower Extremity Orthosis,Femoral Length Sock, Fracture Or Equal, Each		8/yr
L3000		Foot, Insert, Removable, Molded To Patient Model, 'Ucb' Type, Berkeley Shell, Each		2/yr
L3001		Foot, Insert, Removable, Molded To Patient Model, Spenco, Each		2/yr
L3002		Foot, Insert, Removable, Molded To Patient Model, Plastazote Or Equal, Each		2/yr
L3003		Foot, Insert, Removable, Molded To Patient Model, Silicone Gel, Each		2/yr
L3010		Foot, Insert, Removable, Molded To Patient Model, Longitudinal Arch Support, Each		2/yr
L3020		Foot, Insert, Removable, Molded To Patient Model, Longitudinal/Metatarsal Support, Each		2/yr
L3030		Foot, Insert, Removable, Formed To Patient Foot, Each		2/yr
L3040		Foot, Arch Support, Removable, Premolded, Longitudinal, Each		2/yr
L3050		Foot, Arch Support, Removable, Premolded, Metatarsal, Each		2/yr
L3060		Foot, Arch Support, Removable, Premolded, Longitudinal/Metatarsal, Each		2/yr
L3070		Foot, Arch Support, Non-Removable Attached To Shoe, Longitudinal, Each		2/yr
L3080		Foot,Arch Support,Non-Removable Attached To Shoe, Metatarsal,Each		2/yr
L3090		Foot arch support, non-removable, attached to shoe, longitudinal/metatarsal, each		2/yr
L3100		Hallus-Valgus Night Dynamic Splint		2/yr
L3140		Foot, Abduction Rotation Bar, Including Shoes		1/yr
L3150		Foot, Abduction Rotatation Bar, Without Shoes		1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L3170		Foot, Plastic, Silicone Or Equal, Heel Stabilizer, Each		2/yr
L3201		Orthopedic Shoe, Oxford With Supinator Or Pronator, Infant		2/yr
L3202		Orthopedic Shoe, Oxford With Supinator Or Pronator, Child		2/yr
L3203		Orthopedic Shoe, Oxford With Supinator Or Pronator, Junior		2/yr
L3204		Orthopedic Shoe, Hightop With Supinator Or Pronator, Infant		2/yr
L3206		Orthopedic Shoe, Hightop With Supinator Or Pronator, Child		2/yr
L3207		Orthopedic Shoe, Hightop With Supinator Or Pronator, Junior		2/yr
L3208		Surgical Boot, Each, Infant		2/yr
L3209		Surgical Boot, Each, Child		2/yr
L3210		Orthopedic Footwear, Ladies Shoes, Oxford		2/yr
L3211		Surgical Boot, Each, Junior		2/yr
L3212		Benesch Boot, Pair, Infant		2/yr
L3215		Orthopedic Footwear, Ladies Shoe, Oxford, Each		2/yr
L3216		Orthopedic Footwear, Ladies Shoe, Depth Inlay, Each		2/yr
L3217		Orthopedic Footwear, Ladies Shoe, Hightop, Depth Inlay, Each		2/yr
L3219		Orthopedic Footwear, Mens Shoe, Oxford, Each		2/yr
L3221		Orthopedic Footwear, Mens Shoe, Depth Inlay, Each		2/yr
L3222		Orthopedic Footwear, Mens Shoe, Hightop, Depth Inlay, Each		2/yr
L3224		Orthopedic Footwear, Woman's Shoe, Oxford, Used As An Integral Part Of A Brace (Orthosis)		2/yr
L3225		Orthopedic Footwear, Man's Shoe, Oxford, Used As An Integral Part Of A Brace (Orthosis)		2/yr
L3230		Orthopedic Footwear, Custom Shoe, Depth Inlay, Each		2/yr
L3250		Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each		2/yr
L3251		Foot, shoe molded to patient model, silicone shoe, each		2/yr
L3252		Foot, Shoe Molded To Patient Model, Plastazote (Or Similar), Custom Fabricated, Each		2/yr
L3253		Foot, Molded Shoe Plastazote (Or Similar) Custom Fitted, Each		2/yr
L3254		Non-standard size or width		2/yr
L3255		Non-standard size or length		2/yr
L3257		Orthopedic footwear, additional charge for split size		2/yr
L3260		Surgical Boot/Shoe, Each		2/yr
L3265		Plastazote Sandal, Each		2/yr
L3300		Lift, Elevation, Heel, Tapered To Metatarsals, Per Inch		2/yr
L3310		Lift, Elevation, Heel And Sole, Neoprene, Per Inch		2/yr
L3320		Lift, elevation, heel and sole, cork, per inch		2/yr
L3330		Lift, elevation, metal extension, (skate)		2/yr
L3332		Lift, Elevation, Inside Shoe, Tapered, Up To One-Half Inch		2/yr
L3334		Lift, Elevation, Heel, Per Inch		2/yr
L3340		Heel wedge, Sach		2/yr
L3350		Heel Wedge		2/yr
L3360		Sole Wedge, Outside Sole		2/yr
L3370		Sole Wedge, Between Sole		2/yr
L3380		Clubfoot Wedge		2/yr
L3390		Out flare wedge		2/yr
L3400		Metatarsal Bar Wedge, Rocker		2/yr
L3410		Metatarsal bar wedge, between sole		2/yr
L3420		Full Sole And Heel Wedge, Between Sole		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L3430		Heel, Counter, Plastic Reinforced		2/yr
L3440		Heel, counter, leather reinforced		2/yr
L3450		Heel, Sach Cushion Type		2/yr
L3455		Heel, new leather, standard		2/yr
L3460		Heel, new rubber, standard		2/yr
L3465		Heel, Thomas With Wedge		4/yr
L3470		Heel, Thomas Extended To Ball		2/yr
L3480		Heel, Pad And Depression For Spur		2/yr
L3485		Heel, Pad, Removable For Spur		2/yr
L3500		Miscellaneous shoe addition, insole, rubber		2/yr
L3510		Orthopedic Shoe Addition, Insole, Rubber		2/yr
L3520		Miscellaneous shoe addition, insole, felt covered with leather		2/yr
L3530		Miscellaneous shoe addition, sole, half		2/yr
L3540		Orthopedic Shoe Addition, Sole, Full		2/yr
L3550		Miscellaneous shoe addition, toe tap, standard		2/yr
L3560		Orthopedic shoe addition, toe tap, horseshoe		2/yr
L3570		Miscellaneous shoe addition, special extension to instep, (leather with eyelets)		2/yr
L3580		Miscellaneous shoe addition, convert instep to Velcro closure		2/yr
L3590		Miscellaneous shoe addition, convert firm shoe counter to soft counter		2/yr
L3595		Miscellaneous shoe addition, March bar		2/yr
L3600		Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, Existing		2/yr
L3610		Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, New		4/yr
L3610***		Transfer Of An Orthosis From One Shoe To Another, Caliper Plate, New		4/yr
L3620		Transfer Of An Orthosis From One Shoe To Another, Solid Stirrup, Existing		2/yr
L3630		Transfer Of An Orthosis From One Shoe To Another, Solid Stirrup, New		2/yr
L3640		Transfer Of An Orthosis From One Shoe To Another, Dennis Browne Splint (Riveton), Both Shoes		1/yr
L3649		Orthopedic Shoe, Modification, Addition Or Transfer, Not Otherwise Specified		2/yr
L3650		Shoulder Orthosis, Figure Of Eight Design Abduction Restrainer, Prefabricated, Includes Fitting And Adjustment		1/yr
L3660		Shoulder Orthosis, Figure Of Eight Design Abduction Restrainer, Canvas And Webbing, Prefabricated, Includes Fitting And Adjustment		1/yr
L3670		Shoulder Orthosis, Acromio/Clavicular (Canvas And Webbing Type), Prefabricated, Includes Fitting And Adjustment		1/yr
L3671		Shoulder orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1/yr
L3675		Shoulder Orthosis, Vest Type Abduction Restrainer, Canvas Webbing Type Or Equal, Prefabricated, Includes Fitting And Adjustment		2/yr
L3702		Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3710		Elbow Orthosis, Elastic With Metal Joints, Prefabricated, Includes Fitting And Adjustment		2/yr
L3720		EO, double upright, with forearm/arm cuffs, free motion		2/yr
L3730		Elbow Orthosis, Double Upright With Forearm/Arm Cuffs, Extension/ Flexion Assist, Custom-Fabricated		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L3740		Elbow Orthosis, Double Upright With Forearm/Arm Cuffs, Adjustable Position Lock With Active Control, Custom-Fabricated		2/yr
L3760		Eo,With Adjustable Position Locking Joint(S) Prefabricated, Includes Fitting And Adjustments, Any Type		2/yr
L3762		Elbow Orthosis, Rigid, Without Joints, Includes Soft Interface Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L3763		Elbow wrist hand orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3764		Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3765		Elbow wrist hand finger orthosis, rigid, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3766		Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3806		Wrist hand finger orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckle, may include soft interface material, straps, custom		2/yr
L3807		Wrist Hand Finger Orthosis, Without Joint(S), Prefabricated, Includes Fitting And Adjustments, Any Type		2/yr
L3807***		Wrist Hand Finger Orthosis, Without Joint(S), Prefabricated, Includes Fitting And Adjustments, Any Type		2/yr
L3808		Wrist hand finger, orthosis, rigid without joints, may include soft interface material; straps, custom fabricatrd, includes fitting and adjustment		2/yr
L3900		Wrist Hand Finger Orthosis, Dynamic Flexor Hinge, Reciprocal Wrist Extension/ Flexion, Finger Flexion/Extension, Wrist Or Finger Driven, Custom-Fabricated		2/yr
L3901		WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion extension, cable driven		2/yr
L3905		Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3906		Wrist Hand Orthosis, Without Joints, May Include Soft Interface, Straps, Custom Fabricated, Includes Fitting And Adjustment		2/yr
L3908		Wrist Hand Orthosis, Wrist Extension Control Cock-Up, Non Molded, Prefabricated, Includes Fitting And Adjustment		2/yr
L3912		Hand Finger Orthosis, Flexion Glove With Elastic Finger Control, Prefabricated, Includes Fitting And Adjustment		2/yr
L3913		Hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1/yr
L3915		Wrist Hand Orthosis, Includes Oneor More Nontorsion Joint(S), Elastic Bands , Turnbuckles, May Include Soft Interface, Straps, Prefabricated,Includes Fitting And Adjustment		1/yr
