Manual Update Log January 2002

This table contains a listing of updates to the *Alabama Medicaid Provider Manual.* The table lists the affected section of the manual, a description of the update, the updated pages to insert, and affected pages to remove.

To update your paper copy of the manual, replace the pages listed in the column called "Remove old pages" with the change pages you receive in the mail accompanying this update log.

To request additional copes of the *Alabama Medicaid Provider Manual* update, contact the EDS Provider Assistance Center by calling 1-800-688-7989.

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

This online version already contains the updates in this log. 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.

Affected Chapter	***Description of Change***	***Remove old pages***	***Insert updated pages***
Table of Contents	**Replaced pages to Table of Contents**	i to xxiv	i to xxvi
Chapter 3 Verifying Recipient Eligibility	**Removed names from Section 3.3.6 Third Party Liability:** ~~Dolores Lucas, Pearl Brooks and Mary Knight~~	3- 17 to 3-18	3-17 to 3-18
Chapter 5 Filing Claims	**Replaced Entire Chapter**	5-1 to 5-36	5-1 to 5-34
Chapter 8 Ambulance (Ground & Air)	**Section 8.5.1 Time Limit For Filing Claims:** Deleted reference ~~5.1.4~~ Added reference 5.1.5 **Section 8.5.2 Diagnosis Codes Table - Covered Ambulance Diagnosis Codes:** Deleted duplicate value ~~777.9~~ Added asterisk (*) to 772.1 and E888 **Section 8.5.3 Procedure Codes and Modifiers - Procedure Codes for Basic Life Support:** Added to A0380 - (30 miles or more requires prior authorization) **Section 8.5.3 Procedure Codes and Modifiers - Procedure Codes for Advanced Life Support (ALS) Services:** Added to end of paragraph one: Documentation must support need for ALS services. Added Procedure code 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).	8-5 to 8-10	8-5 to 8-10

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Added to A0390 - (30 miles or more requires prior authorization) **Section 8.5.3 Procedure Codes and Modifiers - Procedure Codes Non-emergency Services:** Deleted duplicate verbiage from Procedure Code A0390 - ~~ALS mileage, per mile~~ **Section 8.5.3 Procedure Codes and Modifiers - Procedure Codes for Medicare Crossovers Only:** Moved Procedure Code A0434 to Section 8.5.3 Procedure Codes and Modifiers - Procedure Codes for Advanced Life Support (ALS) Services **Section 8.5.3 Procedure Codes and Modifiers - First Modifier: Second paragraph** Deleted ~~A0330~~; Added A0427 Deleted ~~A0030RH~~; Added A0427RH		
Chapter 10 Audiology/Hearing Services	**Section 10.1 Enrollment:** Deleted verbiage from Section 10.1 Enrollment - Enrollment Policy for Audiology Providers: ~~Self-employed audiologists must also posses a Certificate of Accreditation for their facility.~~ Deleted last bullet from Section 10.1 Enrollment - Enrollment Policy for Audiology Providers: ~~Copy of facility Certificate of Accreditation (for self-employed audiologists only)~~	10-1 to 10-2	10-1 to 10-2
Chapter 13 Dentist	**Replaced Entire Chapter**	13-1 to 13-18	13-1 to 13-18
Chapter 14 Durable Medical Equipment (DME)	**Section 14.2.2 Durable Medical Equipment:** Added Note to end of section - Blood Glucose Test or Reagent Strips and Lancets (A4253, A4259): Effective November 1, 2000, Durable Medical Equipment (DME) Providers of diabetic equipment and supplies who can provide mail order services are allowed to provide these supplies statewide. Medicaid's current policy only allows DME providers to provide equipment, supplies and appliances to recipients living in adjoining counties. This policy will still apply for all services provided with the exception of the diabetic equipment and supplies. These services may be provided by any enrolled Medicaid DME provider offering mail order services of diabetic equipment and supplies. These providers will also offer free replacement of non-functioning diabetic glucose monitors. This updated policy will ensure that all elderly or disabled recipients who are in need of diabetic supplies, and are without any means of transportation will have adequate access to them. Added to heading in section - Hospital Bed/Mattress/Bed Side Rails (E0250, E0255): K0456 Added paragraph to end of section - Hospital Bed/Mattress/Bed Side Rails (E0250, E0255): Effective August 1, 2001, Medicaid will begin coverage of Semi-Electric Extra Heavy Duty Hospital	14-5 to 14-8 14-15 to 14-16 14-19 to 14-30 14-35 to 14-36	14-5 to 14-8 14-15 to 14-16 14-19 to 14-30 14-35 to 14-36

Affected Chapter	Description of Change	Remove old pages	Insert updated pages
	Beds to accommodate recipients who weigh more than 350 pounds, but less than or equal to 600 pounds. Medicaid will cover these semi-electric beds using Medicare's procedure code K0456 (Hospital bed, heavy duty, extra wide, semi-electric [head and foot adjustment] with any type rails, with mattress). Medicaid will use the established prior authorization criteria for the hospital beds, but will add the weight, width and length requirements. Individuals approved for this bed must be fitted and measured by the Durable Medical Equipment Company providing these services. Added third paragraph to section - Wheelchairs: Effective October 1, 2000, Medicaid began reimbursing Durable Medical Equipment providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. Medicaid covers these wheel-chairs as a purchase by using Medicare's procedure code K0007. Added to heading in section - Low Pressure and Positioning Equalization Pad for Wheelchair (E0192): K0108 Added third paragraph to section Low Pressure and Positioning Equalization Pad for Wheelchair (E0192): Effective October 1, 2000, Medicaid also began reimbursing 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. Added Note following third paragraph to section Low Pressure and Positioning Equalization Pad for Wheelchair (E0192): 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. Added to last paragraph in section - Apnea Monitor (E0608): 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.		

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	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. **Section 14.5.1 Time Limit for Filing Claims:** Deleted reference ~~5.1.4~~; Added reference 5.1.5 **Section 14.5.3 Procedure Codes and Modifiers:** Added Procedure Code to section - Hospital Beds: K0456 - Hospital bed heavy duty, extra wide, semi-electric (head and foot adjustments) with any type rails, with mattress. Added Procedure Code to section - EPSDT Referral Services: K0456 - Hospital bed heavy duty, extra wide, semi-electric (head and foot adjustments) with any type rails, with mattress.		
Chapter 15 Eye Care Services	**Section 15.3 Prior Authorization and Referral Requirements:** Added Procedure Code to Patient 1st Referral Requirements: Z5173 Changed descriptions in Table Patient 1st Referral Requirements: Eyeglasses **Section 15.5.3 Procedure Codes and Modifiers:** Updated section - Eyeglasses Codes - Women's Frames now reads: Z5273 - BI - 224 Limited Edition - 11.95 Z5321 - B - 216 - Limited Edition - 11.95	15-5 to 15-6 15-15 to 15-16	15-5 to 15-6 15-15 to 15-16

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
	Deleted ~~Z5290~~ Z5445 - LG6021 Z5446 - Marla Z5293 - IG-4 - Philip Optics - 12.95 Updated section - Eyeglasses Codes - Girl's Frames now reads: Z5160 - Mainstreet 415 - 12.50 Z5165 - IG-27 - Philip Optics - 11.70 Z5398 - IG-25 - Philips Optics - 11.70 Updated section - Eyeglasses Codes - Men's Frames now reads: Z5136 - Hart: Mainstreet 3025 Z5291 - Manchester Limited Edition - 11.95 Deleted ~~Z5168~~ Deleted ~~Z5198~~ Z5447 - Stinger Z5448 - Barry Z5170 - Uptown - 6.95 Updated section - Eyeglasses Codes - Boy's Frames now reads: Z5165 - Mainstreet 415 - 12.50 Z5136 - Mainstreet 302S Changed heading - Eyeglasses Codes - Unisex Frames for Men or Women to read: Unisex Frames for Men, Women, Boys, Girls Updated section - Eyeglasses Codes - Unisex Frames for Men, Women, Boys, Girls now reads: Z5198 - Boulevard 1104 - 8.95 Z5392 - Robby - 11.95 Deleted ~~Z5278~~ Z5443 - Ontario Z5444 - Stanford Z5290 - Oden - 11.95 Z5151 - Boulevard 4502 Z5152 - Boulevard 4508 Z5164 - Bella Italia 23 Limited Edition - 11.95 Z5193 - Boulevard 4509 Z5196 - Boulevard 4511 Z5197 - Boulevard 4517 Z5168 - Benji Limited Edition - 11.95 Deleted heading ~~Unisex Frames for Boys and Girls~~		
Chapter 16 Federally Qualified Health Centers (FQHC)	**Section 16.5.3 Procedure Codes and Modifiers**: Added note to section 16.5.3: PCT code 36415-Routine Venipuncture for Collection of Specimen. The provider providing the service and sending blood to an outside laboratory for processing must use Modifier 90.	16-7 to 16-10	16-7 to 16-10

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 18 Reimbursement for Physician Services	**Section 18.2.9 Reimbursement for Levels of Care:** Added Note to section - Nursing Facility Residents: 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. Deleted Verbiage from section - Medicare/Medicaid Eligibility: ~~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.~~ Added verbiage to section - Medicare/Medicaid Eligibility: 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.	18-7 to 18-8	18-7 to 18-8
Chapter 27 Pharmacy	**Section 27.2.4 Reimbursement for Covered Drugs:** Added verbiage to last paragraph in section - Multiple Source Drugs: Or faxed Changed verbiage in section - Dispensing Fees: From ~~34~~ to 30-day supply	27-5 to 27-6	27-5 to 27-6
Chapter 28 Physician	**Replaced Entire Chapter**	28-1 to 28-24	28-1 to 28-22
Chapter 30 Preventive Health Education	**Section 30.5.1 Time Limit for Filing Claims:** Deleted reference ~~5.1.4~~; Added reference 5.1.5 **Section 30.5.2 Diagnosis Codes:** Deleted ~~V220~~ Added V222 **Section 30.5.3 Procedure Codes and Modifiers:** Deleted ~~V220~~ Added V222 Deleted ~~Z5269~~ Added 99412	30-3 to 30-6	30-3 to 30-6
Chapter 32 Provider-Based Rural Health Clinics	**Section 32.5.1 Time Limit for Filing Claims:** Deleted reference ~~5.1.4~~; Added reference 5.1.5 **Section 32.5.3 Procedure Codes and Modifiers:** PCT code 36415 - Routine Venipuncture for Collection of Specimen The provider providing the service and sending the blood to an outside laboratory for processing must use Modifier 90.	32-5 to 32-6	32-5 to 32-6

Affected Chapter	*Description of Change*	*Remove old pages*	*Insert updated pages*
Chapter 33 Psychiatric Facilities for Individuals Under Age 21	**Replaced entire Section**	33-1 to 33-6	33-1 to 33-6
Chapter 35 Renal Dialysis Facility	**Section 35.5.1 Time Limit for Filing Claims:** Deleted reference ~~5.1.4~~; Added reference 5.1.5 **Section 35.5.3 Procedure Codes, Revenue Codes, and Modifiers** **Deleted Revenue Codes:** ~~829 - Z5256~~ ~~829 - Z5266~~	35-5 to 35-8	35-5 to 35-8
Chapter 36 Rural Health Clinics/Independent	**Replaced entire Section**	36-1 to 36-6	36-1 to 36-8
Appendix E Medicaid Forms	**Deleted the following forms from Section E:** ~~E.4 EPSDT Screening Referral Form~~ ~~E.9 Patient 1st EPSDT Referral Form~~ ~~E-10 Patient 1st Referral Form~~	E-5 to E-34	E-5 to E-30
Appendix H Alabama Medicaid Injectable Drug List	**Section H.2 Injectable Drug List by Name** Deleted the B in (DTaB-Hib) Added a P to read (DtaP-Hib) Deleted the following Procedure Codes: ~~90701~~ ~~90720~~ ~~90745~~ Procedure Code 90732: Added or immunosupressed patient.	H-7 to H-16	H-7 to H-16
Appendix J Provider Explanation of Benefits (EOB) Codes	**Section J.1 EOB Codes:** EOB Code 410 - This procedure is limited to ~~eighteen (18)~~ sixteen (16) units per calendar year Added EOB Code - 995 - Claim recouped. Provider must resubmit services on separate claims in order to be considered for payment by Medicaid. **Section J.2 Adjustment EOB Codes:** Added EOB Code - 875 - Inpatient days have been exceeded for this calendar year.	J-5 to J-10	J-5 to J-10
Appendix M Plan First	Deleted the words ~~Plan First~~: from the heading in Appendix M.	M-1 to M-2	M-1 to M-2

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Glossary

Index

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1

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 EDS to be the fiscal agent for the Medicaid program. Medicaid and EDS developed this manual for Medicaid providers. EDS is responsible for maintaining and distributing the manuals to the Alabama Medicaid provider community.

The EDS 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 EDS Provider Relations at the following address:

EDS Provider Relations
P.O. Box 244035
Montgomery, AL 36124
1 (800) 688-7989
e-mail: provrelations@alxix.hcg.eds.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 Explanation of Payment (EOP) 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, October 1999). 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

➢ Margin notes display like this.

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.state.al.us

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

Step 4 Click on Manuals. The Alabama Medicaid Manuals page displays.

Step 5 Click on Provider Manual. The Alabama Medicaid Provider Manual page displays.

Step 6 If your PC is not equipped with Acrobat Reader version 3.1 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 Provider Manual page.

If your PC is already equipped with Adobe Acrobat Reader version 3.1 or higher, you are ready to download the manual.

Step 7 Click on the appropriate Alabama Medicaid Provider Manual link.

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 8 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.

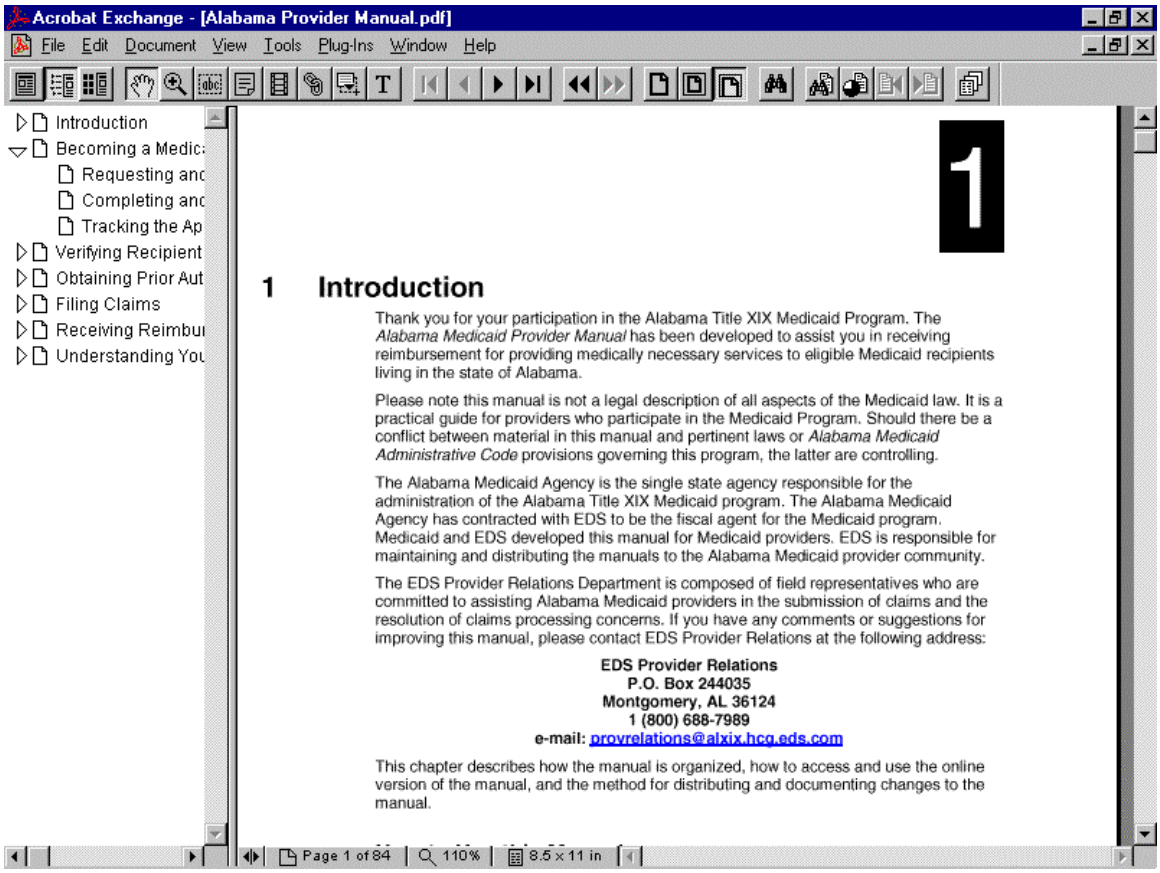
Customized Display Options

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 triangle displays next to the heading.

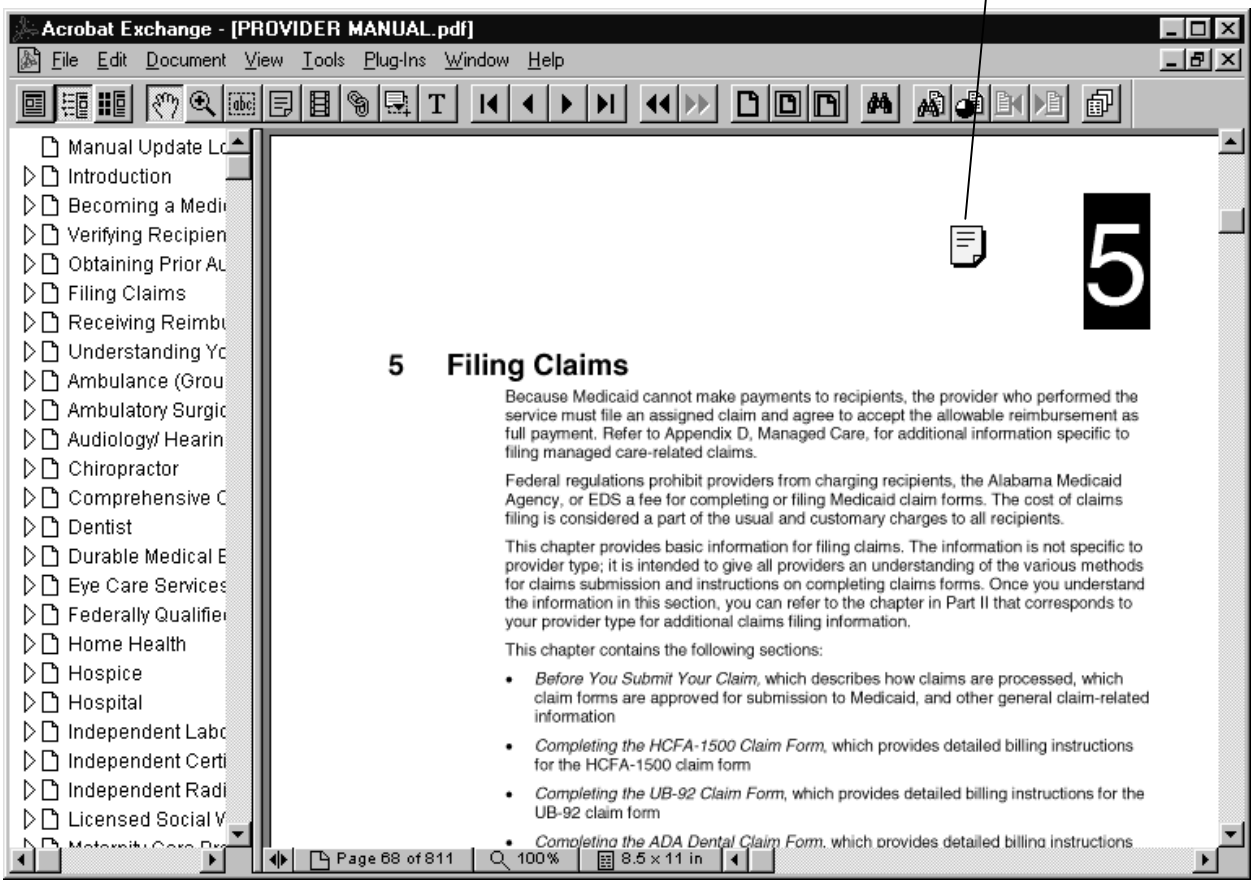


Simply click on the triangle to view all headings beneath that heading level. To jump to a particular section of the manual, click on the corresponding bookmark.

The online version of the manual also allows you to more thoroughly understand modifications to the provider manual. All updates are tracked in the update log, but are also indicated by the electronic notes feature.

