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.

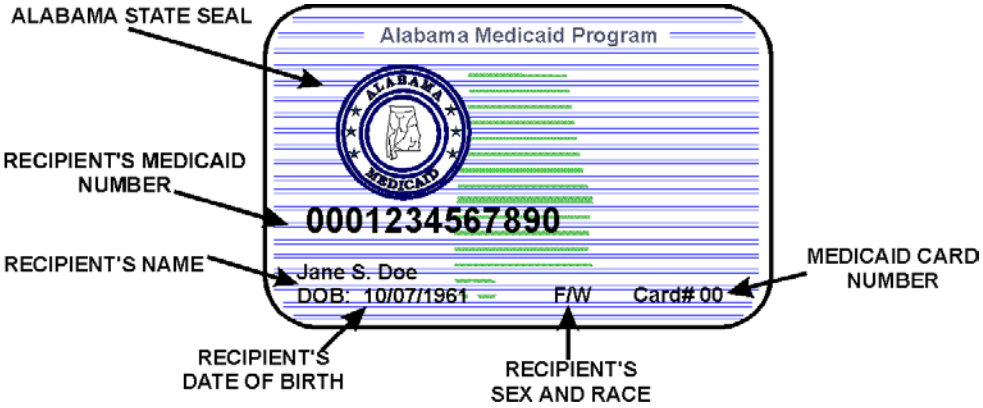
New recipients are issued permanent Medicaid cards within 10-14 working days of eligibility determination.

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:

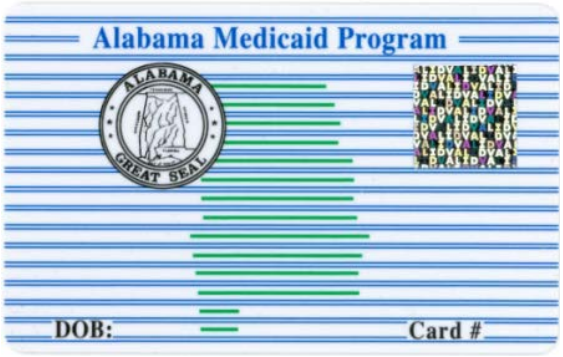


New Medicaid Cards to Contain a Security Hologram

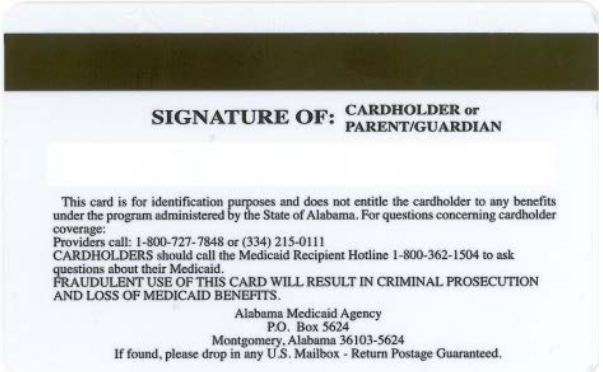
Beginning in June 2011, Medicaid cards will contain a hologram which will be located in the upper right corner. This hologram is designed to make card replication more difficult. New cards will only be issued upon recipient request. Medicaid IS NOT issuing new cards to all recipients.

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.