L3917		Hand Orthosis, Metacarpal Fracture Orthosis, Prefabricated, Includes Fitting And Adjustment		2/yr
L3919		Hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3921		Hand finger orthosis, includes one or more nontorsion joints, elastic bands, tumbuckles, may include soft interface, straps, sustom fabricated, includes fitting and adjustment		2/yr
L3925		Finger Orthosis, Proximal Interphalangeal (Pip), Non Torsion Joint/Spring, Extension/Flexion, May Include Soft Interface Material		2/yr
L3929		Hand Finger Orthosis, Includes One Or More Nontorsion Joint(S), Turnbuckles, Elastic Bands/Springs, May Include Soft Interface Material, Straps,Prefabricated,Includes Fitting And Adjustments		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L3931		Wrist Hand Finger Orthosis, Includes One Or More Nortorsion Joint(S) Turnbuckles, Elastic Bands/Springs, May Include Soft Interface Materials, Straps, Prefabricated, Includes Fitting And Adjustment		2/yr
L3933		Finger Orthosis, Without Joints, May Include Soft Interface, Custom Fabricated, Includes Fitting And Adjustment		3/yr
L3934		Finger Orthosis, Safety Pin, Modified, Prefabricated, Includes Fitting And Adjustment		2/yr
L3935		Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment		2/yr
L3936		Wrist Hand Finger Orthosis, Palmer, Prefabricated, Includes Fitting And Adjustment		2/yr
L3960		Shoulder Elbow Wrist Hand Orthosis, Abduction Positioning, Airplane Design, Prefabricated, Includes Fitting And Adjustment		1/yr
L3961		Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1/yr
L3962		SEWHO, abduction positioning, Erbs Palsey design		1/yr
L3967		Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		1/yr
L3971		Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3973		Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustmen.		2/yr
L3975		Shoulder elbow wrist hand finger orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3976		Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3977		Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3978		Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment		2/yr
L3980		Upper Extremity Fracture Orthosis, Humeral, Prefabricated, Includes Fitting And Adjustment		2/yr
L3982		Upper Extremity Fracture Orthosis, Radius/Ulnar, Prefabricated, Includes Fitting And Adjustment		2/yr
L3984		Upper Extremity Fracture Orthosis, Wrist, Prefabricated, Includes Fitting And Adjustment		2/yr
L3985		Upper extremity fracture orthosis, forearm, hand with wrist hinge		2/yr
L3995		Addition To Upper Extremity Orthosis,Sock,Fracture Or Equal, Each		2/yr
L3999		Upper Limb Orthosis, Not Otherwise Specified	X	2/yr
L4000		Replace girdle for Milwaukee orthosis		2/yr
L4010		Replace trilateral socket brim		2/yr
L4020		Replace quadrilateral socket brim, molded to patient model		2/yr
L4030		Replace quadrilateral socket brim, custom fitted		2/yr
L4040		Replace molded thigh lacer		2/yr
L4045		Replace Non-Molded Thigh Lacer, For Custom Fabricated Orthosis Only		2/yr
L4050		Replace molded calf lacer		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L4055		Replace non-molded calf lacer		2/yr
L4060		Replace high roll cuff		2/yr
L4070		Replace Proximal And Distal Upright For Kafo		2/yr
L4080		Replace metal bands KAFO, proximal thigh		2/yr
L4090		Replace Metal Bands Kafo-Afo, Calf Or Distal Thigh		2/yr
L4100		Replace leather cuff KAFO, proximal thigh		2/yr
L4110		Replace Leather Cuff Kafo-Afo, Calf Or Distal Thigh		2/yr
L4130		Replace Pretibial Shell		2/yr
L4205		Repair Of Orthotic Device, Labor Component, Per 15 Minutes		10/yr
L4210		Repair Of Orthotic Device, Repair Or Replace Minor Parts		5/yr
L4350		Ankle Control Orthosis, Stirrup Style, Rigid, Includes Any Type Interface (E.G., Pneumatic, Gel), Prefabricated, Includes Fitting And Adjustment		2/yr
L4360		Walking Boot, Pneumatic, With Or Without Joints, With Or Without Interface Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L4370		Pneumatic Full Leg Splint, Prefabricated, Includes Fitting And Adjustment		2/yr
L4386		Walking Boot, Non-Pneumatic, With Or Without Joints, With Or Without Interface Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L4392		Replace soft interface material, ankle contracture splint (Effective 1/1/97 this replaces HCPCS code K0127)		2/yr
L4394		Replace soft interface material, foot drop, splint (Effective 1/1/97 this replaces HCPCS code K0128)		2/yr
L4396		Static Ankle Foot Orthosis, Including Soft Interface Material, Adjustable For Fit, For Positioning, Pressure Reduction, May Be Used For Minimal Ambulation,		2/yr
L4398		Foot Drop Splint, Recumbent Positioning Device, Prefabricated, Includes Fitting And Adjustment		2/yr
L5000		Partial Foot, Shoe Insert With Longitudinal Arch, Toe Filler		2/yr
L5010		Partial Foot, Molded Socket, Ankle Height, With Toe Filler		2/yr
L5020		Partial Foot, Molded Socket, Tibial Tubercle Height, With Toe Filler		2/yr
L5050		Ankle, Symes, Molded Socket, SACH Foot		2/yr
L5060		Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot		2/yr
L5100		Below Knee, Molded Socket, Shin, SACH Foot		2/yr
L5150		Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot		2/yr
L5160		Knee Disarticulation (Or Through Knee), Molded Socket, Bent Knee Configuration, External Knee Joints, Shin, SACH Foot		2/yr
L5200		Above knee, molded socket, single axis constant friction knee, shin, SACH foot		2/yr
L5210		Above Knee, Sort Prosthesis, No Knee Joint (Stubbies), With Foot Blocks, No Ankle Joints, Each		2/yr
L5220		Above Knee, Short Prosthesis, No Knee Joint (Stubbies), With Articulated Ankle/Foot, Dynamically Aligned, Each		2/yr
L5230		Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot		2/yr
L5250		Hip disarticulation, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot		2/yr
L5270		Hip disarticulation, tilt table type, molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot		2/yr
L5280		Hemipelvectomy, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L5301		Below Knee, Molded Socket, Shin, SACH Foot, Endoskeletal System		2/yr
L5301***		Below Knee, Molded Socket, Shin, SACH Foot, Endoskeletal System		2/yr
L5311		Knee disarticulation (or through knee), molded socket, external knee joints, shins, SACH foot, endoskeletal system.		2/yr
L5312		Knee Disarticulation (Or Through Knee), Molded Socket, Single Axis Knee, Pylon, SACH Foot, Endoskeletal System		2/yr
L5321		Above Knee, Molded Socket, Open End, SACH Foot, Endoskeletal System, Single Axis Knee		2/yr
L5321***		Above Knee, Molded Socket, Open End, SACH Foot, Endoskeletal System, Single Axis Knee		2/yr
L5331		Knee Disarticulation, Canadian Type, Molded Socket, Endoskeletal System, Hip Joint, Single Axis Knee SACH Foot	X	2/yr
L5400		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee		2/yr
L5410		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, below knee, each additional cast change and realignment		2/yr
L5420		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, and one cast change, “AK” or knee disarticulation		2/yr
L5430		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, ”AK” or knee disarticulation, each additional cast change and realignment		2/yr
L5450		Immediate post-surgical or early fitting, application of non-weight bearing rigid dressing, below knee		2/yr
L5460		Immediate post-surgical or early fitting, application of non-weight bearing rigid dressing, above knee		2/yr
L5500		Initial, below knee, “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, direct formed		2/yr
L5505		Initial, above-knee or knee disarticulation ischial level socket, USMC or equal pylon, no cover, Sach foot, plaster socket, direct formed		2/yr
L5510		Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, molded to model		2/yr
L5520		Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed		2/yr
L5530		Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model		2/yr
L5535		Preparatory, below knee in “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, prefabricated, adjustable open end socket		2/yr
L5540		Preparatory, Below Knee PTB Type Socket, Non-Alignable System, Pylon, No Cover, SACH Foot, Laminated Socket, Molded To Model		2/yr
L5560		Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, molded to model		2/yr
L5570		Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed		2/yr
L5580		Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model		2/yr
L5585		Preparatory, above knee-knee disarticulation, ischial level socket, “USMC” or equal pylon, no cover, SACH foot, prefabricated adjustable open end socket		2/yr
L5590		Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, laminated socket, molded to model		2/yr
L5595		Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model		2/yr
L5600		Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient		2/yr
L5610		Addition to lower extremity, above knee, Hydracadence system		2/yr