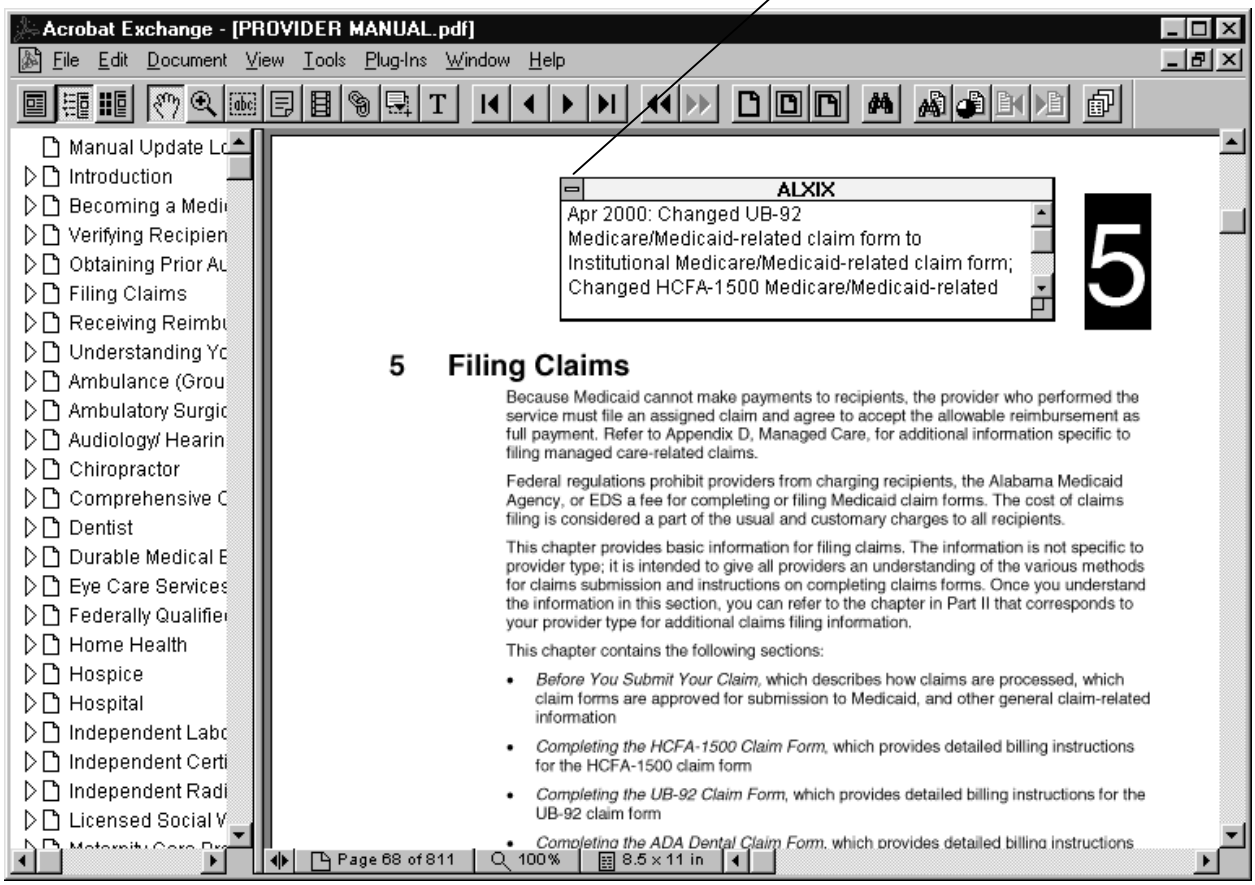
For example, a note displays on the updated page.

Double click on the note icon to display the note.



When you double click the note, the update displays.

Click on the bar to close the note.



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

The following Manual Update Log describes the updates and document pages that were added, modified, or deleted as a result of the updates. EDS 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.

Date	***Description of Updates***	***Pages Affected***
October 1999	Initial manual distribution	All pages

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

EDS 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, EDS receives and reviews all applications. Each application is approved, returned, or denied within five 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 request an application, where to send a completed application, 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 EDS 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 who are participating in a Residency Training program may enroll and receive a pseudo Medicaid license number that must be used on prescriptions issued to Medicaid recipients.

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 Requesting and Receiving 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 receives an individual provider number. If a group consists of more than one physician, each physician receives an individual provider number.

The EDS Provider Enrollment Department is responsible for supplying the application. To receive an application, providers may telephone, e-mail, or mail an application request to the address and phone number below:

EDS Provider Enrollment
P.O. Box 244035
Montgomery, AL 36124
1 (888) 223-3630
e-mail: enrollment@alxix.hcg.eds.com

EDS will send an application within two business days of receipt of the request.

NOTE:

You can download an application from the Alabama Medicaid Web site at **http://www.medicaid.state.al.us**. Follow the instructions provided in Section 1.2.1, Downloading the Online Manual. Both the online manual and the application are provided in Adobe® Acrobat™.

Effective October 1, 1999, Medicaid began using a new form for provider enrollment. It is important to file applications as soon as possible for new enrollments and changes in enrollment status. Physicians and other individual practitioners should no longer wait until they have obtained Medicare approval to file a Medicaid application. A Medicaid number will be assigned for use until the Medicare number is assigned.

2.2 Completing and Submitting the Application

Providers must complete the provider application and include any required attachments as directed in the accompanying instructions. Once the application is complete, providers should mail the application to EDS Provider Enrollment, at the address listed in Section 2.1, Requesting and Receiving an Application.

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

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

A Medicaid provider number is issued when EDS, based upon the qualifications set forth by Medicaid, determines that a provider qualifies for participation.

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

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

EDS tracks the status of each application as it moves from initial review to approval or denial. Upon receipt of the application, EDS date stamps the application and enters the provider name, contact name, contact phone number, and date received into a tracking system. A member of the EDS enrollment team reviews the application based on state-defined criteria and makes a determination within five business days.

- If the application is approved, EDS generates a letter with the new provider number, then mails the letter and a provider manual to the provider within two business days of approval.
- If the application is denied, EDS 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, EDS returns it accompanied by a letter listing the necessary information EDS requires to complete the enrollment process.

When EDS 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, EDS logs the date returned.

Providers may determine the status of their applications by contacting EDS Provider Enrollment at 1 (800) 688-7989.

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

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

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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 taken into consideration 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 understands 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 EDS. 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 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 EDS 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 eligibility.

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 recipient 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, a 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. The toll free number is 1 (800) 824-6584.**

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.

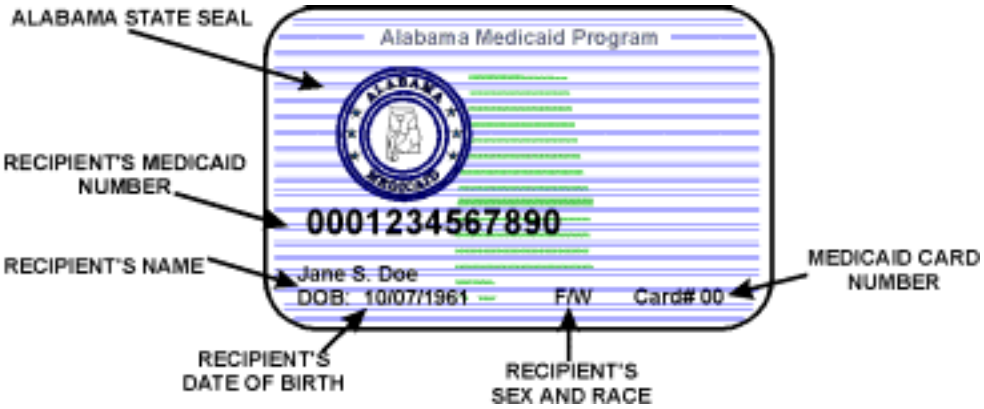
New recipients are issued permanent Medicaid cards within 10-14 working days of eligibility determination.

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 Inquiry Unit available to assist recipients with questions regarding their Medicaid cards. The recipient inquiry unit may be reached at 1 (800) 362-1504.

Below is a sample Medicaid card:



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

DON SIEGELMAN
Governor

W. DALE WALLEY
Acting Commissioner

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

DON SIEGELMAN
Governor

W. DALE WALLEY
Acting Commissioner

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

DON SIEGELMAN
Governor

W. DALE WALLEY
Acting Commissioner

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				

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

DON SIEGELMAN
Governor

W. DALE WALLEY
Acting Commissione

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 PROVIDER #

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 HOSPIT AL 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, and managed care 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 eligibility, the provider may contact the EDS 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 EDS
- Automated Voice Response System (AVRS) at 1 (800) 727-7848
- Contacting the EDS Provider Assistance Center at 1 (800) 688-7989

Appendix B, Electronic Media Claims Guidelines, provides an overview of the EDS 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.

NOTE:

Calling EDS 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

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

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)

Medicare Coverage

Category 2: See the description of Category 2 recipients in Section 3.3.6, 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	
17	27	35	47	58	
1E	2A	37	4A	59	
	2E	3C	4E	5H	
		3D		5L	

Category 3: See the description of Category 3 recipients in Section 3.3.6, 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	
	2D		4D	

No Coverage

Recipients with aid categories 92, 93, 94 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 by 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 Medicaid Provider Number _____

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 HCFA-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 four different managed care plans:

- Patient 1st
- Maternity Care Program
- BAY Health Plan (for dates of service prior to 10/1/99 only)
- Medicare Complete

Refer to Appendix D, Managed Care, for more detailed information about managed care programs.

Patient 1st

Patient 1st is a statewide (with the exception of Mobile county) 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 provider number
- PMP's telephone number (and 24-hour phone number, if applicable)

The PMP must be contacted to authorize any service requiring a referral. Appendix D, Managed Care, provides information on referrals. Once the referral is obtained, the claim is filed directly to EDS for processing. See Section D.1.4 for specific claim filing instructions.

Maternity Care Program

The Maternity Care Program is a statewide program that covers maternity services. The state is divided into 13 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 provider number
- Primary contractor's telephone number

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

BAY Health Plan

BAY Health Plan was a full-risk HMO in Mobile County.

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient was enrolled in BAY Health:

- Verification of the recipient's enrollment in BAY Health
- Primary Care Physician's (PCP) provider number
- PCP's telephone number

Claims for services covered under BAY Health Plan (see Appendix D) must be filed directly to BAY Health Plan.

Medicare Complete

Medicare Complete is a voluntary Medicare HMO operating in Jefferson, Shelby, and Mobile counties. When additional HMOs are added, information specific to the HMOs and counties will be provided.

The eligibility response from AVRS or Provider Electronic Solutions provides the following information if the recipient is enrolled in Medicare Complete:

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

Claims for services covered under this plan must be filed directly to Medicare Complete. Please refer to Appendix D, Managed Care, for more information.

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, and R5 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	1 every other year for recipients 21 years and older
Eyeglass lenses	1 every other year for recipients 21 years and older
Eyeglass fitting exams	1 exam every other year for recipients 21 years and older
Eyeglass exams	1 every other year 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 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 HMO.
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 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. Income may not exceed 100% of the federal poverty level plus $20.

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 which are covered benefits under Medicaid and would have been paid had the recipient not been eligible for Medicare.

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. Ambulance providers will be paid the full deductible and coinsurance amounts. For non-QMB recipients, any Medicaid noncovered 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.

3.3.6 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 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.

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.

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. Both the EDS 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 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. Please provide, if possible, the month, day, and year the coverage ended.

Call the third party representative assigned to recipients whose last names begin with the letters indicated:

A-G	(334) 242-5280
H-P	(334) 242-5254
Q-Z	(334) 242-5279

Submitting Claims to Other Insurance

When you identify a third party resource, you should submit the claim to that resource. Obtain the address from the recipient in instances where you identify the resource through questioning the recipient. When you identify a third party resource through eligibility verification, obtain the company code from the eligibility response. Refer to Appendix K, Top 200 Third Party Carrier Codes, for a list of company names 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, Medicaid payment will be withdrawn by EDS 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
- Write the fiscal agent and request 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 with any third party payment received from a source other than Medicaid as a result of the provider releasing information to the third party or the patient without approval from Medicaid, Third Party Division.

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.

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4

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.

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 using Provider Electronic Solutions
- Submitting Paper PA Requests

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.

4.2.1 Submitting PAs Using Provider Electronic Solutions

Beginning December 1, 1999, you can submit electronic PA requests using EDS 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.

Electronic claims and PA submission saves time and money.

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. No other form or substitute will be accepted. Completed requests should be sent to the following address:

EDS Prior Authorization Unit

P.O. Box 244036

Montgomery, AL 36124-4036.

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.

4.3.1 Blank Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )

Requesting Provider
License # or Provider # _____

Phone ( ) _____

Name _____

Recipient Medicaid Number_____

Name _____

Address _____

City/State/Zip _____

Rendering Provider Medicaid # _____

Phone ( )_____

Fax ( )_____

Name _____

Address _____

City/State/Zip _____

Certification ___ Yes __ No

Recertification/Continued Stay ___ Yes __ No

Date of EPSDT Screening CCYYMMDD _____

Date of Prescription CCYYMMDD _____

First Diagnosis _____ • ____ Ambulance Transport Code ____

Second Diagnosis _____ • ____ Ambulance Transport Reason Codes ____

PA Type_____ Patient Condition _____

(01) Durable Medical Equipment	(06) Physical Therapy	(11) Drugs	(16) Oxygen
(02) Eyeglasses	(07) Speech Therapy	(12) Medical	(17) Prosthetic Devices
(03) Home Health	(08) Private Duty Nursing	(13) Psychiatric*	(18) Inpatient Stay *
(04) Transportation	(09) Ultrasound	(14) Customized Wheelchairs	
(05) Occupational Therapy	(10)Targeted Case Mgt	(15) Surgical	(19) Other

DATES OF SERVICE							
Line Item	START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	PRICE/ 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 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: EDS, P.O. Box 244036 Montgomery, Alabama 36124-4036

Form 342 1/00

Alabama Medicaid Agency

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

Section 1: Requesting Provider Information (Required)

License # or Provider #	Enter the license number or the nine-digit Medicaid provider number 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.
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.

Section 2: Rendering Provider Information (Required)

Medicaid Provider Number	Enter the nine-digit Medicaid provider number 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
Certification	Check this to indicate the initial period of service
Recertification/ continued stay	Check this to indicate a continuation of services previously authorized

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

Date of EPSDT Screening CCYYMMDD	Enter the date of the last EPSDT screening. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001
Date of Prescription CCYYMMDD	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	Enter the primary diagnosis code.
Second Diagnosis	Enter the secondary diagnosis code.
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.**
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 ambulance services and DME providers only.**
PA Type	**Required field for all requests.** Outpatient hospitals requesting physical therapy must use PA type 12 (medical) and not PA type 06 (physical therapy.)

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.
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.
Price/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.

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

Patient Condition Codes

Use this table for the appropriate code to describe the condition of the patient at the time of ambulance transport.

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 our 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 care-giver has been instructed in use of equipment

4.4 Completing the Alabama Prior Review and Authorization Dental Request Form

Providers use this form to submit dental PAs on paper. These forms are available through the Alabama Medicaid Agency.

4.4.1 Blank Alabama Prior Review and Authorization Dental Request Form

Section I – Must be completed by a Medicaid provider.

Requesting Provider License No. _____

Phone( ) _____

Name_____

Address_____

City/State/Zip_____

Provider Medicaid Number _____

(9-digit provider number is required.)

Section II

Medicaid Recipient Identification Number

_____

(13-digit RID number is required.)

Name as shown on Medicaid card_____

Address

_____

City/State/Zip

Section III

DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	REQUIRED PROCEDURE CODE	UNITS	PRICE/DOLLARS

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. Periodontics – Evaluate the periodontal condition._____

_____

_____

_____

A. Indicate pocket depth for root planing (04341)_____

B. Indicate quadrant of diagram for gingival curettage (04220) _____

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

_____

_____

_____

4. Brief Dental/Medical History:_____

_____

_____

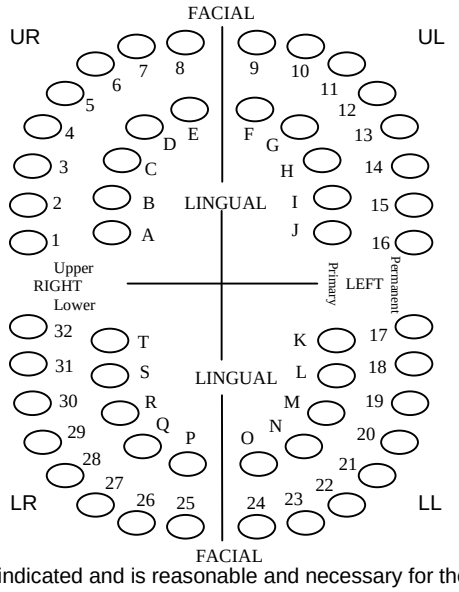
_____

Section IV

Does the Recipient have missing teeth?

Yes_____ No_____

If YES please indicate missing teeth with an X.



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: EDS, P.O. Box 244036, Montgomery, Alabama 36124-4036

Form 343 10/99 Alabama Medicaid Agency

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

Section 1: Requesting Provider Information (Required)

License #	Enter the license number 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.
Provider Medicaid Number	Enter the nine-digit Medicaid provider number 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
Date of EPSDT Screening CCYYMMDD	Enter the date of the last EPSDT screening. Enter dates using the format CYYMMDD. Example: October 1, 1999 would be 19991001

Section 3: Procedure Information

Dates of Service	Enter the start and stop dates of service requested. Enter dates using the format CCYYMMDD. Example: October 1, 1999 would be 19991001.
Place of Service	Enter the appropriate two-digit place of service.
Procedure Code	Enter the five digit procedure code requiring prior authorization.
Units	Enter total number of units.
Price/Dollars	Enter price in dollars.

Section 4: Medical Information

Complete Items 1-4 with the information requested.

Section 5: Tooth Information

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 EDS at the address given on the form.

4.5 Receiving Approval or Denial of the Request

Letters of approval will be sent to the provider and recipient 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.

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

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

4.6 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. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, 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

4.7 Submitting Claims for Prior Authorized Services

Once the **approved** ten-digit PA has been received, providers must indicate that number on the claim form in the appropriate spaces. Claims for services requiring a PA received by EDS without the ten-digit PA number are denied. Refer to Chapter 5, Filing Claims, for more information on completion of the claim form.

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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. Refer to Appendix D, Managed Care, for additional information specific to filing managed care-related claims.

Federal regulations prohibit providers from charging recipients, the Alabama Medicaid Agency, or EDS 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.

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 HCFA-1500 Claim Form*, which provides detailed billing instructions for the HCFA-1500 claim form
- *Completing the UB-92 Claim Form*, which provides detailed billing instructions for the UB-92 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 and institutional crossover claim forms. **Please note that Alabama Medicaid requires paper crossovers to be submitted using the approved Medical and Institutional Medicaid/Medicare-related crossover claim forms.**
- *Required Attachments*, which lists and describes the Alabama Medicaid required attachments
- *Adjustments,* which provides instructions for submitting online and paper adjustments. **Please note that Alabama Medicaid requires paper adjustments to be submitted on the approved Adjustment form.**
- *Refunds,* which provides instructions on receiving refunds
- *Inquiring about Claim and Payment Status,* which describes various methods for contacting EDS to inquire about claim and payment status

5.1 Before You Submit Your Claim

This section discusses claim types, how EDS 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 Appendix D, Managed Care). The claims can be submitted on paper or in electronic format. Alabama recognizes two standard claim forms (UB-92 and HCFA-1500) and four Medicaid non-standard claim forms (Pharmacy, Dental, and two Medicare/Medicaid-related claim forms) for the submission of these claims. The provider's provider type determines which claim type to bill, as illustrated in the table below.

Claim Type	***Claim Form***	***Providers Who Bill Using This Claim Type***
Medical	HCFA-1500	• 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 • Waivered Services (Homebound, Elderly and Disabled, MR/DD) • Maternity Care • State Rehab Services (Mental Health Cinics, DYS/DHR) • CRNA • Nurse Midwife
Dental	ADA	Dentists
Pharmacy	XIX-BC-10-93	Pharmacists

Claim Type	*Claim Form*	*Providers Who Bill Using This Claim Type*
Inpatient	UB-92	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient	UB-92	• Hospitals • Ambulatory Surgical Centers (straight Medicaid) • Hemodialysis • Private Duty Nursing • Hospice Facility • Home Health Services • Lithotripsy (ESWL)
Medical crossover	Medical Medicare/Medicaid-Related Claim	All providers listed under the medical claim type • Ambulatory Surgical Centers (crossover claims) **Exceptions** (these provider types are not covered for Medicare-related claims): • Nurse Midwife • Targeted Case Management • Maternity Care • Waivered Services
Inpatient crossover	Institutional Medicare/Medicaid-Related Claim	• Hospitals • ICF/MR Facility • Nursing Facility
Outpatient crossover	Institutional Medicare/Medicaid-Related Claim	• Hospitals • Dialysis • CORF (Comprehensive Outpatient Rehabilitation Facility) • Nursing Facility (Therapy) • Home Health Services

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 EDS 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 Explanation of Payment (EOP), 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

EDS 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.

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 an Explanation of Payment (EOP) report is produced and checks are written, if applicable. Suspended claims must be worked by EDS 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 EDS. The check is sent to the provider's payee address with an Explanation of Payment (EOP), which also identifies all denied claims, pending claims, and adjustments. If the provider participates in electronic funds transfer (EFT), the payment is deposited directly into the provider's bank account and the EOP is mailed separately to the provider. EOPs are described in Chapter 6, Receiving Reimbursement.

5.1.3 Methods for Submitting Claims

EDS accepts claims in electronic or paper format. Paper claims 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, EDS now scans paper claims and performs Optical Character Recognition (OCR) to enter data from the claims into the Medicaid system. The scanner uses a red bulb that drops any red markings on the claim form, leaving only the data the provider entered on the claim form.

NOTE:

Because EDS uses a new scanning process, **do not use a red pen to complete paper claims.** 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 EDS. Providers may purchase copies of HCFA-1500 and Alabama Medicaid Pharmacy claim forms from EDS by writing or calling the EDS Provider Assistance Center:

EDS Provider Assistance Center
P.O. Box 244035
Montgomery, AL 36124
1 (800) 688-7989

NOTE:

Submit BAY Health claims for services prior to 10/1/99 directly to BAY. Call BAY Health at 1 (800) 894-2291 for claim filing instructions.

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

The Alabama Medicaid Agency and EDS strongly encourage submitting claims electronically. 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 EDS.

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 Explanation of Payment (EOP) 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. EDS furnishes file specifications at no charge. **If you have further questions or wish to order software, contact the EDS 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. 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 and a copy of the dated insurance must be attached to the claim**. The 120-day filing limit may not be waived**. Providers should state the disposition date as "TPL-12-1-99" or "TPL-Dec. 1, 1999."

  Medicare EOMBs are no longer a required attachment. Providers must use the appropriate Medicare/Medicaid-related form (Institutional or Medical). Refer to Appendix E, Medicaid Forms, for a sample. Providers are reminded that claims that are denied by a third party payer must be submitted with a copy of the dated denial sheet attached. Third party payer denials must still be attached with the appropriate claim form or Medicare/Medicaid-related form.

- EDS must receive claims for services rendered to recipients who have been awarded retroactive eligibility **within one year** of the award date.

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

EDS Provider Assistance Center
P.O. Box 244035
Montgomery, AL 36124-4035

Claims for inpatient hospital services provided through Partnership Hospital Programs (PHP) must be filed by the last day of February for the previous year; for example, claims with dates of service 10-1-00 through 9-30-2001 must be filed by 2-28-2002.

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.

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 certifies that the services filed were performed by the provider or supervised by the provider and were medically necessary.

Individual practitioners (not groups or clinics) may sign a medical claims submission agreement with Medicaid for the submission of paper claims instead of signing individual claim forms.

By signing the claim 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 a completed Medical Claims Submission Agreement on file should place the words "**Agreement on File**" in block 31.

If an agreement is not signed, the individual practitioner must personally sign the claim form in the appropriate area or 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 EDS signed by the provider or the billing agent authorizing tape submission of claims.

Tapes that EDS 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 on file with EDS signed by the provider. When applicable, the billing agent's signature must also appear on the contract.

Diskette Billers

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

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 a Medical Claim Submission 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 and partially paid third party claims to Medicaid using the approved paper or online filing methods as described in Chapter 5, Filing Claims. **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*
HCFA-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL paid dates • Amount paid	• Blocks 9-9d • Block 10 • Block 19 • Block 29
UB-92	• Other payer name • Prior payments • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL paid date	• Block 50 • Block 54 • Block 58 • Block 60 • Block 61 • Block 62 • Block 78 • Block 84
ADA Dental	• Is patient covered under another dental plan? • Name, address, and policy number of carrier(s) • Group no(s) • TPL paid date • Is treatment related to an accident? • Carrier Pays	• Block 11 • Block 12a • Block 12b • Block 14c • Blocks 22-24 • Carrier Pays block
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:

Failure to list the third party payment in the appropriate space on the claim may cause the claim to deny.

If the claim is less than one year old, you may submit the claim electronically and Medicaid does not require the attachment of the third party Explanation of Payment (EOP). For claims more than one year old, you must the claim submit on paper and attach a copy of the third party EOP. You must submit claims more than one year old **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:

- The amount paid by the third party will be deducted from the Medicaid allowed amount and the difference will be paid to the provider.
- Third party 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 Explanation of Payment (EOP). **Patients cannot be billed under this condition.**

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*
HCFA-1500	• Other Insured's name, policy number, insurance co. • Was condition related to (accident) • TPL denied dates • Amount paid	• Blocks 9-9d • Block 10 • Block 19 • Block 29
UB-92	• Other payer name • Prior payments • Insured's name • Other payer policy number • Insured's group name • Insurance group number • Medicaid emergency/accident indicator • TPL denied date	• Block 50 • Block 54 • Block 58 • Block 60 • Block 61 • Block 62 • Block 78 • Block 84
ADA Dental	• Is patient covered under another dental plan? • Name, address, and policy number of carrier(s) • Group no(s) • TPL denied date • Is treatment related to an accident? • Carrier pays	• Block 11 • Block 12a • Block 12b • Block 14c • Blocks 22-24 • Carrier Pays block
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 HCFA-1500 Claim Form

This section describes how to complete the HCFA-1500 claim form for submission to EDS. For a list of providers who bill for services using the HCFA-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.

HCFA-1500 Electronic Billing

Electronic billers must submit HCFA-1500 claims in approved formats. Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS 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 EDS Electronic Claims Submission Help Desk at 1 (800) 456-1242.

HCFA-1500 Claims Form Paper Billing

HCFA-1500 forms may be purchased through EDS. 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 HCFA format using red dropout ink.

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

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Payee's nine-digit Medicaid provider number
- Performing provider's nine-digit Medicaid provider number (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 EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.2.1 HCFA-1500 Blank Claim Form

APPROVED QMB-0938-0008

☐☐☐ PICA

HEALTH INSURANCE CLAIM FORM

PICA ☐☐☐

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

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

3. PATIENTS 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 ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT 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? ☐ YES ☐ NO PLACE (state)

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.

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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 _____ DATE _____

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

SAMPLE

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

15. IF PATIENT HAS HAD SOME OR SIMILAR ILLNESS, GIVE FIRST DATE MM | DD | YY

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

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E B LINE)
1. 3.
2. 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OF UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S SUPPLIER'S BILLING NAME , ADDRESS, ZIP CODE, & PHONE #
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

HCFA-1500-1 (Rev. 12-90)

5.2.2 HCFA-1500 Claim Filing Instructions

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

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. **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 PMP 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.
17a	ID number of referring physician	Enter the nine-digit Medicaid provider number corresponding to the provider entered in Block 17, if applicable.
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) 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	If the service requires prior authorization, enter the ten-digit PA number provided on the prior authorization notice here. Do not include the PA notice with the claim. 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	Type of Service (TOS)	TOS is no longer a required field on the Medicaid claim form. The system automatically assigns TOS codes based on the procedure code billed.
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.
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.
24g	Units	Enter the appropriate number of units. Be sure that span-billed daily hospital visits equal the units in this block. Use whole numbers only.
24h	EPSDT Family Plan	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 (PMP) referral • "4" if the procedure is EPSDT and PMP referred
24i	EMG	This block is used to indicate certain copayment exemptions, or Patient 1st referral exemption for Certified Emergency. Enter an "E" for emergency or "P" for pregnancy, if applicable. Do not enter Y or N.
24k	Reserved for local use	Enter the performing provider's nine-digit Medicaid provider number. The performing provider is the one who performs the service.
26	Patient account number	This field is optional. Up to 15 alphanumeric characters may be entered in this field. If entered, the number appears on the provider's Explanation of Payment (EOP) to assist in patient identification.
28	Total charge	Enter the sum of all charges entered in Block 24f lines 1-6.
29	Amount paid	Enter any amount paid by an insurance company or other sources known at the time of submission. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**
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, you may sign a Medicaid Claims Submission Agreement, to be kept on file by EDS. 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	Physician's or supplier's name, address, zip code, and telephone number PIN# GRP#	Enter the payee's name and address in the space provided. The payee name is printed in the upper right corner of the EOP. PIN# is not a required field. Do not enter PIN#. Enter the payee's nine-digit Medicaid provider number in the GRP# field. The payee number is the number printed in the upper left corner of the EOP. **NOTE: If the payee is a group or clinic, the performing provider whose number is listed in Block 24k must be enrolled as a member of the group or clinic.**

5.3 Completing the UB-92 Claim Form

This section describes how to complete the UB-92 claim form for submission to EDS. For a list of providers who bill for services using the UB-92 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.

UB-92 Electronic Billing

Electronic billers must submit UB-92 claims in approved formats. Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS 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 EDS Electronic Claims Submission Help Desk at 1 (800) 456-1242.

UB-92 Claims Form Paper Billing

EDS does not supply the UB-92 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-92 format using red dropout ink.

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

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's eight-character Medicaid provider number

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 EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.3.1 UB-92 Blank Claim Form

APPROVED QMB NO. 0938-0279

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL

5. FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTH DATE | 15 SEX | 16 MS | ADMISSION 17 DATE 18 HR 19 TYPE 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 CODE OCCURRENCE SPAN FROM THROUGH | 37 A B C

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49

50 PAYER | 51 PROVIDER NO. | 52 REL. INFO | 53 ASG BEN | 54. PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 | DUE FROM PATIENT

58 INSURED'S NAME | 59 P.REL | 60 CERT.-SSN-HIC.-ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E | 83 OTHER PHYS. ID A

84 REMARKS | OTHER PHYS. ID B

85 PROVIDER SIGNATURE X | 86 DATE

UB-92 HCFA-1450

TITLE POSITION

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

SAMPLE

5.3.2 UB-92 Claim Filing Instructions

The instructions describe information that must be entered in each of the block numbers on the UB-92 Claim Form. **Block numbers not referenced in the table may be left blank. They are not required for claims processing by EDS.**

Block No.	*Description*	*Guidelines*
1	Provider name, address, and telephone number	Enter the provider name, street address, city, state, ZIP code, and telephone number.
2	Referring Provider number	Enter the referring physician's provider number for the following types of referrals: • EPSDT referrals • Patient 1st referrals • Lock-in Physician referrals The referring provider number should contain nine digits. If a referring provider number is indicated here, you must include a condition code of A1, X2, or X3 in block 24. If not applicable, leave blank.
3	Patient control number	**Optional**: Enter your internal medical record number. This may be an alpha or numeric string (limit 16 characters). If entered, the number appears on the provider's Explanation of Payment (EOP) to assist in patient identification.
4	Type of bill (TOB) Most commonly used: 111 Inpatient hospital 131 Outpatient hospital 141 Nonpatient (laboratory or radiology charges) 211 Long Term Care 331 Home health agency 811 Hospice	Enter the three-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 5-8 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.
7	Covered days	Enter the total days represented on this claim that are to be covered. This is not required for outpatient claims.

Block No.	*Description*	*Guidelines*
8	Non-covered days	Enter the total days represented on this claim that are not covered. This is not required for outpatient claims. **The sum of blocks 7 and 8 must equal the total days billed as reflected in block 46.**
12	Patient 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 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.
17	Admission date	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.
18	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).
19	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)
20	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
21	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.

Block No.	***Description***	***Guidelines***
22	Patient status	For inpatient claims, enter the appropriate two-digit code to indicate the patient's status as of the statement "through" date: 01 Routine discharge 02 Discharged to another short-term general hospital 03 Discharged to NF 04 Discharged to ICF/MR 05 Discharged to another type of institution 06 Discharged to care of home health service organization 07 Left against medical advice 08 Discharged/transferred to home under care of a Home IV provider 20 Expired or did not recover 30 Still patient 62 Discharged/transferred to another rehabilitation facility including rehabilitation distinct part units of the hospital. 63 Discharged/transferred to a long-term care hospital. 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).
23	Medical record number	Enter the patient's medical record number assigned by the hospital. This number will be referenced on the provider's EOP for patient identification.
24-30	Condition Codes	The following UB-92 condition codes are valid for EPSDT referral and/or PMP referrals: A1 Denotes services rendered as the result of an EPSDT screening. Block 2 must also contain the screening provider's 9-digit Medicaid provider number. A4 Denotes family planning and will exempt the claim from the $3 copay. X2 Indicates managed care referral X3 Indicates EPSDT **and** managed care referral (If enrolled in Patient 1st, the PMP must refer) If A1, X2, or X3 are entered here, a referring provider number must be indicated in block 2.
36	Occurrence Span/PSRO Data	For inpatient claims, enter occurrence code X0 and the first and last days that were approved by Utilization.
42, 43	Revenue codes, revenue description	Enter the revenue code(s) for the services billed. Refer to the UB-92 Uniform Billing Manual published by the Alabama Hospital Association for valid codes. Revenue 001 (Total) must appear on every claim.
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, CPT-4, or other Medicaid-assigned procedure code. **The UB-92 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.
51	Medicaid no.	Enter the eight-character Medicaid provider number.

Block No.	*Description*	*Guidelines*
54	Prior payments	Enter any amounts paid by third party commercial insurance carrier(s). **Do not enter Medicaid copayment amount. Do not enter Medicare payment amount.**
58	Insured's name	If a third party carrier is involved, 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. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
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.
63	Treatment authorization code	Enter the ten-digit prior authorization number, if applicable. Do not include the PA notice with the claim. 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.
67	Principal diagnosis code	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.
68-75	Other diagnosis codes	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.
76	Admitting diagnosis	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.
78	Medicaid emergency/accident indicator	Enter an "H" to indicate that the service was rendered as a result of a home accident of treatment due to disease. Enter "E" to indicate a certified emergency. Both values may be entered, as applicable. **Certified emergency ER claim must be certified by the attending physician.**
80-81 a,b,c,d,e	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.
82	Attending physician ID	Enter the attending physician's license number. Refer to the Alabama Medicaid Agency Provider License Book for a complete listing of valid license numbers.
83 a,b	Other physician ID	For inpatient hospital claims only, if surgical procedure codes are entered in Blocks 80-81, enter the surgeon's license number.
84	Remarks	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)
85	Provider representative signature	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
86	Date bill submitted	Enter the date the bill was signed.

5.4 Completing the ADA Dental Form

This section describes how to complete the ADA Dental form for submission to EDS. 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, Dentist.

Only ADA-approved dental claim forms are acceptable. If you experience problems with EDS processing your forms, contact EDS for resolution.

ADA Dental Electronic Billing

Electronic billers must submit ADA Dental claims in approved formats. Providers can obtain Provider Electronic Solutions software from EDS free of charge. EDS 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 EDS Electronic Claims Submission Help Desk at 1 (800) 456-1242.

ADA Dental Form Paper Billing

EDS does not supply the ADA Dental form. Providers may obtain copies of the claim form from a printer of their choice. For scanning purposes, these forms should be printed using blue dropout ink.

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

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's nine-digit Medicaid provider number

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 EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

NOTE:

Because EDS uses a new scanning process, **do not use a blue pen to complete paper claims.** 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.

5.4.1 ADA Dental Blank Claim Form

Please use the approved ADA Dental claim form printed using standard blue dropout ink.

5.4.2 ADA Dental Filing Instructions

The instructions describe information that must 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 EDS.**

ADA Block No.	*ADA Description Alabama Medicaid Use*	*Guidelines*
1	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 7.** 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 "A B Doe" with no punctuation. For recipient D'Andre Doe, enter "D'Andre Doe" with an apostrophe and no spaces.
7	Employer/subscriber Soc. Sec. or ID Number/Medicaid Number	Enter the patient's 13-digit RID from the Medicaid eligibility verification response. **For instructions on performing an eligibility verification transaction, please refer to Chapter 3, Verifying Recipient Eligibility.**
10	Group number/facility	If the services were provided in a facility other than the provider's, enter the nine-digit Medicaid provider number or name, address, and zip code of that facility.
11	Is patient covered by another dental plan?	Indicate by checking the appropriate box.
12a 12b	Name and address of carrier(s) Group no.(s)	If applicable, enter the name, address, and policy number of the dental insurance carrier. Insured's name: Name of person who has dental insurance policy.
14c	Employee/subscriber birth date TPL paid date	Enter the date of payment or denial from the other insurance.
16	Dentist's name, address, ZIP code	Enter the billing provider's name, street, city, state, and ZIP code.
17	Address where payment should be remitted.	Enter the address of the billing provider.
20	Phone number	Enter the telephone number of the provider.
22	Place of treatment	Use the following place of service codes in the appropriate box: office, hospital, or other: • 11 – Dental office • 21 – Inpatient hospital • 22 – Outpatient hospital • 31 – Nursing facility Use the "HOSP" box to indicate outpatient hospital and the "Other" box to indicate inpatient hospital.
23	Radiographs or models enclosed? No. of X-rays enclosed.	Indicate by checking the appropriate box. If yes, enter the number of X-rays enclosed when billing for services requiring X-rays.
24	Is treatment result of occupational illness or injury	As applicable, indicate yes or no. If yes, provide a brief description and dates.
25	Is treatment result of auto accident	Indicate by checking the appropriate box. If yes, provide a brief description and dates.
26	Other accident? Services due to	Emergency, trauma – indicate by checking the appropriate box. **If a box is checked, information about the condition must be provided to the right of the box.**
29	Is treatment for orthodontics?	Indicate by checking the appropriate box.
30a	Tooth number or letter	Enter the appropriate tooth number for permanent teeth (01-34) or the appropriate letter for primary teeth (A-T) as indicated on the claim form. When spacers or partials are required, mark the missing teeth with an "X" on the claim form. Enter "99" for all supernumerary teeth regardless of location in maxilla or mandible. Narrative of location is required.

ADA Block No.	***ADA Description Alabama Medicaid Use***	***Guidelines***
30b	Surface	Enter the appropriate tooth surface alpha character of the tooth on which the service is performed (BDM, MOB, MODL). The block is left blank for exams, X-rays, prophylaxis, fluoride, and crowns. M – Mesial F – Facial B – Buccal or labial O – Occlusal L – Lingual or Cingulum D – Distal I – Incisal
30c	Describe procedures or dental services for each date given	Enter a concise, specific description of all billed services provided to the recipient.
30d	Date of service	Enter numerically (MM/DD/YY) the date of service for each procedure provided.
30e	Procedure number	Enter the appropriate ADA procedure code(s) for the procedure(s) (such as 00110).
30f	Charges (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.
30g	For administrative use only.	This space is for the provider number of the **actual** dentist performing the service. Enter the performing provider's number. NOTE: If the billing provider (payee) entered in the License Number field at the bottom of the form is a group provider, the performing provider must be a member of the group.
31	Remarks • Prior Authorization number • Your patient's account number (if desired) • Statement noting TPL is attached	If the service requires prior authorization, enter the ten-digit PA number provided on the prior authorization notice here. Do not include the PA notice with the claim. Refer to Chapter 4, Obtaining Prior Authorization, for general information. For program-specific prior authorization information, refer to Chapter 13, Dental. Optional: Enter your patient account number. If other insurance has rejected payment for the claim, note, "TPL Rejection Attached."
	Signature of dentist	An authorized representative must sign his or her name or initial his or her computer-generated, stamped, or typed name.
	License number	This space is for the billing (payee) provider number. Enter the billing provider's nine-digit Alabama Medicaid provider number in the license number field. The billing (payee) number is the number printed in the upper left corner of the Explanation of Payments (EOP). The performing provider number and the billing provider number may or may not be the same, but each number **must** be entered in the appropriate location.
	Total fee charge	Enter the total of the charges on the claim.
	Carrier pays	Enter the amount paid by the other insurance or other third party sources known at the time of submission of the claim. Indicate the source of each payment in Blocks 11, 12a, and 14c. **Do not enter Medicaid copayment amount. Do not enter Medicare payment amount.**.

5.5 Completing the Pharmacy Claim Form

This section describes how to complete the pharmacy claim form for submission to EDS. 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 EDS free of charge. EDS 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 EDS Electronic Claims Submission Help Desk at 1 (800) 456-1242.

Pharmacy Paper Billing

Medicaid pharmacy claim forms may be purchased through EDS. 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 Medicaid provider number. Critical claim information includes:

- Recipient's first and last name
- Recipient's 13-digit Medicaid number
- First two characters of the provider group name
- Provider's nine-digit Medicaid provider number
- 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 EDS to omit signature requirement. Refer to section 5.1.7, Provider Signatures, for appropriate signature requirements.

5.5.1 Pharmacy Blank Claim Form

ALABAMA MEDICAID PHARMACY CLAIM XIX-DC-10-93

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

SUBMIT TO
EDS
P.O. BOX 244033
MONTGOMERY, ALABAMA 36124-4033

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.

COPAY	PRIOR AUTHORIZATION NO.

RX NUMBER	LA	DE UCT CO	PK	QUAN	DAYS SUPPLY	LL(S) NO.	US ND CUSTOMARY ARS	CENTS
2								
3								
						TOTAL		

	DOLLARS	CENTS	REASON CODE
1			
2			
3			

SAMPLE

5.5.2 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 EDS.**

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.** 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 EDS 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, which should display on the prescription
Pharmacy license no./name	Enter the nine-digit Medicaid pharmacy provider number 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 an "I" if the recipient resides in a nursing home and "P" if the recipient is pregnant to indicate copay exemptions.
Prior Authorization	Enter the ten-digit prior authorization number issued by Medicaid. The form may contain only six spaces for this number. Enter the first six digits in the blocks provided and continue the number into the space to the right.
Rx number	Enter the prescription number
Drug code	Enter the NDC code
B/N	Brand Necessary. This field is also known as the "Dispense as Written (DAW)" field. Valid values are as follows: 0 No product selection indicated 1 Substitution not allowed by subscriber – Brand necessary 2 Substitution allowed – patient requested product dispensed 3 Substitution allowed – pharmacist selected product dispensed 4 Substitution allowed – generic drug not in stock 5 Substitution allowed – Brand drug dispensed as a generic 7 Substitution not allowed – Brand drug mandated by law 8 Substitution allowed – Generic drug not available in market place **Note: These "Dispense as Written" values are required for the DAW field for electronic pharmacy claims.**

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. 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), round the quantity up to the next number. In this example, the quantity billed should be 00004.**
Days supply	Enter the amount of time the medication dispensed should last. The days supply is limited to 34.
Refills	Auth. Enter the number of refills authorized by the prescribing physician. This is limited to 5. No. Enter the number of the refill being dispensed.
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. A reason code should also be indicated. If the other insurance did not make a payment, the dollars/cents field should be zero, but the reason code must be included.

5.6 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 filing a medical or inpatient crossover claim to EDS either electronically or on hard copy. Outpatient institutional claims, out-of-state Medicare claims, and those medical and inpatient claims 21 days old or older must be submitted either electronically or on hard copy to EDS using the appropriate Medicare/Medicaid-related Claim Form.

Electronic billers must submit crossover claims in approved formats. *Provider Electronic Solutions* software allows crossover billing and is available from EDS free of charge for providers. 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 EDS Electronic Claims Submission Help Desk at 1 (800) 456-1242.

5.6.1 Medical Medicaid/Medicare-related Claim Filing Instructions

For paper billing, the Medical Medicaid/Medicare-related claim form may be obtained from EDS at no charge. For scanning purposes, only those forms printed with red dropout ink will be accepted. Photocopies of this form will be returned.

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

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

Medical Medicaid/Medicare-related Blank Claim Form

MEDICAL MEDICAID/MEDICARE RELATED CLAIM

Do not write in this space.

Do not use red ink to complete this form.

RECIPIENT INFORMATION

Medicaid ID #	
First Name	
Last Name	
HIC #	
Patient Account #	

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			Procedure				Medicare			
From	Thru	POS	Code	Mods	Units	Charges	Allowed	Coinsurance	Deductible	Paid
						TOTALS				

SAMPLE

Remarks

*Enter **TPL Denied (MM/DD/YY)** in this block.*

Performing Provider Number	
Performing Provider Name	

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.

Provider Mailing Address Required in block below.