Deleted: ~~L5301~~
Added: L5301***

Deleted: ~~L5321~~
Added: L5321***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L5611		Addition To Lower Extremity, Endoskeletal System, Above The Knee- Knee Disarticulation, 4 Bar Linkage, With Friction Swing Phase Control		2/yr
L5613		Addition To Lower Extremity, Endoskeletal System, Above Knee-Knee Disarticulation, 4 Bar Linkage, With Hydraulic Swing Phase Control		2/yr
L5618		Addition To Lower Extremity, Test Socket, Symes		2/yr
L5620		Addition To Lower Extremity, Test Socket, Below Knee		2/yr
L5620***		Addition To Lower Extremity, Test Socket, Below Knee		2/yr
L5622		Addition to lower extremity, test socket, knee disarticulation		2/yr
L5624		Addition To Lower Extremity, Test Socket, Above Knee		2/yr
L5624***		Addition To Lower Extremity, Test Socket, Above Knee		2/yr
L5626		Addition to lower extremity, test socket, hip disarticulation		2/yr
L5628		Addition to lower extremity, test socket, hemipelvectomy		2/yr
L5629		Addition To Lower Extremity, Below Knee, Acrylic Socket		2/yr
L5629***		Addition To Lower Extremity, Below Knee, Acrylic Socket		2/yr
L5630		Addition To Lower Extremity, Symes Type, Expandable Wall Socket		2/yr
L5631		Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Acrylic Socket		2/yr
L5631***		Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Acrylic Socket		2/yr
L5632		Addition To Lower Extremity, Symes Type, 'Ptb' Brim Design Socket		2/yr
L5634		Addition To Lower Extremity, Smyes Type, Posterior Opening (Canadian) Socket		2/yr
L5636		Addition To Lower Extremity, Symes Type, Medial Opening Socket		2/yr
L5637		Addition To Lower Extremity, Below Knee, Total Contact		2/yr
L5638		Addition To lower extremity, below knee, leather socket		2/yr
L5639		Addition To lower extremity, below knee, wood socket		2/yr
L5640		Addition To lower extremity, knee disarticulation, leather socket		2/yr
L5642		Addition To lower extremity, above knee, leather socket		2/yr
L5643		Addition To lower extremity, hip disarticulation, flexible inner socket, external frame		2/yr
L5644		Addition To lower extremity, above knee, wood socket		2/yr
L5645		Addition To Lower Extremity, Below Knee, Flexible Inner Socket, External		2/yr
L5646		Addition to lower extremity, below knee, air cushion socket		2/yr
L5647		Addition To Lower Extremity, Below Knee Suction Socket		2/yr
L5648		Addition To lower extremity, above knee, air cushion socket		2/yr
L5649***		Addition To Lower Extremity,Ischial Containment/Narrow M-L Socket		2/yr
L5650***		Additions To Lower Extremity, Total Contact, Above Knee Or Knee Disarticulation Socket		2/yr
L5651***		Addition To Lower Extremity, Above Knee, Flexible Inner Socket, External Frame		2/yr
L5652		Addition To Lower Extremity, Suction Suspension, Above Knee Or Knee Disarticulation Socket		2/yr
L5653		Addition to lower extremity, knee disarticulation, expandable wall socket		2/yr
L5654		Addition To Lower Extremity, Socket Insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote Or Equal)		2/yr
L5655***		Addition To Lower Extremity, Socket Insert, Below Knee (Kemblo, Pelite, Aliplast, Plastazote Or Equal)		2/yr
L5656**		Addition To Lower Extremity, Socket Insert, Knee Disarticulation (Kemblo, Pelite, Aliplast, Plastazote Or Equal)		2/yr

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Added: L5651***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L5658**		Addition To Lower Extremity, Socket Insert, Above Knee (Kemblo, Pelite, Aliplast, Plastazote Or Equal)		2/yr
L5661		Addition To Lower Extremity, Socket Insert, Multi-Durometer Symes		2/yr
L5665		Addition To Lower Extremity,Socket Insert,Multi-Durometer,Below Knee		2/yr
L5666		Addition To Lower Extremity, Below Knee, Cuff Suspension		2/yr
L5668		Addition To Lower Extremity, Below Knee, Molded Distal Cushion		2/yr
L5670		Addition To Lower Extremity, Below Knee, Molded Supracondylar Suspension ('Pts' Or Similar)		2/yr
L5671***		Addition To Lower Extremity, Below Knee / Above Knee Suspension Locking Mechanism (Shuttle, Lanyard Or Equal), Excludes Socket Insert		2/yr
L5672		Addition to lower extremity, below knee, removable medial brim suspension		2/yr
L5673***		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated From Existing Mold Or Prefabricated, Socket Insert, Silicone Gel, Elastomeric Or		4/yr
L5676		Additions To Lower Extremity, Below Knee, Knee Joints, Single Axis, Pair		2/yr
L5677		Additions To lower extremity, below knee, knee joints, polycentric, pair		2/yr
L5678		Additions To Lower Extremity, Below Knee, Joint Covers, Pair		2/yr
L5679***		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated From Existing Mold Or Prefabricated, Socket Insert, Silicone Gel, Elastomeric Or		4/yr
L5680		Addition To Lower Extremity, Below Knee, Thigh Lacer, Nonmolded		2/yr
L5681		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated Socket Insert For Congenital Or Atypical Traumatic Amputee, Silicone Gel, Elastomeric		2/yr
L5682		Addition To Lower Extremity, Below Knee, Thigh Lacer, Gluteal/Ischial, Molded		2/yr
L5683		Addition To Lower Extremity, Below Knee/Above Knee, Custom Fabricated Socket Insert For Other Than Congenital Or Atypical Traumatic Amputee, Silicone Gel,		2/yr
L5684		Addition To Lower Extremity, Below Knee, Fork Strap		2/yr
L5685***		Addition To Lower Extremity Prosthesis, Below Knee, Suspension/Sealing Sleeve, With Or Without Valve, Any Material, Each		2/yr
L5685***		Addition To Lower Extremity Prosthesis, Below Knee, Suspension/Sealing Sleeve, With Or Without Valve, Any Material, Each		2/yr
L5686**		Addition To Lower Extremity, Below Knee, Back Check(Extension Control)		2/yr
L5688		Addition To Lower Extremity, Below Knee, Waist Belt, Webbing		2/yr
L5690		Addition To lower extremity, below knee, waist belt, padded and lined		2/yr
L5692		Addition To Lower Extremity, Above Knee, Pelvic Control Belt, Light		1/yr
L5694		Addition To Lower Extremity, Above Knee, Pelvic Control Belt, Padded And Lined		2/yr
L5695***		Addition To Lower Extremity, Above Knee, Pelvic Control, Sleeve Suspension, Neoprene Or Equal, Each		2/yr
L5696		Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Pelvic Joint		2/yr
L5697		Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Pelvic Band		2/yr
L5698		Addition To Lower Extremity, Above Knee Or Knee Disarticulation, Silesian Bandage		2/yr
L5700***		Replacement, Socket, Below Knee, Molded To Patient Model		2/yr

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Added: L5671***

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Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L5701***		Replacement, Socket, Above Knee/Knee Disarticulation, Including Attachment Plate, Molded To Patient Model		2/yr
L5702		Replacement, socket, hip disarticulation, including hip joint, molded to patient model		2/yr
L5704***		Custom Shaped Protective Cover, Below Knee		2/yr
L5705***		Custom Shaped Protective Cover, Above Knee		2/yr
L5706		Custom Shaped Protective Cover, Knee Disarticulation		2/yr
L5710		Addition, exoskeletal knee-shin system, single axis, manual lock		2/yr
L5711		Additions Exoskeletal Knee-Shin System, Single Axis, Manual Lock, Ultra-Light Material		2/yr
L5712		Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)		2/yr
L5714		Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control.		2/yr
L5716		Addition, exoskeletal knee shin system, polycentric, mechanical stance phase lock		2/yr
L5718		Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control		2/yr
L5722		Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control		2/yr
L5724		Addition, exoskeletal knee-shin system, single axis, fluid swing phase control		2/yr
L5726		Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control		2/yr
L5728		Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control		2/yr
L5780		Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control		2/yr
L5781		Addition To Lower Limb Prosthesis, Vacuum Pump, Residual Limb Volume Management And Moisture Evacuation System		2/yr
L5782		Addition To Lower Limb Prosthesis, Vacuum Pump, Residual Limb Volume Management And Moisture Evacuation System, Heavy Duty		2/yr
L5785		Addition, Exoskeletal System, Below Knee, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)		2/yr
L5790		Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber, or equal)		2/yr
L5795		Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)		2/yr
L5810		Addition, Endoskeletal Knee-Shin System, Single Axis, Manual Lock		2/yr
L5811		Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material		2/yr
L5812***		Addition, Endoskeletal Knee-Shin System, Single Axis, Friction Swing And Stance Phase Control (Safety Knee)		2/yr
L5814		Addition, Endoskeletal Knee-Shin System, Polycentric, Hydraulic Swing Phase Control, Mechanical Stance Phase Lock		2/yr
L5816		Addition, Endoskeletal Knee-shin system, polycentric, mechanical stance phase lock		2/yr
L5818		Addition, Endoskeletal Knee-shin system, polycentric, friction swing, and stance phase control		2/yr
L5822		Addition, Endoskeletal Knee-shin system, single axis, pneumatic swing, friction stance phase control		2/yr
L5824		Addition, Endoskeletal knee-shin system, single axis, fluid swing phase control		2/yr