Submit completed claim to:

EDS
Post Office Box 244037
Montgomery, AL 36124-4037

Form 340 Revised 10/00

Alabama Medicaid Agency

Medical Medicaid/Medicare-related Claim Filing Instructions

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

Field Description	***Guidelines***
Medicaid ID #	Enter the recipient's 13-digit RID number.
First Name	Enter the recipient's first name.
Last Name	Enter the recipient's last name.
HIC#	Enter the recipient's Medicare HIC number.
Patient Account #	Enter recipient's patient account number (to be referenced on the EOP for patient identification).
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.
If payment was received from other insurance, place that amount here.	Enter the amount the other insurance company paid in this block. Do not include Medicaid copayment amounts.
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.
Procedure Code	Enter the five-digit procedure code.
Mods	Enter the modifiers for the procedure code.
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 Medicaid per diem paid amount for each line item.
TOTALS	Total each column.
Performing Provider Number	Enter the performing provider's nine-digit Medicaid provider number. Do not place any alpha characters in this block.
Performing Provider Name	Enter the performing provider's name.
Provider Mailing Address	Enter the billing address, city, state, and zip code for the performing provider.
Remarks	Enter TPL Paid/Denial Date (MMDDYY).

5.6.2 Institutional Medicaid/Medicare-related Claim Filing Instructions

For paper billing, the Institutional Medicaid/Medicare related claim form may be obtained from EDS at no charge. For scanning purposes, only those forms printed with red dropout ink will be accepted. Photocopies of this form will be returned.

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

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

Institutional Medicaid/Medicare-related Blank Claim Form

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

INSTITUTIONAL MEDICAID/MEDICARE RELATED CLAIM

PROVIDER INFORMATION

Provider Number	
Provider Name	

BILL TYPE

RECIPIENT INFORMATION

Medicaid ID #	
First	
Last	
HIC #	
Patient Account #	

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.

ADMISSION

Date	Hour	Type	STAT

STATEMENT COVERS PERIOD *See Remarks.

From	Through	COV D	N C D	C I D	L R.D

Rev	PC/Rate	Mods	Units	DOS	Charges	Non-Cov
001				TOTALS		

ADMIT	
Principal	
Other DX	
Other DX	
Other DX	

Rema

* Enter **TPL Denied (MM/DD/YY)** in this block

Total Medicare Paid
Total Medicare Allowed
Total Medicare Coinsurance
Total Medicare Deductible

SAMPLE

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.

Send completed claim to:

EDS
Post Office Box 244037
Montgomery, AL 36124-4037

Provider Mailing Address Required in block below.

Form 341 Revised 10-00

Alabama Medicaid Agency

Institutional Medicaid/Medicare-related Claim Filing Instructions

This form is required for all medical Medicare-related claims in lieu of the UB-92 claim form and the Medicare EOMB. **The ONLY required attachments are for third party denials.** The Medicare EOMB is no longer required.

Provider Information

Provider Number	Enter the 8-character Medicaid provider number.
Provider Name	Enter the provider name.

Recipient Information

Medicaid ID #	Recipient's 13-digit Medicaid I.D. number
First Name	Recipient's First Name
Last Name	Recipient's Last Name
HIC #	Recipient's HIC I.D. number
Patient Account #	Recipient's patient account number

Other Insurance Information

Covered by other insurance?	Enter a "Y" here if recipient has insurance other than Medicare. Otherwise leave blank.
Name of other insurance company	Enter name of other insurance company (except Medicare).
Insurance company carrier code	Not used at this time
If payment was received from other insurance, place that amount here.	Place the amount the other insurance company paid in this block. **Do not enter Medicaid copayment amount. Do not enter Medicare payments.**

Admission and Statement Covers Period

Date	Enter date of admission
Hour	Enter hour of admission (in military time format)
Type	Enter type of admission
STAT	Enter patient discharge status
From and through dates	Enter from and through dates of service
COVD	Enter number of covered days
NCD	Enter number of non-covered days, if any
CID	Enter number of coinsurance days if applicable
LRD	Enter number of life time reserve days if applicable

Service Data

Rev	Enter the revenue codes for each line item.
PC/Rate	Enter the 5-digit procedure code or the accommodation rate for the line item.
Mods	Enter the 2-character modifiers if applicable
Units	Enter the number of units of service
DOS	Enter the first date of service
Charges	Enter the total line item charge
Non-Cov	Enter the non-covered part of the line item charge if applicable
TOTALS	Enter the column totals.

Diagnosis Codes

ADMIT, Principal, Other, Other, Other	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.

Remarks

Remarks	Enter the TPL Paid/Denied Date (MMDDYY)

Medicare Payment Information

Paid	Enter the amount Medicare paid on each line item.
Allowed	Enter the amount Medicare allowed on each line item.
Coinsurance	Enter the amount of Medicare coinsurance on each line item.
Deductible	Enter the amount of Medicare deductible on each line item.

Mailing Address

Provider mailing address	Enter the billing address for the performing provider.

5.7 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.
Form XIX-TPD-1	This form must accompany the Medicaid claim if the treatment is injury-related or caused as the result of an individual or other entity's wrongdoing and both of the following conditions apply: • The total submitted charge is $250.00 or more • The diagnosis code is 722-724; 800-9099; 920-9299; 940-9599; 982-9848; 985-9894; 9896-9899; 9982; 9984; or 9987 These forms may be obtained from EDS at no charge.

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.

5.8 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.

5.9 Adjustments

Adjustments may be performed only on claims **paid** in error (for example, overpayments, underpayments, 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 may submit their adjustment requests electronically or on paper.

5.9.1 Online Adjustments

Providers can submit electronic adjustments using the EDS Provider Electronic Software or vendor-supplied software designed using specifications received from EDS. Through this process, providers can adjust 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 EDS Provider Electronic Solutions software or provider's vendor system will require that provider enters the following information exactly as it appeared on the Explanation of Payment (EOP):

- Billing Provider Number
- Recipient Identification (RID)
- Internal Control Number (ICN)

Once the system returns an acknowledgement that the adjustment has been accepted, the provider then resubmits the claim for processing as a new claim.

5.9.2 Submitting Adjustments on Paper

Providers must use the Medicaid Adjustment Request form to submit paper adjustments. These forms can be ordered from EDS (see Appendix E). **This is the only approved form that will be accepted for paper adjustments.** The following instructions explain how this form should be completed.

NOTE:

Please do not attach a check with the Adjustment Request Form.

Completing the Adjustment Request Form

Section I - Provider Pay-to Information

Field Name	***Instructions for Completion***
Provider Number	Enter the Alabama Medicaid Provider Number under which payment is made.
Provider Name and Address	Complete this field with the same information used to bill Medicaid.
Overpayment (Credit)	Providers who receive duplicate payments, incorrect payments, or overpayments should submit an adjustment request and check the box labeled overpayment. EDS will withhold (recoup) the overpayment amount from future claims payments.
Underpayment (Debit)	If a claim has been underpaid, check the box labeled underpayment to have the correct amount added to future claims payments.
Information Corrections	Check this box if the claim paid the correct amount using incorrect information such as wrong dates of service. **This box should be checked only if it will not affect the amount paid.**

Section II- Paid Claim Information

Field Name	*Instructions for Completion*
Claim Number (ICN)	Enter the 13-digit number exactly as it is printed on your EOP.
Patient Name	Enter the patient's name exactly as it appears on your EOP.
Recipient ID Number	Enter the 13-digit Medicaid identification number assigned to the recipient as it appears on your EOP.
EOP Date	Enter the date of the EOP, found in the top right corner of your EOP.
Dates of Service	Enter the beginning and ending month, day and year of services rendered.
Billed Amount	Enter the exact amount you billed the Medicaid program for the services rendered.
Paid Amount	Enter the amount actually paid by Medicaid for services.

Section III- Description of Problem

Field Name	*Instructions for Completion*
Description of Problem	Indicate the specific reason for the adjustment request and the nature of the incorrect payment.
Signature and Date	Enter the signature of the requestor and the date the request was prepared.

Adjustments appear in the *Adjusted Claims* section of the provider Explanation of Payment (EOP) and consist of two segments: **Credit To** and **Debit To**. The **Credit To** segment lists the amount owed to EDS from the original paid claim. This amount will also display in the *Financial Items* section of the EOP as a deduction.

The **Debit To** 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 EOP; 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 EOP.

NOTE:

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

5.10 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:

EDS – Refunds
P.O. Box 244035
Montgomery, AL 36124-3035

Please provide the following information in the appropriate fields on the Check Refund Request exactly as it appears on your Explanation of Payment (EOP) for each refund you send to EDS:

- Provider Name and Medicaid ID number
- Your check number, check date, check amount
- 13 digit claim number or ICN (from EOP)
- Recipient's Medicaid ID number and name (from EOP)
- 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
- Writing the fiscal agent and 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 third party.

5.11 Inquiring about Claim and Payment Status

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

- Call AVRS
- Review the Explanation of Payment (EOP) for the corresponding checkwrite
- Contact the EDS Provider Assistance Center at 1 (800) 688-7989
- Contact EDS Provider Relations in writing at **EDS Attn: Provider Relations P.O. Box 244035 Montgomery, AL 36124.**

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 EDS Provider Assistance Center

The EDS 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 before calling the EDS Provider Assistance Center. To ensure the Assistance Center is available to all providers, EDS 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 provider number, 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 EDS 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 EDS to monitor its service to providers.

Contacting EDS in Writing

Providers may contact EDS in writing to resolve more complex billing issues. This correspondence will be reviewed by EDS Provider Relations, which is composed of field representatives who are expert in Medicaid billing policy. EDS 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 EDS' 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.

6

6 Receiving Reimbursement

This chapter describes the Explanation of Payment (EOP) report and the reimbursement schedule for Medicaid fee-for-service claims.

NOTE:

Reimbursement information specific to managed care is described in Appendix D, Managed Care, of this manual.

6.1 Explanation of Payment (EOP) Report

It is the responsibility of each provider to follow up on claims submitted to EDS. The Explanation of Payment (EOP) is a vital tool for this process. The EOP 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 EOP carefully and to maintain the document for future reference. Claims listed as suspended are being processed and will appear on one of the next two EOPs as paid, denied, suspended, or returned to the provider.

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 EDS Provider Assistance Center at 1-800-688-7989. To request an adjustment of a previously paid claim, refer to Section 5.8, Adjustments, for more information.

Any claim that does not appear on an EOP 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 EOP.

6.1.1 Provider Explanation of Payment (EOP)

At the end of each biweekly pay period, providers are issued a single remittance check or Electronic Funds Transfer (EFT) transaction for all claims that have been processed for payment. Providers who choose to have their payments deposited directly to their bank receive their Explanation of Payment (EOP) a few days earlier than providers who receive a paper check. Paper checks are generated and mailed to providers with the EOP.

The EOP 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 EOP are described in the following paragraphs.

-Each page displays the payee provider's name, address, and Medicaid provider number printed as it currently appears on EDS' provider file. The EOP number and checkwrite date display on each page of the EOP as well.

The columns that display at the top of every page correspond to the information in the sections that list paid and denied claims.

MEDICAL ASSISTANCE EXPLANATION OF PAYMENT

STATE OF ALABAMA **ALABAMA MEDICAID INFORMATION SYSTEM EXPLANATION OF PAYMENT**

Anywhere Physicians Clinic
123 Main St.
Anywhere, USA 12345

PROVIDER NUMBER **520000000** CNTRL NUM 000000 REPORT SEQ NUMBER 4 EOP NUMBER 0000000 DATE 01/01/2000 PAGE 1

NAME	SERVICE DATES		DAYS	POS/TOS/PROC/REVENUE/D	TOTAL	NON	TOTAL	PATIENT	OTHER	PAID	EOB
RECIPIENT	FROM	TO	OR	RUG	BILLED	ALLOWED	ALLOWED	LIABILITY	DEDUCTED	AMOUNTS	CODES
ID	MM DD YY	MM DD YY	UNITS	CODE AND DESCRIPTION					CHARGES		

First Page

A "Mini-Memo" from EDS appears on this page. The "Mini-Memo" delivers information to the provider community and includes updates to current policies and procedures.

NOTE:

A single EOP issued for several providers (such as for a corporation or a group) lists each provider number in the group separately in numeric order.

Paid Claims

This section of the EOP 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.

The following table lists the fields in the paid claims section from left to right, top to bottom. Not all paid claims will display data in every field.

Field	*Description*
Recipient Name	Displays the recipient's last name, first name, and middle initial. Claims are displayed in alphabetical order by last name.
CO	Displays the recipient's county of residence.
RCC	Displays the per diem amount for inpatient hospital stays.
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.

Field	*Description*
MRN	Displays the Medical Record Number assigned to the recipient by the provider. This is the patient account number.
Diag	Displays the diagnosis codes submitted on the claim.
Perf Phys	Displays the provider number of the performing provider.
Recipient Medicaid ID	Displays the 12 digit recipient Medicaid ID number. This displays for each line item billed, if applicable.
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.
Place of Service, Procedure Code and Modifier	Displays these codes as they were submitted on the claim, with a description of the procedure code. This displays for each line item billed, if applicable.
Total Billed	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.
Total Allowed	Displays the amount of the billed amount that Medicaid will cover. This displays for each line item billed, if applicable.
Patient Liability	Displays the amount that is the responsibility of the recipient. This displays for each line item billed, if applicable.
Other Deducted Charges	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.
EOB Codes	Displays a the Explanation of Benefit code corresponding to a message about claim adjudication. This displays for each line item billed, if applicable.
Coins	Displays the coinsurance amount paid by the recipient.
DED	Displays the deductible amount on the claim.
MCR PD	Displays the Medicare paid amount.
TPL	Displays the amount paid by a third party insurance.
Total Billed	Displays the total billed for all line items on the claim.

Field	*Description*
Total Non Allowed	Displays the total payment that Medicaid will not cover for all line items on the claim.
Total Allowed	Displays the total allowed amount for all line items on the claim.
Total Patient Liability	Displays the total patient liability for all line items on the claim.
Total other deductible charges	Displays the total deductible charges for all line items on the claim.
Total Paid Amount	Displays the total amount of Medicaid payment for the claim.

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

This section of the EOP lists each denied claim in alphabetical order by recipient last name. An Explanation of Benefits code (EOB) appears beside each claim. Please reference the listing at the end of each EOP that defines the codes used on that EOP.

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.

The following table lists the fields in the denied claims section from left to right, top to bottom. Not all denied claims display data in every field.

Field	*Description*
Recipient Name	Displays the recipient's last name, first name, and middle initial. Claims are displayed in alphabetical order by last name.
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. This is the patient account number.
Diag	Displays the diagnosis codes submitted on the claim.
Perf Phys	Displays the provider number of the performing provider.
Recipient Medicaid ID	Displays the 12 digit recipient Medicaid ID number. This displays for each line item billed, if applicable.
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.
Place of Service, Procedure Code and Modifier	Displays these codes as they were submitted on the claim, with a description of the procedure code. This displays for each line item billed, if applicable.

Field	*Description*
Total Billed	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.
Total Allowed	Displays the amount of the billed amount that Medicaid will cover. In the case of a denied claim, this amount is always $0.00. This displays for each line item billed, if applicable.
Patient Liability	Displays the amount that is the responsibility of the recipient. This displays for each line item billed, if applicable.
Other Deducted Charges	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. In the case of a denied claim, this amount is always $0.00. This displays for each line item billed, if applicable.
EOB Codes	Displays a the Explanation of Benefit code corresponding to a message about claim adjudication. This displays for each line item billed, if applicable.
Coins	Displays the coinsurance amount paid by the recipient.
DED	Displays the deductible amount on the claim.
MCR PD	Displays the Medicare paid amount.
TPL	Displays the amount paid by a third party insurance.
Total Billed	Displays the total billed for all line items on the claim.
Total Non Allowed	Displays the total payment that Medicaid will not cover for all line items on the claim.
Total Allowed	Displays the total allowed amount for all line items on the claim. In the case of a denied claim, this amount is always $0.00.
Total Patient Liability	Displays the total patient liability for all line items on the claim.
Total other deductible charges	Displays the total deductible charges for all line items on the claim.
Total Paid Amount	Displays the total amount of Medicaid payment for the claim. In the case of a denied claim, this amount is always $0.00.

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.

Managed Care Claims Paid

This section of the EOP lists all paid Managed Care claims in alphabetical order by recipient last name.

Managed Care Claims Denied

This section of the EOP lists all denied Managed Care claims in alphabetical order by recipient last name.**Medicare-Related Claims Paid**

This section of the EOP lists all paid Medicare-related claims in alphabetical order by recipient last name.

Medicaid-Related Claims Denied

This section of the EOP lists all denied Medicare-related claims in alphabetical order by recipient last name.

Paid Adjustments

This section of the EOP lists adjustments made to correct payment errors in alphabetical order by recipient last name. Adjustments consist of two sections*: "Credit To"* and *"Debit To."*

The *"**Credit To**"* section lists information in reference to the original payment, including the original claim number, the paid date, and the original paid amount. This is the amount owed to EDS that will be deducted from current explanation of payment.

The *"**Debit To**"* section indicates changes made to the original claim or additional amounts EDS owes the provider. This segment lists a complete breakdown of the corrected information. The repayment is included as a part of the total paid claims amount.

This section also includes paid crossover adjustments. An Explanation of Benefits (EOB) code is assigned to each action that has taken place in the adjustment process. An explanation of these codes is listed after the Summary Page of the EOP.

The Net Adjustment is the difference between the original paid amount ("Credit To"), and the repaid claim ("Debit To") financial Items.

Refunds

This section of the EOP lists, in alphabetical order by recipient last name, those claims for which the provider has sent EDS a refund check.

NOTE:

Because EDS must correct claim payment history, the full payment amount must be credited for claims paid in error before the claim can be reprocessed correctly. If the provider has sent EDS a partial refund, the difference between the payment amount and the refund amount will be credited under the “Provider Refund Checks Processed” section of the summary page.

Claims In Process

The claims in process section of the EOP lists claims currently in process for the provider, in alphabetical order by recipient last name. Claims that appear in this section are paid, denied, suspended, or returned to the provider as appropriate on a future EOP. Providers should not submit inquiries or resubmit suspended claims as long as they appear on the EOP as suspended.

Summary Page

This page of the EOP is divided into two sections. The first section contains *informational dat*a (for example, total claims considered for payment, total claims suspended, total denied claims, and provider refund checks processed) for the current checkwriting period.

The second section contains *payment data* (for example, total claims approved for payment, claims adjusted, and check amount) for the current checkwriting period. Each section displays current and year-to-date totals.

NOTE:

If a credit balance has been established at the end of the payroll, the last entry appears as “Credit Balance Carried Forward,” and the following EOP lists this amount in the “Credit Balance Brought Forward” section of the payment data. The last EOP issued for the calendar year notifies providers of the amount submitted to the Internal Revenue Service for tax reporting.

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. (Refer to Appendix J of this manual for a complete list of the EOB codes).

Encounter Data

The final section of the EOP contains encounter claim data. This section follows the same sequence as the main part of the EOP. 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.

6.2 Reimbursement Schedule

Claims that have been accepted for processing either through electronic submission or manually by EDS staff are processed on a weekly basis. Payment for these claims is disbursed based on the biweekly 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.

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 EDS 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, performing providers). Failure to notify EDS of changes affects accurate processing and timely claims payment.

Send change requests to EDS Provider Enrollment, P.O. Box 244035, Montgomery, AL 36124.

7.1.2 Retention of Records

The provider must maintain and retain all necessary records, Explanation of Payments (EOPs), 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, EDS, 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).

7.1.3 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, EDS.

7.1.4 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

7.1.5 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 two systems: the Surveillance and Utilization Review (SUR) system, and the Codman Pandora Managed Care Information System (MCIS) product. 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 EDS, 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.

7.1.6 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.

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 §447.15.

7.1.7 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. 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.

7.2 Provider Rights

This section describes the fair hearings process, informal conferences, appeals, and EDS 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 EOPs and previous correspondence with EDS 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: Medical Services”).

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

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 EDS’ 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 EDS, P.O. Box 244035, Montgomery, Alabama 36124. Their toll free telephone number is 1-800-688-7989.

EDS provides current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. EDS 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 EDS. Only unsolved problems or provider dissatisfaction with the response of EDS should be directed to Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104, or by calling (334)242-5000.

7.2.4 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.

7.4 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 judgement 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 5.8, 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 the Alabama Medicaid Adjustment form as described in Section 5.8, Adjustments.
- Complete an online adjustment using Provider Electronic Solutions software or approved vendor software as described in Section 5.8, 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
- Writing the fiscal agent and requesting an adjustment of Medicaid payment (a copy of the request **must** be sent to the Third Party Division, Medicaid).

If the provider releases information to third party without approval from Medicaid Third Party Division, providers are responsible for reimbursing Medicaid using any Third Party payment that results.

8

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

EDS 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a transportation provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for transportation-related claims.

NOTE:

All nine digits are required when filing a claim.

Transportation providers are assigned a provider type of 15 (Transportation). Valid specialties for transportation providers include the following:

- Emergency Ground Ambulance (A1)
- Helicopter (TA)
- Fixed Wing (TB)

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

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.

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
- Nursing facility to nursing facility
- Hospital to hospital

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 covers air transportation services only for children under age 21 who are referred through an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening. Screenings must be completed before the transportation takes place.

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.

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. Medicaid does not consider trips of less than 50 loaded air miles to be appropriate unless extreme, extenuating circumstances are present and documented.

8.3 Prior Authorization and Referral Requirements

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix 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.

Prior Authorization for Non-Emergency Transportation (30 miles or greater)

All non-emergency ambulance services 30 miles or greater one way require prior authorization. However, the provider has 48 hours to obtain the prior authorization (PA). For example, if an eligible recipient requires non-emergency transport on a Friday, the ambulance provider would have until Monday to obtain the PA.

Prior Authorization for Repeat Non-Emergency Transportation (Less than 30 miles)

Medicaid reimburses for four (4) non-emergency trips less than 30 miles in the same calendar month without prior authorization, with the exception of trips to a physician's office, which always require prior authorization. The fifth non-emergency trip less than 30 miles in the same calendar month requires prior authorization.

Authorization for Air Transportation

All payments for air transportation services require authorization from Medicaid. Medicaid must receive requests no later than the second business day after the service was rendered. Please include the following:

- Copy of the EPSDT referral form
- Diagnosis
- Any other pertinent medical data as deemed necessary to document air transportation

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.

8.4 Cost Sharing (Copayment)

The copayment does not apply to services provided by transportation providers.

8.5 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.

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 HCFA-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.

8.5.1 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.

8.5.2 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.

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 ground transportation are listed on the next page. If you bill a diagnosis code that is not on this list, your claim will deny.

Covered Ambulance Diagnosis Codes

* 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.

250.1*	298.4	424.1	430	511.0	666.0*	747.49	773.5	801.3*	805.8	808.2	813.81
250.2*	298.8	424.2	431	511.1	666.1*	747.5	774.4	801.4*	805.9	808.3	813.82
250.3*	298.9	424.3	432.0	511.8	666.2*	747.60	775.1	801.5*	806.00	808.41	813.83
251.0	299.0*	424.90	432.1	511.9	666.3*	747.61	775.2	801.6*	806.01	808.42	813.90
282.62	299.1*	424.91	432.9	512.0	707.0	747.62	775.3	801.7*	806.02	808.43	813.91
290.3	299.8*	424.99	433.0*	512.1	741.0*	747.63	775.5	801.8*	806.03	808.49	813.92
290.40	299.9*	425.0	433.1*	512.8	741.9*	747.64	775.6	801.9*	806.04	808.51	813.93
290.41	345.1*	425.1	433.2*	518.0	742.0	747.69	776.2	802.0	806.05	808.52	818.1
290.42	345.2	425.2	433.3*	518.1	742.1	747.81	776.4	802.1	806.06	808.53	819.0
290.43	345.3	425.3	433.8*	518.2	742.2	747.82	776.5	802.20	806.07	808.59	819.1
291.0	345.4*	425.4	433.9*	518.3	742.3	747.89	777.1	802.21	806.08	808.8	820.0*
291.2	345.5*	425.5	434.0*	518.4	742.4	747.9	777.2	802.22	806.09	808.9	820.01
291.3	410.0*	425.7	434.1*	518.5	742.51	748.0	777.3	802.23	806.10	809.1	820.02
291.4	410.1*	425.8	434.9*	518.81	742.53	748.3	777.4	802.24	806.11	810.1*	820.03
291.5	410.2*	425.9	435.0	518.82	742.59	748.8	777.5	802.25	806.12	811.1*	820.09
291.8	410.3*	426.0	435.1	518.89	742.8	750.3	777.6	802.26	806.13	812.10	820.10
291.9	410.4*	426.10	435.2	519.0*	742.9	751.1	777.8	802.27	806.14	812.11	820.11
292.0	410.5*	426.11	435.3	578.0	745.0	751.2	777.9	802.28	806.15	812.12	820.12
292.11	410.6*	426.12	435.8	578.1	745.10	756.6	778.4	802.29	806.16	812.13	820.13
292.12	410.7*	416.13	435.9	578.9	745.11	759.4	779.2	802.30	806.17	812.19	820.19
292.2	410.8*	426.2	436	585	745.12	759.7	779.4	802.31	806.18	812.20	820.20
292.81	410.9*	426.3	437.0	634.1*	745.19	760.2	779.5	802.32	806.19	812.21	820.21
292.82	411.0	426.4	437.1	634.3*	745.2	760.70	780.0*	802.33	806.20	812.30	820.22
292.83	411.1	426.50	437.2	634.5*	745.3	760.71	780.1	802.34	806.21	812.31	820.30
292.84	411.81	426.51	437.3	634.6*	745.4	760.72	780.2	802.35	806.22	812.40	820.31
292.89	411.89	426.52	437.4	635.1*	745.5	760.73	780.31	802.36	806.23	812.41	820.32
292.9	413.1	426.53	437.5	635.3*	745.60	760.75	780.39	802.37	806.24	812.42	820.8
293.0	413.9	426.54	437.6	635.5*	745.61	761.5	785.50	802.38	806.25	812.43	820.9
293.1	414.0*	426.6	437.7	635.6*	745.69	762.1	785.51	802.39	806.26	812.44	821.00
295.0*	414.10	426.7	437.8	636.1*	745.7	762.2	785.59	802.4	806.27	812.49	821.01
295.1*	414.11	426.81	437.9	636.3*	745.8	762.5	786.00	802.5	806.28	812.50	821.10
295.2*	414.19	426.89	480.0	636.5*	745.9	763.5	786.01	802.6	806.29	812.51	821.11
295.3*	414.8	426.9	480.1	636.6*	746.00	765.0*	786.02	802.7	806.30	812.52	821.20
295.4*	414.9	427.0	480.2	637.1*	746.01	765.1*	786.09	802.8	806.31	812.53	821.21
295.5*	415.0	427.1	480.8	637.3*	746.02	767.0	786.1	802.9	806.32	812.54	821.22
295.6*	415.19	427.2	480.9	637.5*	746.09	767.4	786.50	803.0*	806.33	812.59	821.23
295.7*	416.0	427.31	481	637.6*	746.1	767.8	786.51	803.1*	806.34	813.10	821.29
295.8*	416.1	427.32	482.0	638.1	742.2	767.9	786.52	803.2*	806.35	813.11	821.30
295.9*	416.8	427.41	482.1	638.3	746.3	768.4	786.59	803.3*	806.36	813.12	821.31
296.0*	416.9	427.42	482.2	638.5	746.4	768.5	789.0*	803.4*	806.37	813.13	821.32
296.1*	417.0	427.5	482.30	638.6	746.5	768.6	790.1	803.5*	806.38	813.14	821.33
296.2*	417.1	427.60	482.31	639.1	746.6	768.9	790.2	803.6*	806.39	813.15	821.39
296.3*	417.8	427.61	482.32	639.3	746.7	769	790.3	803.7*	806.4	813.16	822.0*
296.4*	417.9	427.69	482.39	639.5	746.81	770.1	799.0	803.8*	806.5	813.17	822.1*
296.5*	420.0	427.81	482.4*	639.6	746.82	770.2	799.1	803.9*	806.60	813.18	823.0*
296.6*	420.90	427.89	482.81	639.8	746.83	770.3	799.2	804.0*	806.61	813.20	823.1*
296.7	420.91	427.9	482.82	640.0*	746.84	770.4	799.3	804.1*	806.62	813.21	823.2*
296.80	420.99	428.0	482.83	640.8*	746.85	770.5	799.4	804.2*	806.69	813.22	823.3*
296.81	421.0	428.1	482.89	640.9*	746.86	770.6	799.8	804.3*	806.70	813.23	823.8*
296.82	421.1	428.9	482.9	641.0*	746.87	770.7	799.9	804.4*	806.71	813.30	823.9*
296.89	421.9	429.0	483*	641.1*	746.89	770.8	800.0*	804.5*	806.72	813.31	824.0
296.90	422.0	429.1	484.1	641.2*	746.9	771.7	800.1*	804.6*	806.79	813.33	824.1
296.99	422.90	429.2	484.3	641.3*	747.0	771.8	800.2*	804.7*	806.8	813.40	824.2
297.0	422.91	429.3	484.5	641.8*	747.10	772.0	800.3*	804.8*	806.9	813.41	824.3
297.1	422.92	429.4	484.6	641.9*	747.11	772.1*	800.4*	804.9*	807.0*	813.42	824.4
297.2	422.93	429.5	484.7	642.5*	747.20	772.2	800.5*	805.0*	807.1*	813.43	824.5
297.3	422.99	429.6	484.8	642.6*	747.21	772.3	800.6*	805.1*	807.2	813.44	824.6
297.8	423.0	429.71	485	644.0*	747.22	772.4	800.7*	805.2	807.3	813.50	824.7
297.9	423.1	429.79	486	644.1*	747.29	773.0	800.8*	805.3	807.4	813.51	824.8
298.0	423.2	429.81	487.0	644.2*	747.3	773.1	800.9*	805.4	807.5	813.52	824.9
298.1	423.8	429.82	487.1	645*	747.40	773.2	801.0*	805.5	807.6	813.53	827.0
298.2	423.9	429.89	487.8	658.2*	747.41	773.3	801.1*	805.6	808.0	813.54	827.1
298.3	424.0	429.9	506*	661.3*	747.42	773.4	801.2*	805.7	808.1	813.80	828.0

828.1	861.03	867.5	873.63	887.0	902.31	928.9	952.3	965.9	975.0	E810*
835.0*	861.10	867.6	873.64	887.1	902.33	929.0	952.4	966.0	975.1	E811*
835.10	861.11	867.7	873.65	887.2	902.34	933.0	952.8	966.1	975.2	E812*
835.11	861.12	867.8	873.69	887.3	902.39	933.1	952.9	966.2	975.3	E813*
835.13	861.13	867.9	873.70	887.4	902.40	934.0	953*	966.3	975.4	E814*
836.0	861.20	868.0*	873.71	887.5	902.41	934.1	954*	966.4	975.5	E815*
836.1	861.21	868.1*	873.72	887.6	902.42	934.8	955*	967.0	975.6	E816*
836.2	861.22	869.0	873.73	887.7	902.49	934.9	956*	967.1	975.7	E817*
836.3	861.30	869.1	873.74	890.0	902.50	935.1	957*	967.2	975.8	E818*
836.4	861.31	870.0	873.75	890.1	902.51	940*	958.0	967.3	976.0	E819*
836.50	861.32	870.1	873.79	890.2	902.52	941.2*	958.1	967.4	976.1	E880.0
836.51	862.0	870.2	873.8	891.0	902.53	941.3*	958.2	967.5	976.2	E880.1
836.52	862.1	870.3	873.9	891.1	902.54	941.4*	958.4	967.6	976.3	E880.9
836.53	862.21	870.4	874.00	891.2	902.55	941.5*	960.0	967.8	976.4	E881.0
836.54	862.22	870.8	874.01	892.0	902.56	942.2*	960.1	967.9	976.5	E881.1
836.59	862.29	870.9	874.02	892.1	902.59	942.3*	960.2	968.0	976.6	E882
836.60	862.31	871.0	874.10	892.2	902.81	942.4*	960.3	968.1	976.7	E883*
836.61	862.32	871.1	874.11	893.0	902.82	942.5*	960.4	968.2	976.8	E884*
836.62	862.39	871.2	874.12	893.1	902.87	943.2*	960.5	968.3	976.9	E885*
836.63	862.8	871.3	874.2	893.2	902.89	943.3*	960.6	968.4	977.0	E886.0
836.64	862.9	871.4	874.3	894.0	902.9	943.4*	960.7	968.5	977.1	E886.9
836.69	863.0	871.5	874.4	894.1	903.0*	943.5*	960.8	968.6	977.2	E887
837.0	863.1	871.6	874.5	894.2	903.1	944.2*	960.9	968.7	977.3	E888*
837.1	863.20	871.7	874.8	895.0	903.2	944.3*	961.0	968.9	977.4	E890*
843.0	863.21	871.9	874.9	895.1	903.3	944.4*	961.1	969.0	977.8	E891*
843.1	863.29	872.00	875.0	896.0	903.4	944.5*	961.2	969.1	977.9	E892
843.8	863.30	872.01	875.1	896.1	903.5	945.2*	961.3	969.2	978.0	E893*
843.9	863.31	872.02	876.0	896.2	903.8	945.3*	961.4	969.3	978.1	E894
844.0	863.39	872.10	876.1	896.3	903.9	945.4*	961.5	969.4	978.2	E895
844.1	863.40	872.11	877.0	897.0	904.0	945.5*	961.6	969.5	978.3	E896
844.2	863.41	872.12	877.1	897.1	904.1	946.2	961.7	969.6	978.4	E897
844.3	863.42	872.61	878.0	897.2	904.2	946.3	961.8	969.7	978.5	E898.0
844.8	863.43	872.62	878.1	897.3	904.3	946.4	961.9	969.8	978.6	E898.1
844.9	863.44	872.63	878.2	897.4	904.40	946.5	962.0	969.9	978.8	E899
850.0	863.45	872.64	878.3	897.5	904.41	947.0	962.1	970.0	978.9	E905.0
850.1	863.46	872.69	878.4	897.6	904.42	947.1	962.2	970.1	979.0	E905.1
850.2	863.49	872.71	878.5	897.7	904.50	947.2	962.3	970.8	979.1	E911
850.3	863.50	872.72	878.6	900.00	904.51	947.3	962.4	970.9	979.2	V44.0
850.4	863.51	872.73	878.7	900.01	904.52	947.4	962.5	971.0	979.3	V44.1
850.5	863.52	872.74	878.8	900.02	904.53	947.8	962.6	971.1	979.4	V55.0
850.9	863.53	872.79	878.9	900.03	904.54	947.9	962.7	971.2	979.5	V55.1
851.0*	863.54	872.8	879.0	900.1	904.6	948.10	962.8	971.3	979.6	
851.1*	863.55	872.9	879.1	900.81	904.7	948.11	962.9	971.9	979.7	
851.2*	863.56	873.0	879.2	900.82	904.8	948.20	963.0	972.0	979.9	
851.3*	863.59	873.1	879.3	900.89	904.9	948.22	963.1	972.1	990	
851.4*	863.80	873.20	879.4	900.9	925.1	948.3*	963.2	972.2	991.6	
851.5*	863.81	873.21	879.5	901.1	925.2	948.4*	963.3	972.3	992.0	
851.6*	863.82	873.22	879.6	901.2	926.0	948.5*	963.4	972.4	992.1	
851.7*	863.83	873.23	879.7	901.3	926.11	948.6*	963.5	972.5	992.2	
851.8*	863.84	873.29	879.8	901.40	926.12	948.7*	963.8	972.6	992.3	
851.9*	863.85	873.30	879.9	901.41	926.19	948.8*	963.9	972.7	992.4	
852.0*	863.89	873.31	880.0*	901.42	926.8	948.9*	964.0	972.8	992.5	
852.1*	863.90	873.32	880.1*	901.81	926.9	949.2	964.1	972.9	992.6	
852.2*	863.91	873.33	880.2*	901.82	927.00	949.3	964.2	973.0	992.7	
852.3*	863.92	873.39	881.0*	901.83	927.01	949.4	964.3	973.1	992.8	
852.4*	863.93	873.40	881.1*	901.89	927.02	949.5	964.4	973.2	992.9	
852.5*	863.94	873.41	881.2*	901.9	927.03	950*	964.5	973.3	993.3	
853.0*	863.95	873.42	882.0	902.0	927.09	951*	964.6	973.4	994.0	
853.1*	863.99	873.43	882.1	902.10	927.10	952.00	964.7	973.5	994.1	
854.0*	864.0*	873.44	882.2	902.11	927.11	952.01	964.8	973.6	994.7	
854.1*	864.1*	873.49	883.0	902.19	927.8	952.02	964.9	973.8	994.8	
860.0	865.0*	873.50	883.1	902.20	927.9	952.03	965.00	973.9	995.0	
860.1	865.1*	873.51	883.2	902.21	928.00	952.04	965.01	974.0	997.1	
860.2	866.0*	873.52	884.0	902.22	928.01	952.05	965.02	974.1	997.3	
860.3	866.1*	873.53	884.1	902.23	928.10	952.06	965.09	974.2	998.0	
860.4	867.0	873.54	884.2	902.24	928.11	952.07	965.1	974.3	998.1*	
860.5	867.1	873.59	885.0	902.25	928.20	952.08	965.4	974.4	998.2	
861.00	867.2	873.60	885.1	902.26	928.21	952.09	965.5	974.5	998.3	
861.01	867.3	873.61	886.0	902.27	928.3	952.1*	965.7	974.6	999.1	
861.02	867.4	873.62	886.1	902.29	928.8	952.2	965.8	974.7	999.4	

8.5.3 Procedure Codes and Modifiers

Transportation providers use the following procedure codes and 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

A BLS ambulance provides transportation for such services as controlling bleeding, splinting fractures, treating shock, performing cardiopulmonary resuscitation (CPR), and others.

Procedure Code	***Description***
A0429	Ambulance Service, basic life support, emergency transport (BLS - Emergency)
A0380	BLS mileage, per mile (30 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 ambulance appropriately equipped and staffed by personnel authorized to administer IVs, establish and maintain a recipient's airway, defibrillate the heart, relieve pneumothorax conditions, and perform other advanced life support procedures or services such as cardiac (EKG) monitoring. Documentation must support need for ALS services.

Procedure Code	***Description***
A0427	Ambulance service, advanced life support, non-emergency transport, Level 1 (ALS1)
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).
A0390	ALS mileage, per mile (30 miles or more requires prior authorization)

Procedure Codes for Non-emergency Services

Procedure Code	***Description***
A0426	Ambulance service, advanced life support, Level 1 (ALS1) non-emergency transport, (cannot be billed with A0422)
A0428	Ambulance service, basic life support, (BLS), non-emergency transport
A0380	BLS mileage, per mile (30 miles or more requires prior authorization)
A0390	ALS mileage, per mile (30 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
A0999	Unlisted ambulance service

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. Prior Authorization is required when billing these codes. These claims should be filed on a medical claim either electronically or on paper. A Medicare EOMB is not required.

- A0380, A0382, A0390, A0426, A0428
- First Modifiers DD, DG, DH, DJ, DN, DP, DR, ED, GD, GN, HD, HP, ND, NG, RD, NP, PE, PH, PN, PR, RD, or RP
- Second Modifiers 1A, 5A, 6A, 7B, 8B, 1C, or 2C

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

Transportation Modifiers

All ground transportation procedure codes require two modifiers. The first modifier is a combination of the origin/destination codes. The second modifier indicates the necessity of ambulance transportation.

NOTE:

If you do not include a modifier in both modifier fields, Medicaid will deny the line item(s).

Air transportation procedure codes only require a modifier when billing for subsequent trips for the same recipient on the same day. See the Repeat Trip modifiers section below.

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***
AS	Ambulance trip to an out-of-state hospital
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:

AS	DN	EH	GE	HE	HN	JE	NE	NR	RJ
DD	DR	EJ	GH	HG	HR	JH	NG	RD	RN
DG	ED	EN	GN	HH	IH	JN	NH	RE	SH
DH	EE	ER	GR	HI	IN	JR	NJ	RG	SI
DJ	EG	GD	HD	HJ	JD	ND	NN	RH	UC

Second Modifier

Modifier	***Description***
1A	Bedridden
2A	Accidental injury home/nursing home
3A	Accidental injury
4A	Recipient in shock
5A	Oxygen used and/or heart monitor
6A	Transported by stretcher
7A	Fracture to hip, leg, knee, trunk (same day as ambulance trip)
8A	Hospital lacks facility (recipient admitted to second hospital)
9A	Rectal bleeding
1B	Myocardial infarction
2B	Possible cerebral vascular incident (CVA)
3B	Blacked out, passed out
4B	Laceration of head
5B	Dead on arrival (DOA) at hospital
6B	Died en route to hospital
7B	Unresponsive or coma
8B	Quadriplegia
9B	Stroke (same day as ambulance service)
1C	Paralysis
2C	Mentally retarded

Repeat Trip

The following modifiers are used in the second modifier position to indicate a repeat trip for the same recipient on the same day:

Modifier	*Description*
Y2	First repeat procedure, same date, same provider
Y3	Second repeat procedure, same date, same provider
Y4	Third repeat procedure, same date, same provider
Y5	Fourth repeat procedure, same date, same provider

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 Y2 modifier for Repeat Trip.

NOTE:

Repeat trip modifiers are the **only** modifiers valid for air transportation claims. This modifier should be placed in the first field after the procedure code.

8.5.4 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

8.5.5 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 HCFA-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

8.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an ASC provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for ASC-related claims.

NOTE:

All eight characters are required when filing a claim.

ASC Providers are assigned a provider type of 28 (ASC). Valid specialties for ASC providers include the following:

- Ambulatory Surgical Center (A4)
- Lithotripsy (L2)

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.

Ambulatory surgical center services are items and services furnished by an outpatient ambulatory surgical center in connection with a covered surgical procedure.

Rates of reimbursement for ambulatory surgical center 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(s) of the surgical procedure(s)
- 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 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) 242-5997. Dental services provided to SOBRA adult females are non-covered.

Ambulatory surgical center 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

Ambulatory surgical center services are reimbursed by means of a predetermined fee established by Medicaid. All ambulatory surgical center 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.

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

Medicaid maintains a listing of the covered surgical procedures in Appendix I, Outpatient Hospital/ASC Surgical Procedures List. This list is reviewed and updated on a regular basis by the appropriate staff at Medicaid.

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 EDS 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.

9.3 Prior Authorization and Referral Requirements

Certain procedures require prior authorization. Please refer to the Outpatient Hospital Covered Procedure Codes in Appendix I for a complete listing. A “Y” in the PA column on the list indicates outpatient surgery 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 Section D.1.3 of the Managed Care appendix 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 EDS, Attention Prior Authorization, P.O. Box 244035, Montgomery, Alabama 36125.

The prior authorization number issued must be listed on the UB-92 claim form when billing for the prior authorization service.

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-92 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)

The copayment amount for an ASC encounter is $3.00 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.

9.5 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.

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-92 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-92 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

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.

Only procedures listed in the Outpatient Hospital/ASC Procedure 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 Outpatient Hospital/ASC Procedure List could 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-92 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:

- Form XIX-TPD-1-76
- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 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-92 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
Outpatient Hospital/ASC Procedure 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. 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

EDS 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.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hearing services provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hearing-related claims.

NOTE:

All nine digits are required when filing a claim.

Hearing service providers are assigned a provider type of 66 (Hearing Aids) and/or 20 (Audiology/Hearing Services). The valid specialty for Hearing Aid providers is Hearing Aid Dealer (H1). The valid specialty for Audiology is 64 (Audiology).

Enrollment Policy for Audiology Providers

Audiologists must hold a valid State license issued by the state in which they practice.

EDS is responsible for enrollment of audiologists. Licensed audiologists desiring to participate in the Alabama Medicaid Program must furnish the following information to EDS 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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

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.

➢ 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.