Deleted: ~~L5812~~
Added: L5812***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L5826		Addition, Endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame		2/yr
L5828		Addition, Endoskeletal Knee-Shin System, Single Axis, Fluid Swing And Stance Phase Control		2/yr
L5830		Addition, Endoskeletal knee-shin system, single axis, pneumatic/swing phase control		2/yr
L5840		Addition, Endoskeletal knee-shin system, multi-axial, pneumatic swing phase control		2/yr
L5848		Addition To Endoskeletal, Knee-Shin System, Hydraulic Stance Extension, Dampening Feature, With Or Without Adjustability		2/yr
L5850***		Addition, Endoskeletal System, Above Knee Or Hip Disarticulation, Knee Extension Assist		2/yr
L5855		Addition, Endoskeletal System, Hip Disarticulation, Mechanical Hip Extension		2/yr
L5856**		Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System, Microprocessor Control Feature, Swing And Stance Phase, Includes Electronic	X	2/yr
L5857		Addition To Lower Extremity Prosthesis, Endoskeletal Knee-Shin System, Microprocessor Control Feature, Swing Phase Only, Includes Electronic		2/yr
L5858**		Addition To Lower Extremity Prosthesis, Endoskeletal Knee Shin System, Microprocessor Control Feature, Stance Phase Only, Includes Electronic	X	2/yr
L5910***		Addition, Endoskeletal System, Below Knee, Alignable System		2/yr
L5920***		Addition, Endoskeletal System ,Above Knee Or Hip Disarticulation, Alignable System		2/yr
L5925		Addition, Endoskeletal System, above knee, knee disarticulation, alignable system		2/yr
L5930		Addition, Endoskeletal System, high activity knee control frame		2/yr
L5940***		Addition, Endoskeletal System, Below Knee, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)		2/yr
L5950***		Addition, Endoskeletal System, Above Knee, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)		2/yr
L5960		Addition, Endoskeletal System, Hip Disarticulation, Ultra-Light Material (Titanium, Carbon Fiber Or Equal)		2/yr
L5962***		Addition, Endoskeletal System, Below Knee, Flexible Protective Outer Surface Covering System		2/yr
L5964***		Addition, Endoskeletal System, Above Knee, Flexible Protective Outer Surface Covering System		2/yr
L5970		All Lower Extremity Prostheses, Foot, External Keel, SACH Foot		2/yr
L5971		All lower extremity prosthesis, solid ankle cushion heel (sach) foot, replacement only		2/yr
L5972		All Lower Extremity Prostheses, Flexible Keel Foot (Safe, STEN, Bock Dynamic Or Equal)		2/yr
L5972***		All Lower Extremity Prostheses, Flexible Keel Foot (Safe, STEN, Bock Dynamic Or Equal)		2/yr
L5974***		All Lower Extremity Prostheses, Foot, Single Axis Ankle/Foot		2/yr
L5976		All Lower Extremity Prostheses, Energy Storing Foot (Seattle Carbon Copy II Or Equal)		2/yr
L5978		All Lower Extremity Prostheses, Foot, Multiaxial Ankle/Foot		2/yr
L5979		All Lower Extremity Prosthesis, Multi-Axial Ankle, Dynamic Response Foot, One Piece System		2/yr
L5980		All Lower Extremity Prostheses, Flex Foot System		2/yr

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Added: L5850***

Deleted: ~~L5972~~
Added: L5972***

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L5982		All exoskeletal lower extremity prostheses, axial rotation unit		2/yr
L5984		All Endoskeletal Lower Extremity Prosthesis, Axial Rotation Unit, With Or Without Adjustability		2/yr
L5985		All Endoskeletal Lower Extremity Prostheses, Dynamic Prosthetic Pylon		2/yr
L5986***		All Lower Extremity Prostheses, Multi-Axial Rotation Unit (MCP Or Equal)		2/yr
L5987		All Lower Extremity Prosthesis, Shank Foot System With Vertical Loading Pylon		2/yr
L5990		Addition To Lower Extremity Prosthesis, User Adjustable Heel Height		2/yr
L5995		Addition To Lower Extremity Prosthesis, Heavy Duty Feature (For Patient Weight > 300 Lbs)		2/yr
L5999		Lower extremity prosthesis, not otherwise specified		2/yr
L6000		Partial hand, Robin-Aids, thumb remaining, (or equal)		2/yr
L6010		Partial hand, Robin-Aids, little and/or ring finger remaining, (or equal)		2/yr
L6020		Partial hand, Robin-Aids, no finger remaining, (or equal)		2/yr
L6025		Transcarpal/Metacarpal Or Partial Hand Disarticulation Prosthesis, External Power, Self-Suspended, Inner Socket With Removable Forearm Section, Electrodes		2/yr
L6050		Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad		2/yr
L6055		Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad		2/yr
L6100		Below elbow, molded socket, flexible elbow hinge, triceps pad		2/yr
L6110		Below elbow, molded socket, (Muenster or Northwestern suspension types)		2/yr
L6120		Below elbow, molded double wall split socket, step-up hinges, half cuff		2/yr
L6130		Below elbow, molded double wall split socket, stump activated locking hinge, half cuff		2/yr
L6200		Elbow Disarticulation, Molded Socket, Outside Locking Hinge, Forearm		2/yr
L6205		Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm		2/yr
L6250		Above elbow, molded double wall socket, internal locking elbow, forearm		2/yr
L6300		Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm		2/yr
L6310		Shoulder disarticulation, passive restoration, (complete prosthesis)		2/yr
L6320		Shoulder disarticulation, passive restoration, (shoulder cap only)		2/yr
L6350		Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm		2/yr
L6360		Interscapular thoracic, passive restoration (complete prosthesis)		2/yr
L6370		Interscapular thoracic, passive restoration, (shoulder cap only)		2/yr
L6380		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components and one cast change, wrist disarticulation or below elbow		2/yr
L6382		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components and one cast change, elbow disarticulation or above elbow		2/yr
L6384		Immediate postsurgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic		2/yr
L6386		Immediate post-surgical or early fitting, each additional cast change and realignment		2/yr
L6388		Immediate post surgical or early fitting, application of rigid dressing only		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L6400		Below Elbow, Molded Socket, Endoskeletal System, Including Soft Prosthetic Tissue Shaping		2/yr
L6450		Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2/yr
L6500		Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2/yr
L6550		Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2/yr
L6570		Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping		2/yr
L6580		Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control “USMC” or equal pylon, no cover, molded to patient model		2/yr
L6582		Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, “USMC” or equal pylon, no cover, direct formed		2/yr
L6584		Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, “USMC” or equal pylon, no cover, molded to patient model		2/yr
L6586		Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead table control, “USMC” or equal pylon, no cover, direct formed		2/yr
L6588		Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control “USMC” or equal pylon, no cover, molded to patient model		2/yr
L6590		Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, “USMC” or equal pylon, no cover, direct formed		2/yr
L6600		Upper extremity additions, polycentric hinge, pair		2/yr
L6605		Upper extremity additions, single pivot hinge, pair		2/yr
L6610		Upper extremity additions, flexible metal hinge, pair		2/yr
L6615		Upper extremity addition, disconnect locking wrist unit		2/yr
L6616		Upper extremity addition, additional disconnect insert for locking wrist unit, each		2/yr
L6620		Upper extremity addition, flexion-friction wrist unit		2/yr
L6621		Upper Extremity Prosthesis Addition, Flexion/Extension Wrist With Or Without Friction, For Use With External Powered Terminal Device		2/yr
L6623		Upper extremity addition, spring assisted rotational wrist unit with latch release		2/yr
L6625		Upper extremity addition, rotation wrist unit with cable lock		2/yr
L6628		Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal		2/yr
L6629		Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal		2/yr
L6630		Upper extremity addition, stainless steel, any wrist		2/yr
L6632		Upper extremity addition, latex suspension sleeve, each		2/yr
L6635		Upper extremity addition, lift assist for elbow		2/yr
L6637		Upper extremity addition, nudge control elbow lock		2/yr
L6638		Upper Extremity Addition To Prosthesis, Electric Locking Feature, Only For Use With Manually Powered Elbow		2/yr
L6640		Upper extremity additions, shoulder abduction joint, pair		2/yr
L6641		Upper extremity addition, excursion amplifier, pulley type		2/yr
L6642		Upper extremity addition, excursion amplifier, lever type		2/yr
L6645		Upper extremity addition, shoulder flexion/abduction joint, each		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L6647		Upper Extremity Addition, Shoulder Lock Mechanism, Body Powered Actuator		2/yr
L6648		Upper Extremity Addition, Shoulder Lock Mechanism, External Powered Actuator		2/yr
L6650		Upper extremity addition, shoulder universal joint, each		2/yr
L6655		Upper Extremity Addition, Standard Control Cable, Extra		2/yr
L6660		Upper extremity addition, heavy duty control cable		2/yr
L6665		Upper Extremity Addition, Teflon, Or Equal, Cable Lining		2/yr
L6670		Upper extremity addition, hook to hand, cable adapter		2/yr
L6672		Upper extremity addition, harness, chest or shoulder, saddle type		2/yr
L6675		Upper extremity addition, harness, figure-(ib 8lg) eight type, for single control		2/yr
L6676		Upper Extremity Addition, Harness, (E.G. Figure Of Eight Type), Dual Cable Design		2/yr
L6680		Upper Extremity Addition, Test Socket, Wrist Disarticulation Or Below Elbow		2/yr
L6682**		Upper Extremity Addition, Test Socket, Elbow Disarticulation Or Above Elbow		2/yr
L6882		Microprocessor control feature, addition to upper limb prosthetic terminal device	X	2/yr
L6684		Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic		2/yr
L6686		Upper extremity addition, suction socket		2/yr
L6687		Upper Extremity Addition, Frame Type Socket, Below Elbow Or Wrist Disarticulation		2/yr
L6688		Upper Extremity Addition, Frame Type Socket, Above Elbow Or Elbow Disarticulation		2/yr
L6689		Upper extremity addition, frame type socket, shoulder disarticulation		2/yr
L6690		Upper extremity addition, frame type socket, interscapular-thoracic		2/yr
L6691		Upper Extremity Addition, Removable Insert, Each		2/yr
L6692		Upper Extremity Addition, Silicone Gel Insert Or Equal, Each		2/yr
L6703		Terminal Device, Passive Hand/Mitt, Any Material, Any Size		1/yr
L6704		Terminal Device, Sport/Recreational/Work Attachment, Any Material, Any Size		1/yr
L6706		Terminal Device, Hook, Mechanical, Voluntary Opening, Any Material, Any Size, Lined Or Unlined		1/yr
L6707		Terminal Device, Hook, Mechanical, Voluntary Closing, Any Material, Any Size, Lined Or Unlined		1/yr
L6708		Terminal Device, Hand, Mechanical, Voluntary Opening, Any Material, Any Size		1/yr
L6709		Terminal Device, Hand, Mechanical, Voluntary Closing, Any Material, Any Size		1/yr
L6882**		Microprocessor Control Feature, Addition To Upper Limb Prosthetic Terminal Device	X	2/yr
L6890**		Addition To Upper Extremity Prosthesis, Glove For Terminal Device, Any Material, Prefabricated, Includes Fitting And Adjustment		2/yr
L6895		Terminal device, glove for above hands, custom glove		2/yr
L6900		Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining		2/yr
L6905		Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining		2/yr
L6910		Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining		2/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L6915		Hand restoration (shading and measurements included), replacement glove for above		2/yr
L6920		Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device		2/yr
L6925**		Wrist Disarticulation, External Power, Self-Suspended Inner Socket, Removable Forearm Shell, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One	X	2/yr
L6930		Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device		2/yr
L6935		Below Elbow, External Power, Self-Suspended Inner Socket, Removable Forearm Shell, Otto Bock Or Equal Electrodes, Cables, Two Batteries And One Charger,		2/yr
L6940		Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device		2/yr
L6945		Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		2/yr
L6950		Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device		2/yr
L6955		Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries one charger, myoelectronic control of terminal device		2/yr
L6960		Shoulder disarticulation, external power, molded innersocket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device		2/yr
L6965		Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device		2/yr
L6970		Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, switch control of switch device		2/yr
L6975		Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of switch device		2/yr
L7007		Electric Hand, Switch Or Myoelectric Controlled, Adult		1/yr
L7008		Electric Hand, Switch Or Myoelectric, Controlled, Pediatric		1/yr
L7009		Electric Hook, Switch Or Myoelectric Controlled, Adult		1/yr
L7040		Prehensile actuator, Hosmer or equal, switch controlled		1/yr
L7045		Electronic hook, child, Michigan or equal, switch controlled		1/yr
L7170		Electronic elbow, Hosmer or equal, switch controlled		1/yr
L7180		Electronic elbow, Boston, Utah or equal, myoelectronically controlled		1/yr
L7185		Electronic elbow, Variety Village or equal, switch controlled		1/yr
L7186		Electronic elbow, child, variety village or equal, switch controlled		2/yr
L7190		Electronic elbow, Variety Village or equal, myoelectronically controlled		2/yr
L7191		Electronic elbow, child, variety village or equal, myoelectronically controlled		2/yr
L7260		Electronic wrist rotator, Otto Bock or equal		2/yr
L7261		Electronic wrist rotator, for Utah arm		2/yr
L7360		Six Volt Battery, Otto Bock Or Equal, Each		1/yr