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 HCFA-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 Procedure Codes and Modifiers

Audiological function tests must be referred by the attending physician before testing begins.

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
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
92569	Acoustic reflex decay test
92571	Filtered speech test
92572	Staggered spondaic word test
92573	Lombard test
92575	Sensorineural activity level test
92576	Synthetic sentence identification test

Procedure Code	Description
92577	Stenger test, speech
92583	Select picture audiometry
92584	Electrocochleography
92585	Brainstem evoked response recording
92587	Evoked otoacocestic emissions
92588	Comprehensive/diagnostic evaluation
92589	Central audiotory function test(s) (specify)
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

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

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

(Extra ear mold is a billable expense in connection with binaural aids.)

Hearing Aid Accessories

Procedure Code	*Description*
Z5150	Stethoscope (1 every 2 years)
Z5064	Harness (Huggies)
Z5065	Batteries (1 package every 2 months for use with monaural aid)
Z5066	Battery Cover
Z5067	Batteries (2 packages every 2 months for use with binaural aids)
Z5068	Receiver
Z5069	Ear mold (1 every 4 months for use with monaural aid)
Z5070	Garment Bag
Z5071	Cords
Z5072	Ear Hook
Z5073	Factory Repair of Aid (out of warranty) (1 every 6 months for use with monaural aid)
Z5074	Ear Mold (2 every 4 months for use with binaural aids)
Z5179	Factory Repair of Aids (out of warranty) (2 every 6 months for use with binaural aids)

NOTE:

Should one of the binaural aids need repair, use code Z5179 billing one unit. Indicate modifier LT (left) or RT (right) for the aid needing repair.

10.5.4 Place of Service Codes

The following place of service codes apply when filing claims for hearing services:

POS Code	*Description*
11	Office
99	Other Unlisted Facility

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 HCFA-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
HCFA-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

EDS 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*.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a chiropractor is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for chiropractic-related claims.

NOTE:

All nine digits are required when filing a claim.

Chiropractors are assigned a provider type of 18 (Chiropractor). Valid specialties for chiropractors include the following:

- Chiropractor (35)
- QMB/EPSDT (EQ)

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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

11.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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.

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:

- Form XIX-TPD-1-76
- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-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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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).

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a CORF provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for rehabilitation-related claims.

NOTE:

All eight characters are required when filing a claim.

CORF providers are assigned a provider type of 26 (Rehabilitation Center). The valid specialty for CORF providers is Rehabilitation Hospital (R1).

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-92 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

➢ 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.

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-92 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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-92 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-92 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 under age 21 through Medicaid as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

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.

The policy provisions for dental providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 15.

13.1 Enrollment

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a dental provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for dental-related claims.

NOTE:

All nine digits are required when filing a claim.

Dental providers are assigned a provider type of 08 (Dentist). Valid specialties for dental providers include the following:

- General Dentistry (V2)
- Oral and Maxillofacial Surgery (SE)

Oral Surgeons are assigned a provider type of 79 or 01, depending on the source of the licensure information sent to the EDS provider enrollment unit. The valid specialty for Oral Surgeons is Oral and Maxillofacial Surgery (SE).

Oral Surgeons billing medical procedures or CPT procedure codes should refer to Chapter 28, Physician. Only dental procedures (CDT-3 procedure codes) should be billed on the ADA dental claim form.

Enrollment Policy for Dental Providers

To participate in the Alabama Medicaid Program, dental providers must be licensed to practice in the state of Alabama. Each dental provider **must** enroll with EDS, who assigns a provider number for each office location. Each claim filed constitutes a contract with the Alabama Medicaid Agency.

Dentists who perform anesthesia or IV sedation services must submit a copy of their GA/IV certification to EDS with their provider enrollment application.

13.2 Benefits and Limitations

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

Dental care is limited to Medicaid eligible individuals who are under age 21 and are eligible for treatment under the EPSDT Program.

13.2.1 Examinations

Only one of the following four examinations may be billed at a single appointment, when applicable and considering program limitations.

Periodic Oral Examination

A periodic oral examination is an evaluation on 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 for eligible Medicaid recipients.

Limited Oral Examination (Problem Focused)

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 should report the tooth number or area of the oral cavity in the dental record where the specific problem is suspected on the dental record. This procedure cannot be billed in conjunction with periodic or comprehensive oral examinations.

Comprehensive Oral Examination

A comprehensive oral examination is 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. It may require interpretation of information acquired through additional procedures. Report additional diagnostic procedures separately. This would include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, etc. This examination is limited to once per recipient, per provider.

Re-evaluation - Limited (Problem Focused) Oral Examination

A re-evaluation - limited (problem focused) examination is used to assess a previously existing condition. For example, traumatic injury needing follow-up monitoring, evaluation of undiagnosed pain and soft tissue lesion requiring follow-up evaluation.

13.2.2 Dental Sealants

Dental sealants covered by Medicaid are limited to one application per tooth in a recipient's lifetime. Sealant (per tooth) is limited to one per permanent molar only and is non-covered for children less than 5 or greater than 13 years of age. The covered tooth numbers are 02, 03, 14, 15, 18, 19, 30, and 31. Teeth to be sealed must be free of proximal caries, and there can be no previous restorations on the surface to be sealed. Sealant material must be ADA approved opaque or tinted.

13.2.3 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 or 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/or 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.

Specific **non-covered services** include the following diagnoses:

- Dento-facial Anomaly, NOS
- Orofacial Anomaly, NOS
- Severe Malocclusion

13.2.4 Radiology

Radiological procedures are limited to those required to make a diagnosis. The radiographs should show all areas where treatment is anticipated. All x-ray films must be properly mounted suitable for interpretation and identification, with the patient's name, date, name of dentist, and marked "left" and "right."

A full series consisting of at least 14 periapical and two posterior bitewing films is permitted every three years if professional judgement dictates.

A panoramic film and two posterior bitewing films may be substituted for a full mouth series at the dentist's discretion. A panoramic film is limited to once per recipient every three years.

Posterior bitewing and single anterior films may be taken every six months as part of an examination, if medically necessary. If required, a single x-ray may be taken at any time in order to establish a diagnosis.

13.2.5 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:

- Surgical periodontal treatment (Exceptions require prior authorization: Pharmaceutically induced hyperplasia and idiopathic juvenile periodontosis)
- Orthodontic treatment (Exception: medically necessary orthodontic services when prior authorized by Medicaid)
- Prosthetic treatment, such as fixed or removable bridgework, 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)
- Dental transplants
- Dental implants
- Prosthetic implants
- Esthetic veneers
- Silicate restorations
- Acrylic, plastic restorations (class III or V)
- Acrylic, plastic restorations (class IV)
- Plastic crowns (acrylic)
- Porcelain/ceramic substrate crowns
- Adult Dental Care

Palliative (emergency) treatment cannot be billed with another therapeutic (definitive) procedure but can be billed with diagnostic procedures. Professional consultation is stand-alone. Only single restorations code can be billed per date of service per tooth.

13.3 Prior Authorization and Referral Requirements

Prior authorization from Medicaid is required for the following services:

- Periodontal treatment (scaling and root planing, curettage, full mouth debridement, periodontal maintenance procedures)
- Excision of hyperplastic tissue
- Hospitalizations for dental care (not required for any out-of state hospitalizations or for children aged 5 or under on date(s) of Alabama hospital service)
- 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)
- Post and cores (cast or prefabricated)
- Core buildups
- Space maintainers (after the first two)
- Apicoectomy/periradicular surgery (if more than one root involved)
- Removal of completely bony impactions
- Excision of malignant tumors
- Malar and/or zygomatic arch reduction (open or closed)
- Open dislocation reduction
- Condylectomy
- Surgical discectomy (with/without implant)
- Arthrocentesis
- Home visits or treatment of any recipient under age 21 in a licensed medical institution (nursing facility)
- Professional consultation with another dentist
- Diagnostic models (when requested by Medicaid)
- Oral/Facial Images (e.g., photographs or slides when requested by Medicaid)

Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

13.3.1 Obtaining Prior Authorization for Dental Services

Providers must use the Prior Review and Authorization Dental Request Form (form 343) to request prior authorization for any of the above procedures. All sections of this form must be completed. The form should be forwarded to EDS, P.O. Box 244036, Montgomery, AL 36124-4036. Refer to Chapter 4, Obtaining Prior Authorization, of the Alabama Medicaid Provider Manual for instructions on obtaining prior authorization and completion of the form.

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 the Alabama Medicaid Agency's Dental Program at (334) 242-5997. 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)
- Provider number of dentist
- Phone number of dentist
- Nature of emergency
- Contact person, if other than dentist for follow-up

An Alabama Prior Review and Authorization Dental Request Form (form 343) must be received by the fiscal agent within ten calendar days of the telephone/voice message request. If the request is not received within ten calendar days of the telephone call, the authorization will be denied. The request must meet established guidelines and criteria.

13.3.2 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 13.5.3, Procedure Codes and Modifiers.

When completing the Alabama Prior Review and Authorization Dental Request (Form 343), **ONLY** list those procedures that require prior authorization.

Additional dental prior authorization criteria will be provided to all Medicaid dental providers as they become available.

Periodontal Maintenance Procedures – CDT-3 Code D4910

Prior authorization for Periodontal/Special Maintenance following active therapy 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)

- CDT-3 procedure code
- The number of units or visits

Approval is typically given for a specified time frame of one to three months.

Gingival Curettage – CDT-3 code D4220

The gingival curettage surgical procedure is per quadrant and at least one of the following conditions must exist:

- Treatment of periodontally compromised patients
- Debridement of localized sites of recalcitrant periodontitis
- Treatment of juvenile periodontitis
- When esthetics is a concern
- Treatment of other types of periodontitis

Prior authorization for gingival curettage requires radiographs and complete periodontal charting (probing depths, free gingival margins in relation to CEJs, etc.) be provided with prior authorization request.

Documentation must support at least one of the above indications. Root instrumentation is routinely accomplished in conjunction with this procedure, usually performed under local anesthesia.

Gross Debridement (Full Mouth) – CDT-3 Code D4355

Indicated when a subgingival and/or supragingival plaque and calculus obstruct the ability to perform a complete oral evaluation. This is a preliminary procedure and does not rule out the need for other procedures. This procedure requires that appropriate radiographs be sent with the request.

Scaling and Root Planing – CDT-3 Code D4341

Prior authorization for scaling and root planing requires documentation of pocket depths as follows:

- Patients over 12 years old must have a generalized pocket depth greater than 4 mm. (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 (bitewings and anterior periapicals) 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 planing will be permitted for each date of service, except for patients treated as inpatient/outpatient hospitalization cases.

Third Space Maintainer – CDT-3 Codes D1510-D1525

Prior authorization for third space maintainer must meet at least one of the following indications:

- Premature loss of second primary molar in a time frame of six months or less
- Premature loss of first primary molar (has just occurred) except in mixed dentition with normal class I occlusion

Inpatient/Outpatient Hospitalization – Code Z5158

For prior authorization for patients six years through 20 years of age, at least one of the following criteria must be met:

- Child or adolescent who requires dental treatment has a physical or mentally compromising condition
- Young child who requires dental treatment is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder
- Patient has extensive orofacial and dental trauma
- Procedure is of sufficient complexity or scope to warrant hospitalization

Approval is typically given for a specified time frame not to exceed three months. Treatment must be dentally necessary and supported by appropriate radiographs, where applicable.

Outpatient/ASC Admission – Code Z5363

Prior authorization is not required for procedure code Z5363 for children under 6 years.

Adult Anesthesia and Facility Fees – Code Z5158

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.

13.3.3 Referral Requirements

Dental care is available as a result of EPSDT referral or of the recipient seeking treatment.

EPSDT Referral

If the EPSDT screening provider determines a recipient requires dental care or if the recipient is 3 years of age or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and/or treatment. After the recipient's dental care is initiated, the Consultant's portion of the EPSDT Referral For Services Form must be completed by the dentist and the appropriate copy must be returned to the screening provider.

Recipient Seeking Treatment

If a recipient who has not been screened through the EPSDT Program requests dental care, care may be provided without having an EPSDT Referral Form. Dental care, provided upon recipient request, is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT provider to obtain a complete medical assessment.

Patient 1st Referrals

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

13.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by dental providers.

13.5 Completing the Claim Form

Only ADA-approved forms are acceptable. If you experience problems with EDS processing your forms, contact EDS for resolution. Refer to Section 5.4, Completing the ADA Dental Form, for complete instructions on filling out the ADA Dental 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.

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.

13.5.1 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 Section 5.1.5, Filing Limits, for more information regarding timely filing limits and exceptions.

13.5.2 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

13.5.3 Procedure Codes and Modifiers

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.

NOTE:

Effective for claims **received** January 1, 2001, and thereafter, the CDT-3 procedure codes must be used. This will require conversion to the D-codes.

Diagnostic Clinical Oral Examinations

Limited oral exam – problem-focused (D0140) and Re-evaluation – limited, problem-focused (D0170) must document the tooth number or area of the mouth treated in the dental record. These procedures cannot be billed in conjunction with a periodic or comprehensive oral examination.

Procedure Code	*Description of Procedure*	*PA Required*
D0120	Periodic oral examination (limited to once every 6 months)	No
D0140	Limited oral evaluation – problem focused (emergency treatment)	No
D0150	Comprehensive oral examination (Once per recipient’s lifetime per provider or provider group)	No
D0170	Re-evaluation – limited, problem-focused	No

Radiographs

All films must be suitable for interpretation, mounted in proper x-ray mounts marked Right and Left, and identified by type. When billing Intraoral - Periapical, each additional film (D0230) or Extraoral - each additional film (D0260), a quantity (unit) of service is required in tooth number column on electronic or paper claim.

Procedure Code	*Description of Procedure*	*PA Required*
D0210	Intraoral – Complete series, including bitewings (once every 3 years)	No
D0220	Intraoral – Periapical, first film	No
D0230	Intraoral – Periapical, each additional film	No
D0240	Intraoral – Occlusal film	No
D0250	Extraoral – first film	No
D0260	Extraoral – each additional film	No
D0272	Bitewings – two films	No
D0274	Bitewings - four films	No

Procedure Code	Description of Procedure	PA Required
D0330	Panoramic film (Cannot be billed in addition to D0210, and limited to once per recipient every three years)	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	PA 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 polishing.

Procedure Code	Description of Procedure	PA Required
D1110	Prophylaxis - Adult (over 12 years of age)	No
D1120	Prophylaxis - Child (up to and including 12 years of age)	No
D1201	Topical fluoride with prophylaxis – Child (up to and including 12 years of age) **Trays, Not Paste**	No
D1203	Topical application of fluoride (excluding prophylaxis) – Child (up to and including 12 years of age)	No
D1204	Topical application of fluoride (excluding prophylaxis) – Adult (over 12 years of age)	No
D1205	Topical fluoride with prophylaxis – Adult (over 12 years of age) **Trays, Not Paste**	No
D1351	Sealant, per tooth - (Once per permanent molar only for children aged five through 13 years)	No

Space Maintainers

The first two space maintainers do not require prior authorization. Prior authorization with justification is required for third and later space maintainers.

Procedure Code	Description of Procedure	PA Required
D1510	Space maintainer- fixed, unilateral	After first two
D1515	Space maintainer- fixed, bilateral	After first two
D1520	Space maintainer – removable, unilateral	After first two
D1525	Space maintainer- removable, bilateral	After first two
D1550	Re-cement space maintainer	After first two

Restorative Services

Fee for restorative service includes lining or base, restoration, and local anesthesia or analgesia, if necessary.

Amalgam Restorations (Including Polishing)

Procedure Code	Description of Procedure	PA Required
D2110	Amalgam – one surface, primary	No
D2120	Amalgam – two surfaces, primary	No
D2130	Amalgam – three surfaces, primary	No
D2131	Amalgam – four or more surfaces, primary	No
D2140	Amalgam – one surface, permanent	No
D2150	Amalgam – two surfaces, permanent	No
D2160	Amalgam – three surfaces, permanent	No

Procedure Code	Description of Procedure	PA Required
D2161	Amalgam – four or more surfaces, permanent	No

Composite Restorations

Composite restorations are now authorized for all surfaces including occlusal surfaces.

Procedure Code	Description of Procedure	PA 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
D2380	Resin – one surface, posterior, primary	No
D2381	Resin – two surfaces, posterior, primary	No
D2382	Resin – three or more surfaces, posterior, primary	No
D2385	Resin – one surface, posterior, permanent	No
D2386	Resin – two surfaces, posterior, permanent	No
D2387	Resin – three or more surfaces, posterior, permanent	No
D2388	Resin – four or more surfaces, posterior, permanent	No

Crowns, Single Restorations Only

Medicaid covers crowns and core buildups following root canal therapy **only.** Crowns (excluding stainless steel crowns) are limited to the permanent anterior and posterior teeth following root canal therapy. **Posterior molars are limited to cast metal crowns only (Procedure code D2792)**. Prior authorization requests for codes D2950, D2952, D2953, D2954, and D2957 must include a periapical radiograph showing the completed root canal therapy.

Procedure Code	Description of Procedure	PA Required
D2750	Crown – porcelain fused to high noble metal	No
D2751	Crown – porcelain fused to predominantly base metal	No
D2752	Crown – porcelain fused to noble metal	No
D2792	Crown – full cast metal	No

* No prior authorization is required for crowns if a completed root canal treatment is in Medicaid's history. If no root canal is in Medicaid's history, send xray of completed root canal with completed claim form directly to: AL Medicaid Agency ATTN: Dental Program, 501 Dexter Ave, P.O. Box 5624 Montgomery, AL 36130-5624.

Other Restorative Services

Procedure Code	Description of Procedure	PA Required
D2920	Re-cement crown	No
D2930	Prefabricated stainless steel crown, primary tooth	No
D2931	Prefabricated stainless steel crown, permanent tooth	No
D2932	Prefabricated resin crown	No
D2940	Sedative fillings (not to be used with liners or bases)	No
D2950	Core buildup, including any pins-requires prior authorization	Yes
D2951	Pin retention – per tooth in addition to restoration	No
D2952	Cast post and core in addition to crown	Yes
D2953	Each additional cast post – same tooth (maximum of 2)	Yes
D2954	Prefabricated post and core in addition to crown	Yes
D2957	Each additional prefabricated post – same tooth (maximum of 2)	Yes

Endodontics

Pulp Capping
Pulp Capping applies to permanent teeth only, and is limited to one per tooth. Bases and sedative fillings do not qualify as pulp caps.

Procedure Code	Description of Procedure	PA Required
D3110	Pulp cap, Direct (excluding final restoration) Pulp cap must cover exposed pulp	No
D3120	Pulp cap, Indirect (excluding final restoration)	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.

Procedure Code	Description of Procedure	PA Required
D3220	Therapeutic pulpotomy (excluding final restoration)	No

Primary Endodontics

Procedure Code	Description of Procedure	PA Required
D3230	Pulpal therapy, anterior primary tooth	No
D3240	Pulpal therapy, posterior primary tooth	No

Endodontics on Permanent Teeth
Root canal therapy applies to permanent teeth only. Therapy includes treatment plan, clinical procedures, radiographs, and follow-up care.

Procedure Code	Description of Procedure	PA Required
D3310	Anterior, excluding final restoration	No
D3320	Bicuspid, excluding final restoration	No
D3330	Molar, excluding final restoration	No
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	No
D3351	Apexification, per treatment visit	No

Periapical Services

Procedure Code	Description of Procedure	PA Required
D3410	Apicoectomy, per tooth - first root	No
D3426	Apicoectomy/periradicular surgery, each additional root	Yes
D3430	Retrograde filling - per root	No

Periodontics

Periodontics require prior authorization. Prior authorization for periodontal therapy codes D4220, D4341, or D4910 requires the following:

- Complete periodontal charting (including probing depths) and free gingival margins in relation to CEJs
- Bitewing radiographs and any involved anterior periapical radiographs to be submitted with the prior authorization request

Full mouth debridement (D4355) is indicated when a subgingival and/or supragingival plaque and calculus obstruct the ability to perform a complete oral evaluation. Bitewing radiographs and any involved anterior periapical radiographs must be submitted with the prior authorization request.

Procedure Code	***Description of Procedure***	***PA Required***
D4220	Gingival curettage, per quadrant	Yes
D4341	Periodontal scaling and root planing, per quadrant	Yes
D4355	Full mouth debridement	Yes
D4910	Periodontal maintenance procedures	Yes

Oral Surgery

Extractions

Extractions include local anesthesia and routine postoperative care.

Procedure Code	***Description of Procedure***	***PA Required***
D7110	Single tooth	No
D7120	Each additional tooth	No
D7130	Root removal - exposed roots	No

Surgical Extractions

Surgical Extractions include local anesthesia, minor alveoloplasty, sutures, and routine postoperative care. Radiographs are required with PA request for procedure codes D7240 and D7241.

Procedure Code	***Description of Procedure***	***PA Required***
D7210	Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	No
D7220	Removal of impacted tooth – soft tissue	No
D7230	Removal of impacted tooth – partially bony	No
D7240	Removal of impacted tooth – completely bony	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	No

Other Surgical Procedures Applied To Teeth

Procedure Code	***Description of Procedure***	***PA Required***
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	No
D7281	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

Alveoplasty

Procedure Code	***Description of Procedure***	***PA Required***
D7310	Alveoplasty in conjunction with extractions - per quadrant	No
D7320	Alveoplasty not in conjunction with extractions - per quadrant	No

Removal of Tumors, Cysts, and Neoplasms

Procedure Code	Description of Procedure	PA Required
D7430	Excision of benign tumor, lesion diameter up to 1.25 cm	No
D7431	Excision of benign tumor, lesion diameter greater than 1.25 cm	No
D7440	Excision of malignant tumor, lesion diameter up to 1.25 cm	Yes
D7441	Excision of malignant tumor, greater than diameter over 1.25 cm	Yes
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	PA Required
D7471	Removal of exostosis – per site	No
D7510	Incision and drainage of abscess, intraoral soft tissue	No
D7520	Incision and drainage of abscess, extraoral soft tissue	No

Treatment of Fractures - Simple

Procedure Code	Description of Procedure	PA 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
D7650	Malar and/or zygomatic arch-open reduction	Yes
D7660	Malar and/or zygomatic arch-closed reduction	Yes

Reduction of Dislocation - Management of Other Temporomandibular Joint Dysfunctions

Procedure Code	Description of Procedure	PA Required
D7810	Open reduction of dislocation	Yes
D7820	Closed reduction of dislocation	No
D7840	Condylectomy	Yes
D7850	Surgical diskectomy; with or without implant	Yes
D7870	Arthrocentesis	Yes

Other Repair Procedures

Excision of hyperplastic tissue (D7970) requires:

- Complete periodontal charting (including probing depths and free gingival margins in relation to CEJs)
- Medical documentation, if applicable
- Possible oral images/photographs (if required by Medicaid)

Procedure Code	Description of Procedure	PA Required
D7911	Complicated suture, up to 5 cm.	No
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	No
D7970	Excision of hyperplastic tissue; per arch	Yes
D7971	Excision of pericoronal gingiva	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.