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
L7362		Battery Charger, Six Volt, Otto Bock Or Equal		1/yr
L7364		Twelve Volt Battery, Utah Or Equal, Each		1/yr
L7366		Battery charger, twelve volt, Utah or equal		1/yr
L7367		Lithium Ion Battery, Replacement		2/yr
L7368		Lithium Ion Battery Charger		1/yr
L7400		Addition To Upper Extremity Prothesis, Below Elbow/Wrist Disarticulation, Ultralight Material (Titanium, Carbon Fiber Or Equal		2/yr
L7403		Addition To Upper Extremity Prothesis, Below Elbow/Wrist Disarticulation, Acrylic Material		2/yr
L7499		Upper extremity prosthesis, not otherwise specified		2/yr
L7500		Repair of prosthetic device, hourly rate (Excludes V5335 repair of oral or laryngeal prosthesis or Artificial larynx)		8/yr
L7510		Repair Of Prosthetic Device, Repair Or Replace Minor Parts		8/yr
L7520		Repair Prosthetic Device, Labor Component, Per 15 Minutes		8/yr
L8000		Breast Prosthesis, Mastectomy Bra		6/yr
L8015		External Breast Prosthesis Garment, With Mastectomy Form, Post Mastectomy		2/yr
L8020		Breast Prosthesis, Mastectomy Form		2/yr
L8030		Breast Prosthesis, Silicone Or Equal		2/yr
L8035		Custom Breast Prosthesis, Post Mastectomy, Molded To Patient Model		2/yr
L8039		Breast Prosthesis, Not Otherwise Specified		2/yr
L8300		Truss, single, with standard pad		1/yr
L8310		Truss, double, with standard pads		1/yr
L8320		Truss, addition to standard pad, water pad		1/yr
L8330		Truss, addition to standard pad, scrotal pad		1/yr
L8400*		Prosthetic sheath, below knee, each		12/yr
L8400***		Prosthetic Sheath, Below Knee, Each		12/yr
L8410*		Prosthetic Sheath, Above Knee, Each		12/yr
L8410***		Prosthetic Sheath, Above Knee, Each		12/YR
L8415		Prosthetic sheath, Wool, upper limb, each		12/yr
L8417		Prosthetic Sheath/Sock, Including A Gel Cushion Layer, Below Knee Or Above Knee, Each		12/yr
L8420***		Prosthetic Sock, Multiple Ply, Below Knee, Each		12/yr
L8430***		Prosthetic Sock, Multiple Ply, Above Knee, Each		12/yr
L8435		Prosthetic Sock, Multiple Ply, Upper Limb, Each		12/yr
L8440***		Prosthetic Shrinker, Below Knee, Each		12/yr
L8460***		Prosthetic Shrinker, Above Knee, Each		2/yr
L8465		Prosthetic Shrinker, Upper Limb, Each		2/yr
L8470***		Prosthetic Sock, Single Ply, Fitting, Below Knee, Each		12/yr
L8480***		Prosthetic Sock, Single Ply, Fitting, Above Knee, Each		12/yr
L8485		Prosthetic Sock, Single Ply, Fitting, Upper Limb, Each		12/yr
L8501		Tracheostomy Speaking Valve		1/yr
S5498		Home Infusion Therapy (HIT),Catheter Care/Maintenance, Single (Single Lumen), Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day

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Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
S5501		HIT, Catheter Care/Maintenance, Complex (More Than One Lumen), Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S5520		HIT, All Supplies (Including Catheter) Necessary For Peripherally Inserted Central Venous Catheter (PICC) Line Insertion		5/mo
S5521		HIT, All Supplies (Including Catheter) Necessary For Midline Catheter Insertion		5/mo
S8189		Tracheostomy Supply , Not Otherwise Classified (Ex. Custom Specialty Trach)	X	N/A
S8270		Enuresis Alarm		1/5 yrs
S8999		Resuscitation Bag (For Use By Patients On Artificial Respiration During Power Failure Or Other Catastrophic Event)		2/yr
S9326		HIT, Continuous (24 Hours Or More) Pain Management Infusion, Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9330		HIT, Continuous (24 Hours Or More) Chemotherapy Infusion, Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9336		HIT, Continuous Anticoagulant Infusion,(E.G. , Heparin) Includes Administration Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9347		HIT, Uninterrupted, Long Term, Controlled Rate Intravenous Or Subcutaneous Infusion Therapy (E.G. Epoprostenol), Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9351		HIT, Continuous Or Intermittent Anti-Emetic Infusion Therapy; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9373		HIT, Hydration; Once Every 6 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9379		HIT, Infusion Therapy; Not Otherwise Classified; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately) Anticipating That New Infusion Therapies Will Be Developed Or That A Current Therapy Has Been Overlooked, The Ltc Medical And Quality Review Unit Will Consider Authorization Of Other Therapies On An Individual Basis. These Special Requests Will Require Peer Reviewed Medical Literature Documentation And Review By Medicaid's Medical Director	X	1/day
S9490		HIT, Corticosteroid Infusion; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9500		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 24 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9501		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 12 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day

Procedure Code	Modifier	Procedure Code Description	Requires PA	Benefit Limit
S9502		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 8 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9503		HIT, Antibiotic, Antviral, Or Antifungal; Once Every 6 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
S9504		HIT, Antibiotic, Antviral, Or Antifungal Therapy; Once Every 4 Hours; Includes Administrative Services, Professional Pharmacy Services, Care Coordination, And All Necessary Supplies And Equipment (Drugs And Nursing Visits Coded Separately)		1/day
T4521		Adult Sized Disposable Incontinence Product, Brief/ Diaper Small, Each	X	180/mo
T4522		Adult Sized Disposable Incontinence Product, Brief/Diaper Medium, Each	X	180/mo
T4523		Adult Sized Disposable Incontinence Product, Brief/Diaper Large, Each	X	150/mo
T4524		Adult Sized Disposable Incontinence Product, Brief/Diaper Extra Large, Each	X	150/mo
T4529		Pediatric Sized Disposable Incontinence Product ,Brief/Diaper Small/Medium Size, Each	X	210/mo
T4530		Pediatric Sized Disposable Incontinence Product, Brief/Diaper, Large Size, Each	X	210/mo
V5336		Repair/Modification Of Augmentative Communicative System Or Device (Excludes Adaptive Hearing Aid)	X	1/yr
Call The Automated Voice Response System (AVRS) 1-800-727-7848 For Current Reimbursement Amounts				

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Alabama Medicaid Glossary of Terms

A

ACSW	Academy of Certified Social Workers
ADA	Americans with Disabilities Act, also American Dental Association
ADM	Alcohol, drug or mental disorder
ADS	Alternative delivery system
AEAC	Alabama Estimated Acquisition Cost
AEIS	Alabama's Early Intervention System
AEVCS	Automated Eligibility Verification and Claims Submission System
AFDC	Aid to Families with Dependent Children
AHA	American Hospital Association
AHC	Alternative health care
AMA	American Medical Association
ARC	Adjustment Reason Code
AWP	Average wholesale price
Absent Parent	A parent who is responsible for child's medical payments that Medicaid locates. Used in Third Party Liability.
Access	A patient's ability to obtain medical care. The ease of access is determined by components such as the availability of medical services and their accessibility to the patient, the location of health care facilities, transportation, hours of operation and cost of care.
Accounts Payable	Money that Medicaid should pay out
Accounts Receivable	Money owed to Medicaid
Adjudication	The process of determining whether a claim (credit or adjustment) is to be paid
Adjustment Reason Code	Codes used to explain the basis for a denial, reduction, or increase in payment for a service.
Adjustments	Changes made on a paid claim to correct an input or payment error. Adjusted claims receive a new internal claim number that begins with 50 and references the original claim.
Administrative costs	The costs incurred by a carrier such as an insurance company or HMO for administrative services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per member per month basis.
Admits	The number of admissions to a hospital or inpatient facility
Alabama Estimated Acquisition Cost	The Average Acquisition Cost (AAC) of a drug or, in cases where no AAC is available, the Wholesale Acquisition Cost (WAC) + 9.2%.
Alabama Medicaid Management Information System (AMMIS)	The automated system used to process Medicaid claims and support program administration

Alcoholism	A primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.
Allowable costs	Charges for services rendered or supplies furnished by a health provider which qualify as covered expenses
Alternative care	Medical care received in lieu of inpatient hospitalization. Examples include outpatient surgery, home health care and skilled nursing facility care. Also may refer to nontraditional care delivered by providers such as midwives.
American Medical Association	A doctor's group which endorses the development of practice parameters. The AMA's directory of practice parameters includes 1,600 listings of guidelines ranging from prenatal diagnoses to decisions near the end of life.
American National Standards Institute (ANSI) Standards Board	The American National Standards Institute (ANSI) Standards Board coordinates the U.S. voluntary standards system that develops standards for electronic interchange.
Ancillary	A term used to describe additional services performed related to care, such as lab work, x-ray and anesthesia.
Ancillary charge	The fee associated with additional services performed prior to and/or secondary to a significant procedure, such as lab work, x-ray, and anesthesia. Also, a charge in addition to the copayment and deductible amount which the covered person is required to pay to a participating pharmacy for a prescription which, through the request of the covered person or participating prescriber, has been dispensed in non conformance with the plan's maximum allowable cost (MAC) list.
Ancillary services	Health care services conducted by providers other than primary care physicians.
Appeal	A formal request by a covered person or provider for reconsideration of a decision, such as a utilization review recommendation, a benefit payment or an administrative action, with the goal of finding a mutually acceptable solution
Attending Physician/Attending Provider	The physician rendering the major portion of care or having primary responsibility for care of the major condition or diagnosis
Audit	A system check for history validation, comparing a claim to other claims in the client’s file. The system reviews the client’s history and looks for “red flags” — two claims for the same service on the same date, a claim in excess of limitation, expired eligibility, etc. Audits may result in a claim being manually reviewed to determine if a suspended claim should be paid or denied.
Audit Trail	Record of actions performed. In systems operations, it is a record of database updates.
Automated Eligibility Verification and Claims Submission System	This system performs basic edits on claims to ensure data integrity before the claim enters the adjudication cycle.

Automated Voice Response System (AVRS)	The automated voice information system available 24 hours a day to Medicaid providers for inquiries of recipient eligibility, lock-in, other insurance, last check information, National Drug Code (NDC) information, procedure code pricing, claim statistics, and PA information.

B

BAY Health Plan	A full-risk HMO operating in Mobile county (This program was terminated effective 10/1/99)
BCBS	Blue Cross/Blue Shield
Beneficiary	A person designated by an insuring organization as eligible to receive insurance benefits
Benefits	Amount payable by an insurance company to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy or the available coverage under an insurance plan
Billed claims	The fees or costs for health care services provided to a covered person submitted by a health care provider
Billing Provider	Provider submitting claim and receiving payment
Blue Cross/Blue Shield (BCBS)	A non-profit commercial insurer designed to cover consumers for medical expenses, regardless of risk
Board certified	A physician who had passed an examination given by a medical specialty board and who has been certified as a specialist in that medical area
Board eligible	A physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training, and practiced for a specified amount of time.
Bulletin Board System (BBS)	An electronic medium for posting information. Providers transmit claims in batches to the BBS using Provider Electronic Solutions Software, or vendor supplied software, when performing electronic claims submission.
Buy-in	A monthly premium payment made by the State to the Social Security Administration to enroll eligible clients in Medicare Part B program as a cost-saving measure

C

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT (Current Procedural Terminology) Code	Code used to determine procedures on claim forms, taken from the CPT - 4 Manual, an American Medical Association (AMA) approved listing of medical terms and identifying codes for reporting medical services and procedures performed by providers
Calendar year	The period of time from January 1 of any year through December 31 of the same year, inclusive. Most often used in connection with deductible amount provisions of major medical plans providing benefits for expenses incurred within the calendar year. Also found in provisions outlining benefits in basic hospital, surgical, and medical plans.

Capitation	Method of payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.
Capitation rates	Payment for health services in which a physician or hospital is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided to each person
Carrier	The CMS-designated statewide or regional contractor responsible for Medicare Part B claims administration. Also used generically to refer to private third party payers.
Case management	Planned approach to manage service or treatment to an individual with a serious medical problem. Its dual goal is to contain costs and promote more effective intervention to meet patient needs. Often referred to as large case management. Nurses are often case managers.
Case manager	An experienced professional (such as a nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health
Chronic Stable Medical Condition	A condition that has persisted over six months and clinical documentation supports that there has been no significant changes in the past 60 days or in the 60 day period prior to admission.
Civilian Health and Medical Program of Uniformed Services.	The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a federal program providing cost-sharing health benefits for dependents and survivors of active duty personnel and for retirees and their dependents and survivors
Claim	A request for payment for services rendered on a standardized form or electronic record
Claims	Demands to the insurer by or on behalf of an insured person for the payment of benefits under a policy. Information submitted by a provider or a covered person to establish that medical services were provided to a covered person from which processing for payment to the provider or covered person is made. The term generally refers to the liability for health care services received by covered persons.
CMS	Center for Medicare and Medicaid services
Coinsurance	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Often coinsurance applies after first meeting a deductible requirement. Also referred to as a copayment.
Consolidated Omnibus Budget Reconciliation Act	A Federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated

Copayment	Portion of incurred medical expenses, usually a fixed percentage, that the patient must pay out-of-pocket. Also referred to as a coinsurance. A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital service. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered. Also called copay.
Cost Effectiveness	A State-run process that determines if paying insurance premiums for a client is less expensive than paying straight Medicaid payments. Medicaid buys insurance coverage for a client when premiums are cheaper than medical costs.
Cost sharing	When there is no financial risk involved, consumers have no incentive to seek the most cost-effective health care. However, for cost sharing methods to be beneficial they must be strong enough for people to conserve, without discouraging them from getting care. Copays and deductibles are examples of cost-sharing methods.
Crossover Claim	Claim for which both Medicare and Medicaid are liable to pay for services rendered to a client entitled to benefits under both programs
Current Procedural Terminology (CPT)	Set of five-digit codes describing medical services delivered that are used for billing by professional providers

D

DME	Durable Medical Equipment
DO	Doctor of osteopathy
DOB	Date of birth
DOS	Date of service
DRG	Diagnosis related group
DSH	Disproportionate Share Hospital Payments
DUR	Drug Utilization Review
DUR Review Board	Agent or unit of the State responsible for Drug Utilization Review activities, such as reviewing clients and providers whose prescriptions set a large number of DUR alerts when pharmacists use the POS system. The board also determines and alerts the HP pharmacist when updates to DUR criteria are necessary.
Date of Service	The date on which health care services were provided to the covered person
Deductible	Amount of covered expenses that must be incurred and paid by an insured person before benefits become payable by the insurer
Deferred compensation administrator (DCA)	A company that provides services through retirement planning administration, third party administration, self-insured plans, compensation planning, salary survey administration and workers compensation claims administration
Denial of payment	When services are deemed to be inappropriate, unnecessary, or of poor quality, payment may be denied. The insurer or payer will not pay for services that do not conform to benefit standards.