Adjunctive General Services
Palliative (emergency) treatment (D9110) should not be billed with the following definitive or emergency procedures: D0210, D0350, D0470, D1110 through D7970, D7971, D9220 and D9610. D9110 is not to be used to bill for anything other than pallative treatment. This is **not** a non-specific code and must not be used to bill for any procedure that has its own unique code. Always bill the most appropriate CDT-3 code.

Procedure Code	***Description of Procedure***	***PA Required***
D9110	Palliative (emergency) treatment of minor dental pain. *Limited to one per visit and may not be billed with separately listed procedures.*	No

Procedures

The following procedures are limited to one per visit when not covered by separately listed procedures.

Anesthesia

Procedure Code	***Description of Procedure***	***PA 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 or uncooperative patients. Documentation of medical necessity must be in the medical record.	No
D9241	Intravenous sedation/analgesia (requires current state board IV or GA permit)	No

Professional Consultation

Procedure Code	***Description of Procedure***	***PA Required***
D9310	Consultation, per session	Yes

Drugs

Procedure Code	***Description of Procedure***	***PA Required***
D9610	Therapeutic drug injection, by report Billable only when no definitive treatment rendered in same visit	No

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.

The following codes may be used in conjunction with those listed on the claim form:

Code	***Designation***	***Code***	***Designation***
UR	Upper Right Quadrant	FM	Full mouth
UL	Upper Left Quadrant	LR	Lower Right Quadrant
UA	Upper Arch	LL	Lower Left Quadrant
LA	Lower Arch	99	Supernumerary Tooth

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		

When more than one surface on the same tooth is affected, use the following combinations:

2 Surfaces			*3 Surfaces*				*4 Surfaces*	
MO	IF	ML	MOD	IFL	BOL	MID	MODB	MIFL
DB	IL	OB	MOB	MIL	DOB	MIF	MODL	DIFL
MB	DI	DO	MOL	DIL	DOL	DIF	MOBL	MIDL
DL	MI	OL	MBD	MLD			MIDF	

13.5.4 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
21	Inpatient hospital
22	Outpatient hospital
31	Skilled nursing facility or nursing facility

NOTE:

Place of service codes other than 11 require prior authorization before delivery of the service.

13.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

13.6 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

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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.

NOTE:

A recipient does not have to be a Home Health Care recipient in order to receive services of this program.

The policy provisions for DME providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 13.

14.1 Enrollment

EDS 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 your 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a DME provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for DME-related claims.

NOTE:

All nine digits are required when filing a claim.

DME providers are assigned a provider type of 91 (DME). The valid specialty for DME providers is Durable Medical Equipment/Oxygen (V4).

Enrollment Policy for DME Providers

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

- 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.
- There must be at least one person present to conduct business at the physical location. Answering machines and/or answering services are not acceptable as personal coverage during normal business hours (8:00 a.m. – 5:00 p.m.) The provider may serve all counties adjoining the county in which he has a business license and is physically located. 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 the satellite could enroll with a separate provider number.
- Medicaid will enroll manufacturers of augmentative/alternative communication devices (ACDs) regardless of location.
- The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations.

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 and Appliances

A written order or a signed prescription from the attending physician to a participating supplier determines medical necessity for covered items of supplies and appliances. Prior authorization by Medicaid is not required for supplies and appliances except for when more than the Medicaid allowed units are required (i.e. blood glucose test strips and lancets).

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.

Upon receipt of the prescription, the DME provider must:

- Verify Medicaid eligibility by checking the RID number and verifying that number using AVRS, AEVCS or the Provider Assistance Center at EDS
- Obtain necessary managed care referrals and prior authorization
- Collect the appropriate copayment amount
- Furnish the covered item(s) as prescribed
- Retain the prescription on file
- Submit the proper claim form to EDS

14.2.2 Durable Medical Equipment

Medicaid covers new standard items for long-term use, defined as the use of durable medical equipment that exceeds six months.

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.

Warranty, Maintenance, Replacement, and Delivery

All standard durable medical equipment must have a manufacturer's warranty of a minimum of one year. 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.

Medicaid covers repair of standard durable medical equipment. These services must be prior approved by Medicaid. Documentation submitted must support the need for servicing of the equipment. Providers should submit their usual and customary charges for the service.

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. 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.

NOTE:

This section describes medical policy for DME. For valid procedure codes and modifiers, refer to Section 14.5.3, Procedure Codes and Modifiers.

Suction Pump, Home Model, Portable (E0600)

A physician must prescribe a suction pump as medically necessary for the equipment to qualify for Medicaid reimbursement. EDS must receive a request for coverage within **seven State working 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. 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.

NOTE:

Purchase of the suction pump will be limited to one per lifetime for recipients who meet the above criteria.

Home Blood Glucose Monitor (E0607)

Home blood glucose monitors will be considered for Medicaid beneficiaries diagnosed as having either Type 1, Type 2, or Gestational Diabetes Mellitus. Home blood glucose monitors must be prescribed as medically necessary by the primary physician and prior authorized by EDS, and **at least two** of the following medical criteria must be met:

- Home blood glucose monitoring is required two or more times a day.
- Physician identifies or diagnoses a recurrence in the recipient's symptoms (hyperglycemia, hypoglycemia) that may be prevented, delayed, or controlled by self-monitoring the blood sugar.
- Recipient has had at least one emergency room visit or one hospital admission related to diabetes complications within the 12 months prior to the date of the request.
- Recipient has uncontrolled diabetes manifested by two or more fasting blood sugars of greater than 126 mg/dl, hemoglobin Alc > 7.0%, or random blood sugar > 150 mg/dl.
- Recipient experiences complications resulting from poor diabetes control including neuropathy, nephropathy, retinopathy, recurrent hyperglycemia/hypoglycemia, repeated infections or non-healing wounds, stroke, and cardiovascular disease.
- Recipient has experienced two or more HbAlc levels < 4.0 % or >7.0%, at least three months apart.

The dispensing provider must submit documentation that justifies at least two of the medical criteria above to EDS for prior authorization within **seven State working days** from the date the equipment was dispensed. This alone does not guarantee approval. Medical necessity must be determined by Medicaid professional staff. A review of the submitted documentation will determine medical necessity. The request may be approved or denied, or additional information may be requested. Documentation must also include the physicians' certification that the recipient or their caregiver is receiving, or has received, diabetes education and training for the use the glucose monitor in the appropriately prescribed manner for use in the home.

Requests for Medicaid's authorization of a replacement glucose monitor will be accepted for review **every two years** from the initial physician's certification date. Medicaid will consider requests for the exceptions from this time frame only if the replacement is needed due to an occurrence beyond the recipient's control. The request for a replacement glucose monitor must be accompanied by the documentation of the reason for the request. Negligence will not be considered a valid reason for exception.

Blood Glucose Test or Reagent Strips and Lancets (A4253, A4259)

Blood glucose test or reagent strips for home blood glucose monitor, along with lancets, will be considered for beneficiaries diagnosed as having either Type 1, Type 2, or Gestational Diabetes Mellitus. Blood glucose test or reagent strips must be prescribed as medically necessary by the primary physician, and **at least two** of the following medical criteria must be met:

- Home blood glucose monitoring is required two or more times a day.
- Physician identifies or diagnoses a recurrence in the recipient's symptoms (hyperglycemia, hypoglycemia) that may be prevented, delayed, or controlled by self-monitoring the blood sugar.
- Recipient has had at least one emergency room visit or one hospital admission related to diabetes complications within the 12 months prior to the date of the request.
- Recipient has uncontrolled diabetes manifested by two or more fasting blood sugars of greater than 126 mg/dl, hemoglobin Alc > 7.0%, or random blood sugar > 150 mg/dl.
- Recipient experiences complications resulting from poor diabetes control including neuropathy, nephropathy, retinopathy, recurrent hyperglycemia/hypoglycemia, repeated infections or non-healing wounds, stroke, and cardiovascular disease.
- Recipient has experienced two or more HbAlc levels < 4.0 % or >7.0%, at least three months apart.

The dispensing provider is responsible for maintaining documentation from the prescribing physician that justifies the medical criteria is met. Documentation must not be greater than six months from the date of the prescription. Failure to maintain this documentation on file for at least three years may result in recoupment of charges billed to Medicaid.

- **A4253** - Blood glucose test or reagent strips for home glucose monitor, per box of 50 (limited to 3 boxes per month). If additional strips are needed, a prior authorization request must be submitted to Medicaid for review. The request must include documentation from the primary physician that justifies medical necessity for the additional strips.

- **A4259** – Lancets, per box of 100. (limited to two boxes per month). If additional lancets are needed, a prior authorization request must be submitted to Medicaid for review. The request must include documentation from the primary physician that justifies medical necessity for the additional lancets.

If additional strips or lancets are needed and at least two of the above medical criteria continue to be met, a prior authorization request must be submitted by the dispensing provider to EDS within **seven State working days** from the date the item was dispensed.

Medical necessity must be determined by Medicaid professional staff. A review of the submitted documentation will determine medical necessity. The request may be approved or denied, or additional information may be requested. Documentation must also include the physicians' certification that the recipient or his/her caregiver is receiving, or has received, diabetes education and training for the use the glucose monitor, strips, and lancets in the appropriately prescribed manner for use in the home.

NOTE:

Effective November 1, 2000, Durable Medical Equipment (DME) Providers of diabetic equipment and supplies who can provide mail order services are allowed to provide these supplies statewide. Medicaid's current policy only allows DME providers to provide equipment, supplies and appliances to recipients living in adjoining counties. This policy will still apply for all services provided with the exception of the diabetic equipment and supplies. These services may be provided by any enrolled Medicaid DME provider offering mail order services of diabetic equipment and supplies. These providers will also offer free replacement of non-functioning diabetic glucose monitors. This updated policy will ensure that all elderly or disabled recipients who are in need of diabetic supplies, and are without any means of transportation will have adequate access to them.

Hospital Bed/Mattress/Bed Side Rails (E0250, E0255) (K0456)

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. EDS must receive the request for coverage within **seven State working days** after the date that the equipment was dispensed. The recipient must be bed confined and have one or more of the following conditions:

- Recipient's condition necessitates positioning or transferring that would not be feasible in an ordinary bed
- Recipient experiences severe contractures
- Recipient is comatose or semi-comatose

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.

Effective August 1, 2001, Medicaid will begin coverage of Semi-Electric Extra Heavy Duty Hospital Beds to accommodate recipients who weigh more than 350 pounds, but less than or equal to 600 pounds.

Medicaid will cover these semi-electric beds using Medicare's procedure code K0456 (Hospital bed, heavy duty, extra wide, semi-electric [head and foot adjustment] with any type rails, with mattress). Medicaid will use the established prior authorization criteria for the hospital beds, but will add the weight, width and length requirements. Individuals approved for this bed must be fitted and measured by the Durable Medical Equipment Company providing these services.

NOTE:

Purchase of the hospital bed/mattress/bed side rails is limited to one per lifetime for recipients who meet the above criteria.

Alternating Pressure Pad (E0181)

A physician may consider alternating pressure pads (APP) for Medicaid payment only when prescribed as medically necessary. Requests for the equipment must be received by EDS within **seven State working days** after the date that the APP was dispensed. The following medical criteria must be met:

- Documentation must indicate the recipient has, or is highly susceptible to, decubitus ulcers.
- The recipient must be essentially bed confined.
- The recipient's physician must supervise the use of the APP in connection with the course of treatment.

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.

NOTE:

Alternating pressure pads are limited to one every three years for recipients who meet the above criteria.

Gel or Gel-like Pressure Pad for Mattress (E0185)

Gel or gel-like pressure pads will be considered for Medicaid payment when prescribed as medically necessary by a physician. Request for coverage must be received by EDS within **seven State working 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.
- The recipient must be essentially bed confined.
- The recipient's physician must supervise the use of the gel or gel-like pressure pad in connection with the course of treatment.

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.

NOTE:

Purchase of the gel or gel-like pressure pad is limited to one every two years for recipients who meet the above criteria.

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 EDS within **seven State working 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.
- The recipient's physician must supervise the use of the gel or gel-like pressure pad in connection with the course of treatment.

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.

NOTE:

Purchase of the mattress replacement is limited to one every three years for recipients who meet the above criteria.

Bed Side Rails (E0310)

A physician must prescribe bedside rails as medically necessary in order for a recipient to qualify for Medicaid reimbursement. EDS must receive the request for coverage within **seven State working 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

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.

NOTE:

Purchase of the bedside rails is limited to one per lifetime for recipients who meet the above criteria.

Recipient Hydraulic Lift With Seat or Sling (E0630)

Recipient hydraulic lifts will be considered for Medicaid payment when prescribed as medically necessary by a physician. Request for coverage must be received by EDS within **seven State working 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.
- The recipient must be essentially bed confined.
- The recipient's physician must supervise the use of the gel or gel-like pressure pad in connection with the course of treatment.

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.

NOTE:

Purchase of the recipient hydraulic lift is limited to one per lifetime for recipients who meet the above criteria.

Trapeze Bar, AKA Recipient Helper, Attached to Bed with Grab Bar (E0910)

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 EDS within **seven State working 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.

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 under the EPSDT program. The information submitted must include documentation that the recipient meets the above medical criteria.

NOTE:

Purchase of the trapeze bar is limited to one per lifetime for recipients who meet the above criteria.

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 recipient under the age of 21 who is referred through the EPSDT Program.

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** 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 a 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 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 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 two years for recipients who meet the above criteria.

Iron Chelation Therapy Equipment (Z5220, Z5221, Z5222, Z5223)

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.
- A Sickle Cell Foundation office must submit the request for the equipment.
- EDS must receive a prior authorization request after obtaining the above information within **seven State working days** after the date that the equipment was dispensed. This includes the Auto-Syringe Infusion Pump for Iron Chelation Therapy (Z5220) and the Auto-Infusion Pump Repair for Iron Chelation Therapy (Z5223).

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 (Z5400)

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.

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 as described above • 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 as described above • 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. Evaluation by interdisciplinary professionals must 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

Evaluations by 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

Prior Authorization Process

ACDs and services are available only through the Alabama Medicaid prior approval 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.

Medicaid requires the following recipient information with the prior authorization request:

Topic	***Information required for the PA***
Identifying information	• Name • Medicaid RID 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

Topic	***Information required for the PA***
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 Two (2)	• 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
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, 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	Manufacturer's invoice must be forwarded to the Medicaid Prior Authorization unit at the time claim is filed.
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.
Repair	Repairs are covered only to the extent not covered by manufacturers' warranty. Repairs must be prior approved. Battery replacement is not considered repair and does not require prior authorization.
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.

Wheelchairs

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 EDS within **seven State working 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 to Section 14.5.3, Procedure Codes and Modifiers.

Effective October 1, 2000, Medicaid began reimbursing Durable Medical Equipment providers for Extra Heavy Duty Wheelchairs. These wheelchairs accommodate weight capacities up to 600 lbs. Medicaid covers these wheel-chairs as a purchase by using Medicare's procedure code K0007.

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 recipient under the age of 21 who is referred under the EPSDT program. The information submitted must include documentation that the recipient meets the above medical criteria.

NOTE:

Purchase of the wheelchair is limited to one every five years for recipients who meet the above criteria.

Low Pressure and Positioning Equalization Pad for Wheelchair (E0192) (K0108)

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 EDS within **seven State working 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.

Effective October 1, 2000, Medicaid also began reimbursing 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.

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 based on medical necessity and requires prior authorization. Requests for coverage must be received by EDS within seven State work days after the oxygen equipment is dispensed. In order to receive a prior authorization number, both forms must be completed and submitted to EDS. 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:

1. 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.

2. 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**:

1. type of oxygen equipment
2. oxygen flow rate or concentration level
3. frequency and duration of use
4. estimate of the period of need
5. 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 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

1. 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.

2. 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 consisting of one tank and up to four refills 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.

3. Medicaid will reimburse for only one stationary system.

4. **The DME supplier or a related corporation may not perform the ABG study or oximetry analysis used to determine medical necessity**.

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.

Include a copy of the EPSDT Screening and Referral form with oxygen requests for children under age 21. This form is used to allow additional medical necessity equipment and/or supplies to be covered beyond current limitations. 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.

Volume Ventilator – Stationary or Portable (E0450)

A ventilator is covered for EPSDT referred recipients. A physician must prescribe it as medically necessary. EDS must receive request for coverage within **seven State working days** after the date the equipment was dispensed. The recipient must meet the following conditions:

- The recipient is unable to maintain respiration spontaneously.
- The recipient is unable to maintain safe levels of arterial carbon dioxide or oxygen with spontaneous breathing.
- The recipient has a medical condition that requires mechanically assisted ventilation that is appropriate for home use without continuous technical or professional supervision.

The appropriate EPSDT Screening Referral form must be attached to the prior authorization request. The information submitted must include documentation that the recipient meets the above criteria.

Home Phototherapy (S9120)

Home phototherapy is a covered service with prior authorization in the DME Program for EPSDT referred recipients. To administer the treatment of phototherapy safely and properly in the home, an attending physician must prescribe it as medically necessary for hyperbilirubinemia. EDS must receive requests for coverage within **seven State working days** after the first home phototherapy treatment.

The attending physician is responsible for determining the length of time the infant is to receive the therapy based on serum bilirubin levels and clinical condition of the infant. Treatment of bilirubin levels of 12.0 or less will not be covered.

Providers of home phototherapy must meet the following:

- Be enrolled as a Medicaid DME provider
- Have currently licensed registered nurses to perform the home visits and associated professional services
- Submit in writing the following information on each registered nurse who will be performing nursing visits:
  - Name
  - Registered Nurse's license number with effective date and expiration date
- Submit in writing bilirubin levels and treatment start and stop dates

Procedure code S9120 is established for home phototherapy with a global fee per day that includes equipment, nursing visits, and collection of lab work.

Apnea Monitor (E0608)

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 must be received by EDS within **seven State working days** after the date that the monitor was dispensed.

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.’

14.2.3 *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 comfort or the caring person's convenience
- Items not listed as covered by Medicaid
- Rental of equipment, with exceptions noted below
  - EPSDT referred services
  - Medicare crossovers
  - Certain intravenous therapy equipment
  - Short term use due to institutionalization
  - Short term use due to death of a recipient

14.3 Prior Authorization and Referral Requirements

Certain DME requires prior authorization. Please refer to Section 14.5.3, Procedure Codes and Modifiers, for items that require prior authorization from Medicaid. Payment will not be made for these procedures unless they are authorized prior to the service being rendered. 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 Section D.1.3 of the Managed Care appendix 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 EDS Provider Electronic Solution software or mailed in hardcopy to the Prior Authorization Unit, P.O. Box 244036, Montgomery, Alabama 36124-4036. The PA Unit at Medicaid will approve, deny, or return the request. Any requests containing missing or invalid information will be returned by EDS. Please see Chapter 4, Obtaining Prior Authorization, for additional information.

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.

Prior authorization requests for purchase, rental, or re-certification of DME must be received within **seven State working days** of the signature date of the physician prescribing the equipment. Time limits for submitting requests for services and resubmitting additional information are as follows:

- All prior authorization requests for the **purchase** of DME received beyond **seven State working days** after equipment is provided will be denied.
- All prior authorization requests for certification of **rental** services received beyond **seven State working days** of beginning services will be authorized for reimbursement effective the date of receipt at EDS.
- All prior authorization requests for re-certifications of DME rental services must be submitted to EDS within **seven State working 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 EDS.

Medicaid will review the request and assign a status of approved, denied, or suspended. 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 also be notified on denied requests.

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.

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 was 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 *EPSDT 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 EPSDT Referral for Services form (Form 167) or Patient 1st EPSDT Referral for Services form (Form 345) as applicable, and any supporting documentation must be sent to EDS, Prior Authorization Unit, for review. Complete documentation describing how prescribed items will treat or improve a condition must be included on Form 167 or 345. Indicate prescribed items and appropriate procedure codes, and units billed in blank areas on the form.

Requests for EPSDT-referred specialized wheelchair systems

Requests for EPSDT-referred specialized wheelchair systems must be sent hard copy. 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.

14.3.3 *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 the name of the staff member giving the referral.

As a specialty provider, DME providers are required to get a referral from the recipient's PMP before rendering services. Without a referral from the PMP, no reimbursement can be made. Refer to Chapter 5, Filing Claims, for specifics on completing the HCFA-1500 claim form with this referral information.

14.4 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.

The Medicaid DME Program requires copayment at the following rates:

Item	***Copay Amount***
Durable Medical Equipment, including crossovers	$3.00 for each purchased item totaling $50.01 or more $2.00 for each purchased item totaling $25.01-$50.00 $1.00 for each purchased item totaling $10.01-$25.00
Supplies and Appliances, including crossovers	$3.00 for claims totaling $50.01 or more $2.00 for claims totaling $25.01-$50.00 $1.00 for claims totaling $10.01-$25.00 $.50 for claims totaling $10.00 or less
Iron Infusion Pump Repair	$3.00 for each Prior Authorization (PA) Number

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

14.5 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.

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 HCFA-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.

14.5.1 *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.