Dependent	An individual who relies on an employee for support or obtains health coverage through a spouse, parent or grandparent who is the covered person. See also eligible dependent and member.
Diagnosis	The identification of a disease or condition through analysis and examination
Diagnosis-related group (DRG)	System of determining specific reimbursement fees based on the medical diagnosis of a patient. System of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.
Disability	Any condition that results in function limitations that interferes with an individual's ability to perform their customary work and which results in substantial limitation in one or more major life activities
Dispensing Fees	Fees set, and periodically reviewed for fairness, by Medicaid. These fees are set considering such factors as inflation and fee studies or surveys. When deemed appropriate by Medicaid, these fees may be adjusted.
Dual diagnosis	Coexistence of more than one disorder in an individual patient. Commonly refers to a patient who is diagnosed with mental illness in conjunction with substance abuse.
Durable Medical Equipment (DME)	Medical equipment that • can withstand repeated use • generally is not useful to a person in the absence of an illness or injury • generally is not useful to a person in the absence of an illness or injury • is appropriate for use in the home Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

E

ECS	Electronic Claims Submission
EFT	Electronic funds transfer
EOB (Explanation of Benefits) Code	Code(s) appearing on the provider's EOP to let them know what action is taken on claims
EOMB	Explanation of Medicare benefits
EOP	Explanation of payment
EOP Message	Message appearing on the top of the remittance advice mailed to providers to address issues and provide information
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Medicaid program for children (until age 21), covering any medically necessary service allowable under Medicaid regulations

Edit	A system run data verification. When the system processes a claim, it runs edits to verify that data on the claim is correct. Examples of edits include: • Match of RID and recipient name • Match of provider name and number
Electronic Claims Submission	A form of electronic submission of claims for services rendered. ECS is the most efficient and effective means of processing claims, ensuring swift adjudication and payment to providers.
Eligibility date	The defined date a covered person becomes eligible for benefits under an existing contract

F

FFS	Fee for service
FQHC	Federally Qualified Health Clinic
Fee-for-service	Method of payment for provider services based on each visit or service rendered
Fee-for-service reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment based on billed charges for each service provided
Frequency	The number of times a service was provided

G

GUI	Graphical user interface
Gatekeeper model	A situation in which a primary medical physician, the "gatekeeper" serves as the patient's initial contact for medical care and referrals.
Gatekeepers	Primary medical providers (PMP) are usually the gatekeepers. Role description of the PCP in HMOs who coordinate services and referral of enrollees.
Generic drug	A generic drug is one that has the identical makeup as a brand name drug. A generic is typically less expensive and sold under a common or "generic" name for that drug; for instance, the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.
Generic equivalent	See generic drug.
Generic substitution	Dispensing a generic drug in place of a brand name medication. Substitution guidelines are defined by state regulations.
Graphical user interface (GUI)	The visual interface that characterizes Microsoft Windows and the Macintosh.
Group Practice	Medical practice in which several physicians render and bill for services under a single provider number

H

HCFA	Health Care Financing Administration
HCFA Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies offered by physicians and other providers. HCPCS include CPT (Current Procedural Terminology) codes, national alphanumeric codes and local alphanumeric codes. The national codes are developed by HCFA to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy, and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit is a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.
HCPCS	HCFA Common Procedural Coding System
HHA	Home health agency
HHS	Department of Health and Human Services
HID	Health Information Designs
HIC	Health Insurance Claim Number
HIPC	Health insurance purchasing cooperative
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health maintenance organization
Health Care Financing Administration(HCFA)	A branch of the U.S. Department of Health and Human Services charged with oversight and financial management of government-related health care programs such as Medicare and Medicaid
Health Care Quality Improvement Act	This Act requires health care provider organizations and insurers to report malpractice cases that have been settled or lost. Created in 1986, malpractice suits and other related reference checks can be obtained through the National Practitioner Data Bank.
Health Information Designs (HID)	Organization that provides prior authorization for drugs requiring prior approval
Health Maintenance Organization (HMO)	Organization that provides for a wide range of comprehensive health care services for a specified group of enrollees for a fixed, periodic prepayment. There are several HMO models including: staff model, group model, IPA, and mixed (or network) model. Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO: An organized system for providing health care or otherwise assuring health care delivery in a geographic area, an agreed upon set of basic and supplemental health maintenance and treatment services, and a voluntarily enrolled group of people.
Home health agency (HHA)	A facility or program licensed, certified or otherwise authorized pursuant to state and federal laws to provide health care services in the home
HP	The fiscal agent for the Medicaid program
Home health services	Comprehensive, medically necessary range of health services provided by a recognized provider organization to a patient in the home
Hospice	Concept of care provided to terminally ill patients and their families that emphasizes emotional needs and coping with pain and death.

Hospital privileges	The approved means by which physicians can provide care to their patients who have been hospitalized. A physician without hospital privileges cannot treat patients or be reimbursed for services.
Hospital-based Physician	Physician having an arrangement with a hospital whereby they receive fees for services performed for that hospital

I/J

ICD-9-CM	International Classification of Disease, Ninth Edition, Clinical Modification. A listing used by providers in coding diagnosis on claims.
ICF	Intermediate care facility
IDT	Interdisciplinary team
ICN (Internal Control Number)	The number assigned to each Medicaid claim that allows tracking in the system. The ICN indicates when the claim was received and whether it was sent by paper or electronic media.
IFSP	Individualized Family Service Plan
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function such as hearing loss
Inpatient	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours
Intermediate care facility (ICF)	A facility providing a level of care that is less than the degree of care and treatment that a hospital or skilled nursing facility (SNF) is designed to provide, but greater than the level of room and board
International classification of diseases	The International classification of diseases, 9th Edition (Clinical Modification) (ICD-9-CM) is a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.
Julian Date	Chronological date of the year, 001 through 365 or 366, preceded by a two-digit year designation. Example: 93321 is the 321st day of the 93rd year

K/L

LCSW	Licensed clinical social worker
Local Code(s)	A generic term for code values that are defined for a state or other political subdivision, or for a specific payer.
Lock-in	The term used to describe the status of a recipient who may be potentially overusing or misusing Medicaid services and benefits. The recipient is locked in to one physician and/or pharmacy to receive services.
LOS	Length of stay
Length of stay (LOS)	The number of days that a covered person stayed in an inpatient facility
Long Term Care Facility	A nursing facility that provides 24-hour nursing care

Long Term Care	Care that must be provided over a long period of time. Elderly people tend to need long-term care. Nursing home care is a type of long-term care. The goal of Long Term Care is to help people with disabilities be as independent as possible. A person who requires help with the activities of daily living (ADLs) or who suffers from cognitive impairment needs long Term Care.

M

MAC	Maximum allowable cost
MH/CD	Mental health/chemical dependent
MH/SA	Mental health/substance abuse
MMIS	Medicaid Management Information Systems
MSW	Masters in social work
Managed care	The coordination of financing and provision of health care to produce high quality health care for the lowest possible cost
Medicaid	A state-run program, with matching federal funds, for public assistance to persons, regardless of age, whose income and resources are insufficient to pay for health care
Medicaid eligible	Recipients in the Alabama Medicaid program. Medicaid reimburses for services rendered while the recipient is eligible for Medicaid benefits.
Medical necessity	Term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted clinical standards
Medical supplies	Items which, due to their therapeutic or diagnostic characteristics are essential in carrying out the care which the physician has ordered for the treatment of the patient's illness or injury. Examples of medical supplies are catheters, needles, syringes, surgical dressings and materials used for dressings, irrigating solutions and intravenous fluids.
Medicare	Federally sponsored program under the Social Security Act that provides hospital benefits, supplementary medical care, and catastrophic coverage to persons age 65 years and older. Includes some younger people who are covered under social security benefits. Medicare covers two parts: Medicare Part A-Covers hospitalization and inpatient costs. Medicare Part B-Covers physician services, ancillary services and outpatient costs.
Mental Health provider	A psychiatrist, licensed consulting psychiatrist, social worker, hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received
Mental health services	Behavioral health care services that may be provided on an inpatient, outpatient, or partial hospitalization basis
Morbidity	An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons

N

NCPDP	National Council of Prescription Drug Programs
NDC	National Drug Code
NHIC	National Heritage Insurance Company
National Council for Prescription Drug Programs Standards	Pharmacy claim telecommunications standards that dictate the order and content of the fields relayed to the pharmacist when the system generates a DUR alert
National drug code (NDC)	A national classification for identification of drugs. Similar to the Universal Product Code (UPC).
National Provider Identifier (NPI)	A 10-digit identification number for healthcare providers.
Non-participating provider (non-par)	A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care
Noncovered Services	(1) Services not medically necessary; (2) Services provided for the personal convenience of the client; or (3) Services not covered under the Medicaid Program.
Non-emergency Transportation (NET) Program	Program that provides necessary non-ambulance transportation services to Medicaid recipients

O

OBRA 90	Federal law directing how federal monies are to be expended
OLTP	On-line transaction processing
OSCAR	Online Survey Certification and Reporting
OSHA	Occupational Safety and Health Administration
OTC	Over-the-counter
Omnibus Budget Reconciliation Act (OBRA)	This Act granted states greater flexibility in structuring managed care arrangements for Medicaid beneficiaries. Also, up to 75 percent of enrollees in an HMO can be a part of Medicaid or Medicare. Waivers of the freedom-of-choice provisions of the Social Security Act permitted states to establish primary care case management and to select Medicaid providers according to their cost-effectiveness.
Optical character recognition (OCR)	A process that recognizes typewritten and handwritten characters by matching them against character templates. Paper claims submitted to HP are scanned using OCR to enter the data on those claims into the system.
Outpatient	A person who receives health care services without being admitted to a hospital
Over-the-counter (OTC) drug	A drug product that is available to the public without a prescription; however, Medicaid reimbursement requires a prescription.
Override	A code to bypass specific edits or audits
Overutilization	Term used to describe inappropriate or excessive use of medical services that add to health care costs

P

PA Criteria	Criteria that must be present for Medicaid to approve a PA request
PA Denial	A denial of a prior authorization because the services requested by the provider are non-covered services, or non-medically justifiable
Patient 1st	A statewide (with the exception of Mobile county) Primary Care Case Management (PCCM) system
PACE	Program of All-Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PES	Provider Electronic Solutions software used by providers to submit claims electronically
PRO	Professional (or peer) review organization
Paid claims	The amounts paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any covered person liability for ineligible charges or for deductibles or copayments. If the carrier has preferred payment contracts with providers such as fee schedules or capitation arrangements, lower paid claims liability will usually result.
Participating provider	A provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility, or a physician who has contractually accepted the terms and conditions as set forth by the health plan.
Pay and Chase	A situation where Medicaid pays a claim, knowing that a third party is probably responsible for the payment, then tries to recover the money. Also referred to as postpayment.
Peer review organization(PRO)	An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates and reducing lengths of stay while insuring against inadequate treatment. Also known as professional standards review organization.
Per diem	Literally, per day. Term that is applied to determining costs for a day of care and is an average that does not reflect true cost for each patient.
Pharmaceutical services	Pharmacy management programs help to monitor and control the utilization and cost of prescription drugs. These programs also help with the collection and interpretation of information about the prescribing habits of physicians.
Pharmacy and Therapeutics Committee	An organized panel of physicians from varying practice specialties, who function as an advisory panel to the plan regarding the safe and effective use of prescription medications. Often comprises the official organizational line of communication between the medical and pharmacy components of the health plan. A major function of such a committee is to develop, manage, and administer a drug formulary.
Physician	Any doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received or as defined in the summary plan description

Physician's Current Procedural Terminology	A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.
Place of service	The location where health services are rendered, such as office, home, or hospital
PMPM	Per member per month
Point of sale (POS) device	Enables the real time electronic transfer of information between two places; the user keys information into the POS device and perhaps swipes a card with a magnetic strip through the device
Prescription medication	A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician
Prevailing charges	Amounts charged by health care providers that are consistent with charges from similar providers for identical or similar services in a given locale
Preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care
Preventive services	Wellness and health promotion services that are part of the basic benefits package of a managed health care plan
Primary Medical Provider (PMP)	Primary deliverers and managers of health care, central to providing appropriate health care. The PMP provides basis care to the enrollee, initiates referrals to specialists, and provides follow-up care. Usually defined as a physician practicing in such areas as internal medicine, family practice, and pediatrics, although an obstetrician/gynecologist may be considered a primary medical physician.
Principal diagnosis	The condition established after study to be mainly responsible for the patient's need for health care services from a provider. Commonly refers to the condition most responsible for a patient's admission to the hospital.
Prior Authorization	Approval provided by Medicaid for specified services for a specific recipient to a specific provider, or the process of obtaining prior approval as to the appropriateness of the service or medication. Prior authorization does not guarantee coverage.
Private Duty Nurse	Service covered by Medicaid that provides hourly nursing care in a home setting
Prospective DUR	Required at the point of sale or distribution before each prescription is filled or delivered to a Medicaid recipient. It must include the screening, patient counseling, and patient profiles.
Provider	Any health care professional enrolled with the Medicaid agency who provides or is eligible to provide a covered service to a Medicaid recipient
Provider Assistance Center (PAC)	This center answers your questions about claim status, eligibility, or other claims-related issues
Provider networks	Groups of physicians, or hospitals, who provide health care to enrollees. Some large employers are establishing their own provider networks to ensure their employees a choice.

Provider	A physician, hospital, group practice, nursing home, pharmacy, or any individual group of individuals that provides a health care service
Providers	Medical professionals and service organizations that provide health care services

Q/R

QA	Quality assurance
QMB	Qualified Medicare beneficiary
Qualified Medicare beneficiary (QMB)	A Part A Medicare beneficiary whose verified income does not exceed certain levels. Income may not exceed 100 percent of the federal poverty level plus $20.
Quality assurance (QA)	A set of activities that measures the characteristics of health care services and may include corrective measures
Remittance Advice Code (RAC)	National code set for providing either claim-level or service-level related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice EDI transaction.
R&C	Reasonable and customary
Recipient	Person eligible to receive Medicaid covered services
Recipient Aid Categories	Categories assigned to a recipient used to assign benefits
Recipient Identification Number (RID)	A unique 13-digit number that identifies a Medicaid recipient
Recoupments	Reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills to offset overpayments previously made to the provider. Also, payment made directly to Medicaid by a provider as a settlement for overpayment.
Referral	Primary care provider-directed transfer of a patient to a specialty physician or specialty care
Referral provider	A provider that renders a service to a patient who has been sent to the referral provider by a participating provider in the health plan
Remittance Advice	Notice advising Medicaid providers on claim status (paid, denied, returned, or suspended). This is available on the provider web portal after each checkwrite.

S

SNF	Skilled nursing facility
SSI	Social Security Income
Skilled nursing facilities	Institution providing the degree of medical care required from, or under the supervision of, a registered nurse or physician
Social Security Act	Law under which the federal government operates the Old Age, Survivors, Disability, and Health Insurance Program (OSDHI). Includes Medicare and Medicaid.
Specialty	Specialized area of practice for a provider
Specialty HMOs	Those group practices and organizations of providers who contract with managed care organizations to provide non-primary care medical services

Specialty services	Services that are outside of the realm of general practice
Subrogation	A procedure under which an insurance company can recover from third parties the full or some proportionate part of benefits paid to an insured. For example, should a claim and who has received benefits under a state's statutory plan covering disability benefits enter into litigation to make claims against a third parts, the insurance carrier has a right to place a lien against any benefit the third action party may provide.
Suspend	A claim status in which the claim must be reviewed. Claim type needing in-depth investigation to allow HP adjudicators and provider relations team members to work together to resolve the claim.

T

TPL	Third party liability
Third Party Liability (TPL)	A condition whereby a person or an organization other than the recipient or Medicaid is responsible for all, or some portion of the medical costs for health or medical services incurred by a Medicaid recipient (health or casualty insurance company, or another person in the case of an accident)
Third-party payer	A public or private organization that pays for or underwrites coverage for health care expenses of another entity, usually an employer. Examples of third-party payers are Blue Cross, Blue Shield, and Medicare.
Transaction	Exchange of information between two parties to carry out financial and administrative activities related to health care. Examples include health claims, health care payment, coordination of benefits, health claim status, enrollment or disenrollment, referrals, etc

U

U&C	Usual and customary
UB04	The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-04, requiring the hospitals to send additional itemized bills. The UB-04 replaced the UB-92 in 2008.
UCR	Usual, customary, and reasonable charge
UR	Utilization review
Underutilization	Underutilization is providing fewer services than are necessary for adequate levels of care
Uniform Billing Code of 1992 (UB-92)	A revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, which was implemented October 1, 1993.
Unstable Medical Condition (Long Term Care Admission Criteria)	One in which there is documentation of an episode of acute illness or exacerbation of a diagnosis which requires active treatment in the 60 days prior to the admission date. The provider must have supporting documentation of the acute illness or exacerbation and active treatment.

Usual and Customary Charges	Amount which a provider usually and most frequently charges patients for a specific service in normal medical circumstances
Usual, customary and reasonable (UCR)	See reasonable and customary
Usual, customary, and reasonable fees (UCR)	Charges of health care providers that is consistent with charges from similar providers for identical or similar services in a given locale.
Utilization Control Procedures	These procedures safeguard against unnecessary care and services (both under and over utilization), monitor quality, and ensure payments are appropriate according to the payment standards defined by Medicaid.
Utilization Review (UR)	Programs designed to reduce unnecessary medical services, both inpatient and out. URs may be prospective, retrospective, concurrent, or in relation to discharge planning.

V/W

Vaccines for Children (VCF)	Program that offers free vaccines to qualified health care providers for children 18 years of age and under who are Medicaid eligible, American Indian or Alaskan Native, uninsured, or under insured
Value Added Networks (VANs)	Networks that provide billing services on behalf of an Alabama Medicaid provider
Waiver	Term usually associated with the Medicare or Medicaid programs by which the government waives certain regulations or rules for a managed care or insurance program to operate in a certain geographic area.

X/Y/Z

X12	An ANSI-accredited group that defines EDI standards for many American industries, including health care insurance. Most of the electronic transaction standards proposed under HIPAA are X12 standards
X12 270	X12's Health Care Eligibility & Benefit Inquiry EDI transaction
X12 271	X12's Health Care Eligibility & Benefit Response EDI transaction
X12 276	X12's Health Care Claims Status Inquiry EDI transaction
X12 277	X12's Health Care Claim Status Response EDI transaction
X12 834	X12's Benefit Enrollment & Maintenance EDI transaction
X12 820	X12's Payment Order & Remittance Advice EDI transaction
X12 835	X12's Health Care Claim Payment & Remittance Advice EDI transaction
X12 278	The X12 Referral Certification and Authorization transaction
X12 837	The X12 Health Care Claim or Encounter transaction. This transaction can be used for institutional, professional, dental, or drug claims

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