14.5.2 *Diagnosis Codes*

DME providers must bill diagnosis code V729 on hard copy and electronically submitted claims.

14.5.3 *Procedure Codes and Modifiers*

The medical supplies and appliances listed in Section 14.5.3 are available to eligible Medicaid recipients for use in their homes as prescribed by the attending physician and dispensed by a Medicaid contract provider.

NOTE:

All **rental equipment** must be billed with the appropriate procedure code with modifier RR.

The following procedure codes apply when filing claims for DME services.

Ambulation Devices

Procedure Code	*Description of Item*	*PA Required*
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip	No
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	No
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and hand grips	No
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and hand grips (limited to every 2 years)	No
E0130	Walker, rigid (pickup), adjustable or fixed height	No
E0135	Walker, folding (pickup), adjustable or fixed height	No
E0146	Walker, wheeled with seat (child's rollator)	No

NOTE:

Procedure codes for the ambulation devices listed above may not be billed at the same time.

Ambulation Devices, continued

Procedure Code	*Description of Item*	*PA Required*
L1900	Ankle-Foot Orthosis (AFO), spring wire, dorsiflexion assist calf band	No
L1930	AFO, plastic	No
L1940	AFO, molded to recipient, plastic	No
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar `BK' orthosis)	No

Catheters

Procedure Code	*Description of Item*	*PA Required*
A4338	Indwelling catheter, Foley type, two-way, latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic), (limited to two per month)	No
A4344	Indwelling catheter, Foley type, two-way, all silicone (limited to two per month)	No
K0135	Intermittent urinary catheter, reusable straight tip (limited to 30 per month)	No
Z5119	Catheters, suction	No

Catheter Supplies

Procedure Code	*Description of Item*	*PA Required*
A4213	Syringe, sterile, 10cc or greater, each (for catheter or wound irrigations or bolus feeds)	No
A4214	Sterile saline or water, 30cc vial	No
A4323	Sterile saline irrigation solution, 1000 ml	No
A4354	Insertion tray with drainage bag, without catheter (limited to two per month)	No
A4357	Bedside drainage bag, day or night, with or without antireflux device, with or without tube, each (limited to two per month)	No
A4358	Urinary leg bag, vinyl, with or without tube, each (limited to two per month)	No

Commode Chairs

Procedure Code	*Description of Item*	*PA Required*
E0163	Commode chair, stationary, with fixed arms	No
E0164	Commode chair, mobile, with fixed arms	No
E0165	Commode chair, stationary, with detachable arms	No
E0166	Commode chair, mobile, with detachable arms	No

Suction Equipment

Procedure Code	*Description of Item*	*PA Required*
E0600	Suction pump, home model portable	Yes
Z5119	Catheters, suction	No

Heat Application Appliance

Procedure Code	*Description of Item*	*PA Required*
E0210	Electric heat pad, standard	No

Oxygen

Procedure Code	*Description of Item*	*PA Required*
E0424	Stationary compressed gaseous oxygen system, rental; includes contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes
E0431	Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask, tubing. (Medicaid billing includes 4 refills)	Yes
E0441	Oxygen contents, gaseous, (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)	Yes
E0443	Portable oxygen contents, gaseous, per unit for use only with portable gaseous systems when no stationary gas or liquid system is used.	Yes
E1390	Oxygen concentrator capable of delivering 85% or greater oxygen concentration at the prescribed flow rate	Yes

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.

Home Glucose Monitor and Supplies

Procedure Code	*Description of Item*	*PA Required*
A4250	Urine test or reagent strips or tablets, per 50 (limited to 100 strips or tablets, two bottles per month)	No
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per box of 50 (limited to three boxes per month)	No
A4259	Lancets, per box of 100 (limited to two boxes per month)	No
E0607	Home blood glucose monitor (limited to one every two years)	Yes

Home IV Therapy Only

Procedure Code	*Description of Item*	*PA Required*
A4208	Syringe with needle, sterile 3cc, each (billed with IV therapy only)	No
A4215	Needles only, any size (in-site IV catheter)	No
A4245	Alcohol wipes, per 100 (limited to 300 wipes per month)	No
A4247	Betadine or iodine swabs/wipes, per 100 (limited to 200 swabs/wipes per month)	No
A4927	Gloves, sterile or non-sterile, per pair, 100 gloves per box (limited to two boxes per month)	No
B9004	Parenteral nutrition infusion pump, portable, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
B9006	Parenteral nutrition infusion pump, stationary, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
E0776	IV pole	No
E0781	Ambulatory infusion pump, single or multiple channels, with administrative equipment, worn by recipient (monthly rental but must be prorated on a daily basis if pump is used less than one month).	Yes
Z5315	IV administration kit including tubing, filters, IV start kit, administration set, Y connector	No

Hospital Beds

Procedure Code	*Description of Item*	*PA Required*
E0250	Hospital bed, with side rails, fixed height, with mattress	Yes
E0255	Hospital bed, with side rails, variable height, Hi-Lo, with mattress	Yes
Z5122	Hospital crib with mattress	Yes
K0456	Hospital bed heavy duty, extra wide, semi-electric (head and foot adjustments) with any type rails, with mattress.	Yes

Hospital Bed Accessories

Procedure Code	*Description of Item*	*PA Required*
E0181	Pressure pad, alternating with pump, heavy duty (limited to one every three years)	Yes
E0185	Gel or gel like pressure pad for mattress (limited to one every two years)	Yes
E0271	Mattress, innerspring (replacement for medically necessary hospital bed owned by recipient)	Yes
E0310	Bed side rails, full length	Yes
E0621	Sling or seat, recipient lift, canvas or nylon	No
E0630	Recipient lift, hydraulic, with seat or sling	Yes
E0910	Trapeze bars, AKA recipient helper, attached to bed, with grab bar	Yes

Nebulizer

Procedure Code	*Description of Item*	*PA Required*
E0570	Nebulizer, with compressor (limited to one every two years)	No
A7003	Administration set, small volume non-filtered pneumatic nebulizer (limited to 3 sets per month)	No
A7005	Administration set, small volume non-filtered pneumatic nebulizer, non-disposable (limited to two per year)	No

Supplies

Procedure Code	*Description of Item*	*PA Required*
A4362	Skin barrier; solid, 4 x 4 or equivalent; each (limited to 20 per month)	No
A4364	Adhesive for ostomy or catheter; liquid (spray, brush, etc.), Cement, powder or paste; any composition (e.g. Silicone, latex, etc.); Per oz.	No
A4367	Ostomy belts, each	No
A4400	Ostomy irrigation set	No
A4404	Ostomy rings	No
A4454	Tape, all types, all sizes (limited to six rolls per month)	No
A4455	Ostomy skin bond or cement, remover	No
A5052	Pouch, closed; without barrier attached (one piece), per bag (limited to 60 per month)	No
A5061	Pouch drainable with barrier attached (one piece), per bag (limited to 30 per month)	No
A5063	Pouch, open; without barrier attached (one piece), per bag (limited to 30 per month)	No
A5071	Pouch, urinary; with barrier attached; (one piece), limited to 40 per month.	No
A5121	Skin barrier; solid, 6 x 6 or equivalent, each (limited to 15 per month)	No
A5123	Skin barrier; with flange (limited to 30 per month)	No

NOTE:

Procedure codes A4362 and A5121 may not be billed on the same date of service as A5123. Procedure code A5063 may not be billed on the same date of service as A5052.

Supplies, continued

Procedure Code	*Description of Item*	*PA Required*
A6216	Gauze pad, non-impregnated, non-sterile; pad size 16 sq. in. or less	No
A6217	Gauze pad, non-impregnated, non-sterile; pad size more than 16 sq. in. (limited to 100 per month)	No
A6402	Gauze pad, non-impregnated, sterile; pad size 16 sq. in. or less **(used only on areas requiring sterile pads)**	No
A6403	Gauze pad, non-impregnated, sterile; pad size more than 16 sq. In. (limited to 100 per month) **(used only on areas requiring sterile pads)**	No
B4081	Nasogastric tubing with stylet	No
B4082	Nasogastric tubing without stylet	No
B4084	Gastrostomy/jejunostomy tubing	No
E0188	Synthetic sheepskin pad	No
E0191	Heel or elbow protector, each	No
E0210	Electric heat pad, standard	No
E0275	Bedpan, standard, metal or plastic	No
E0276	Bedpan, fracture, metal or plastic	No

Procedure Code	Description of Item	PA Required
L8100	Elastic support, elastic stocking, below knee, medium weight, each; limited to eight (8) stockings per year (4 pairs)	No
L8130	Elastic support, elastic stocking, above knee, medium weight, each; limited to eight (8) stockings per year (4 pairs)	No
X2015	Skin gel, each	No
X2045	Karaya powder, each 2.5 oz	No
Z5120	Trays, tracheostomy	No
Z5121	Tubes, tracheostomy	No

Iron Chelation Therapy

Procedure Code	Description of Item	PA Required
Z5220	Auto-syringe infusion pump for iron chelation	Yes
Z5221	Infusion tubing for iron chelation therapy (box)	No
Z5222	Battery (5.6 volt) for iron chelation therapy	No
Z5223	Auto-syringe infusion pump repair for iron chelation therapy	Yes

External Breast Prosthesis

Procedure Code	Description of Item	PA Required
L8000	Breast prosthesis, mastectomy bra (limited to 6 per year)	Yes
L8015	External breast prosthesis garment, with mastectomy form (limited to 2 per year)	Yes
L8020	Breast prosthesis, mastectomy form (limited to 2 per year)	Yes
L8030	Breast prosthesis, silicone or equal (limited to 2 per year)	Yes
*L8035	Custom breast prosthesis, post mastectomy, molded to patient model	Yes
*L8039	Breast prosthesis, not otherwise classified	Yes

NOTE:

* Evaluated on a case-by-case basis with submission of pricing information and medical documentation.

Augmentative Communication Devices

Procedure Code	Description of Item	PA Required
Z5400	Augmentative communication devices (portable electronic or non electronic aids, devices, or systems)	Yes

Wheelchairs

Procedure Code	Description of Item	PA Required
E1050	Fully-reclining wheelchair, fixed full-length arms, swing away detachable elevating leg rests	Yes
E1060	Fully reclining wheelchair, detachable arms, (desk or full length) swing away detachable elevating leg rests	Yes
E1070	Fully-reclining wheelchair, detachable arms (desk or full length), swing away detachable footrest	Yes
E1092	Wide, heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1093	Wide heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes

Procedure Code	*Description of Item*	*PA Required*
E1110	Semi-reclining wheelchair, detachable arms, (desk or full length), elevating leg rests	Yes
E1130	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	Yes
E1140	Standard wheelchair, detachable arms, (desk or full length), swing away detachable footrests	Yes
E1150	Wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1160	Standard wheelchair, fixed full length arms, swing away detachable elevating leg rests	Yes
E1180	Amputee wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1190	Amputee wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1200	Amputee wheelchair, fixed full length arms, swing away detachable footrest	Yes
E1240	Lightweight wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1280	Heavy duty wheelchair, detachable arms (desk or full length), elevating leg rests	Yes
E1285	Heavy duty wheelchair, fixed full length arms, swing away detachable footrests	Yes
E1290	Heavy duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
K0007	Extra Heavy Duty Wheelchair	Yes
Z5117	Reclining (fully) wheelchair with fixed arms, swing away detachable footrests	Yes
Z5124	Travel chair (transporter) child's	Yes
Z5129	Narrow wheelchair, with detachable arms, swing away detachable footrests	Yes
Z5130	One arm drive wheelchair, with detachable arms, swing away detachable foot rests	Yes
Z5131	One arm drive wheelchair, with detachable arms and elevating leg rests	Yes
Z5133	Junior sized standard wheelchair	Yes
Z5134	Child's standard wheelchair	Yes

NOTE:

Wheelchairs are limited to one every five years per recipient.

Wheelchair Accessories

Procedure Code	*Description of Item*	*PA Required*
E0192	Low pressure and positioning equalization pad for wheelchair (limited to 1 every 2 years) (examples - Roho, Jay, Stimulite).	Yes
E0963	2" cushion for wheelchair – for example: Tempur-Med, DMI, GEL-T	No
E0964	3" cushion for wheelchair – for example: Tempur-Med, DMI, GEL-T	No
E0965	4" cushion for wheelchair – for example: Tempur-Med, DMI, GEL-T	No
K0108	Wheelchair component or accessory not otherwise specified	Yes

DME Repair

Procedure Code	*Description of Item*	*PA Required*
E1399	Durable medical equipment, miscellaneous	Yes

EPSDT Referred Services

The following 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.

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
A4206		1cc syringe with needle	No
A4208 *		3cc syringe w/needle (HOME IV ONLY)	No
A4209		Syringe with needle, sterile 5 cc or greater	No
A4210		Needle-free injection device – inj. cap with luer lock, monojector	No
A4213 *		Syringe, sterile, 20cc or greater (for catheter or wound irrigations or bolus feeds)	No
A4214 *		Sterile saline or water, 30cc vial	No
A4215 *		Needles only, sterile, any size (HOME IV ONLY)	No
A4244		Alcohol or peroxide	No
A4245 *		Alcohol wipes, per 100	No
A4246		Betadine or Phisohex solution	No
A4247 *		Betadine or iodine swabs/wipes (home IV only), per box of 100	No
A4250 *		Urine test or reagent strips or tablets, per 50	No
A4253 *		Blood glucose test or reagent strips for home blood glucose monitor, per box of 50	No
A4259 *		Lancets, per box of 100	No
A4323 *		Sterile Saline Irrigation Solution (1000 ml)	No
A4338 *		Indwelling catheter, Foley type, two-way, latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.)	No
A4340		Indwelling catheter; specialty type (for enteral feeding)	No
A4344 *		Indwelling catheter, Foley type, two-way, all silicone	No
A4347		Male external catheter with or w/out adhesive, with or w/out anti-reflux device	No
A4352	ZN	Intermittent urinary catheter, coude (curved) tip	No
A4354 *		Insertion tray with drainage bag, without catheter	No
A4357 *		Bedside drainage bag, day or night, with or without antireflux device, with or without tube, each	No
A4358 *		Urinary leg bag, vinyl, with or without tube, each	No
A4362 *		Skin barrier; solid, 4 x 4 or equivalent; each	No
A4364 *		Adhesive for Ostomy or catheter; liquid (spray, brush, etc.), cement, powder or paste; any composition (e.g. silicone, latex, etc.)	No
A4367 *		Ostomy Belt (each)	No
A4400 *		Ostomy Irrigation Set	No
A4402		Lubricant (KY jelly)	No
A4404 *		Ostomy Ring	No
A4454 *		Tape, all types, all sizes	No
A4455 *		Ostomy Skin Bond or Cement Remover	No
A4611		Battery, heavy duty; replacement for recipient owned ventilator	No
A4615		Cannula, nasal	No
A4618		Breathing circuits, permanent ventilator circuits	No
A4621		Tracheostomy mask or collar	No
A4622		Tracheostomy or laryngectomy tube	No
A4624		Tracheal suction catheter, any type	No
A4625		Tracheostomy care kit	No
A4627		Spacer, bag or reservoir, with or without mask	No
A4631		Replacement batteries for medically necessary electronic wheelchair owned by recipient	Yes
A4714		Treated water (deionized, distilled, reverse osmosis) for use in dialysis system	No

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
A4927 *		Gloves, sterile or non-sterile, per pair, 100 gloves per box	No
A5052 *		Pouch, closed; without barrier attached (one piece), per bag	No
A5061 *		Pouch, closed; without barrier attached, one piece (Ostomy)	No
A5063 *		Pouch, open; without barrier attached (one piece), per bag	No
A5071 *		Pouch, urinary, with barrier attached; (one piece) limited to 40 per month)	No
A5121 *		Skin barrier; solid, 6 x 6 or equivalent, each	No
A5123 *		Skin barrier; with flange	No
A6216 *		Gauze pad, non-impregnated, non-sterile; pad size 16 sq. in. or less	No
A6217 *		Gauze pad, non-impregnated, non-sterile; pad size more than 16 sq. in. (limited to 100 per month)	No
A6263		Gauze, elastic, non-sterile, all types, per linear yard	No
A6264		Gauze, non-elastic, non-sterile, per linear yard	No
A6402 *		Gauze pad, non-impregnated, sterile; pad size 16 sq. in. or less (used only in areas requiring sterile pads)	No
A6403 *		Gauze pad, non-impregnated, sterile; pad size more than 16 sq. in. (limited to 100 per month) (used only in areas requiring sterile pads)	No
A7003 *		Administration set, small volume non-filtered pneumatic nebulizer (limited to 3 sets per month)	No
A7005 *		Administration set, small volume non-filtered pneumatic nebulizer, non-disposable (limited to 2 per year)	No
A9190		Diapers - recipient must be at least 2 years old, bed confined, and highly susceptible to skin breakdown due to existing medical condition - limit 10 units per month (1 unit=1 package) - Maximum reimbursement by Medicaid is $13.50 per package	Yes
B4035		Enteral feeding supply kit; pump fed (monthly/1 set per day) kit includes tubing & bags	Yes
B4036	ZN	Enteral feeding supply kit; gravity fed (monthly/1 set per day)	Yes
B4081 *		N/G Tubing with stylet	No
B4082 *		N/G Tubing without stylet	No
B4084 *		Gastrostomy/Jejunostomy Tubing	No
B9002	RR	Enteral nutrition infusion pump w/alarm	Yes
B9004 *	RR	Parenteral nutrition infusion pump, portable, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
B9006 *	RR	Parenteral nutrition infusion pump, stationary, (monthly rental, but must be prorated on a daily basis if pump is used less than one month)	Yes
B9998	ZN	Not otherwise classified for enteral supplies • Catheter plug adapter • Enteral feeding adapter, “Y” • GT button adapter 18 fr cont. and/or bolus • GT button decompression tube 24 fr 1.7 • R angle adapter	Yes
E0100 *		Cane, includes canes of all materials, adjustable or fixed, with tip	No
E0105 *		Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	No
E0110 *		Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	No
E0112 *		Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	No
E0130 *		Walker, rigid (pickup), adjustable/fixed height	No
E0135 *		Walker, folding (pickup), adjustable or fixed height	No
E0146 *		Walker, wheeled with seat	No
E0153	ZN	Platform attachment, forearm crutch	Yes
E0163 *		Commode chair, stationary with fixed arms	No
E0164 *		Commode chair, mobile with fixed arms	No
E0165 *		Commode chair, stationary with detachable arms	No
E0166 *		Commode chair, mobile with detachable arms	No
E0178	ZN	Gel pressure pad or cushion, non-positioning	Yes

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E0180	ZN	Pressure pad, alternating	Yes
E0181 *		Pressure pad, alternating with pump, Heavy Duty	Yes
E0184		Dry pressure mattress	No
E0185 *		Gel or gel-like pressure pad for mattress (limited to one every two years)	Yes
E0188 *		Synthetic sheep skin pad	No
E0191 *		Heel or elbow protector, each	No
E0192 *		Low pressure and positioning equalization pad for wheelchair	Yes
E0210 *		Electric heat pad, standard	No
E0250 *		Hospital bed, with side rails, fixed height, with mattress	Yes
E0255 *		Hospital bed, with side rails, variable height, HI-LO, with mattress	Yes
E0271 *		Mattress, inner-spring (replacement for medically necessary hospital bed owned by recipient)	Yes
E0275 *		Bedpan, standard, metal or plastic	No
E0276 *		Bedpan, fracture, metal or plastic	No
E0310 *		Bed side rails (full length)	Yes
E0450		Volume ventilator; portable (includes battery, battery charger, & battery cables) (E0451ZN)	Yes
E0455		Oxygen tent, excluding croup or pediatric tents	Yes
E0480	ZN	Percussor, electric or pneumatic, home model	Yes
E0550		IPPB machine; (with automatic valves, electronically driven with internal compressor, built-in nebulization. (E0515ZN)	Yes
E0565		Compressor	Yes
E0565	ZN	Compressor; air power source for equipment not self-contained or cylinder driven; large volume air compressor	Yes
E0570 *		Nebulizer, with compressor	No
E0575		Nebulizer, self-contained, ultrasonic	Yes
E0575	ZN	Nebulizer, self-contained, ultrasonic	Yes
E0585	ZN	Nebulizer with compressor & heater	Yes
E0600 *		Suction Pump, home model, portable	Yes
E0601	ZN	Continuous airway pressure (CPAP) device	Yes
E0607 *		Home blood glucose monitor	Yes
E0608		Apnea monitor	Yes
E0621 *		Sling or seat for patient lift, canvas or nylon	No
E0630 *		Patient lift, hydraulic, with seat or sling	Yes
E0667		Pneumatic appliance for use with segmental pneumatic compressor, leg	Yes
E0668		Arm appliance for linear pump	Yes
E0776 *		IV Pole (HOME IV ONLY)	No
E0781 *	RR	Ambulatory Pump (HOME IV ONLY)	Yes
E0791		Parenteral infusion pump, stationary, single or multi-channel (for chemotherapy or morphine)	Yes
E0850		Traction stand, free standing, simple cervical traction	Yes
E0890	ZN	Traction frame, attached to footboard, simple pelvic traction	Yes
E0910 *		Trapeze bars, AKA patient helper, attached to bed, with grab bar	Yes
E0953	ZN	Pneumatic tire	Yes
E0963 *		2” cushion for wheelchair	No
E0964 *		3” cushion for wheelchair	No
E0965 *		4” cushion for wheelchair	No
E0972		Transfer bench	Yes
E0996	ZN	Tire, solid	Yes
E0999	ZN	Pneumatic tire	Yes
E1000	ZN	Tire, pneumatic caster	Yes

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E1050 *		Fully-reclining wheelchair, fixed full-length arms, swing away detachable elevating leg rests	Yes
E1060 *		Fully reclining wheelchair, detachable arms, (desk or full length) swing away detachable elevating leg rests	Yes
E1070 *		Fully-reclining wheelchair, detachable arms (desk or full length), swing away detachable footrest	Yes
E1088		High strength lightweight wheelchair, detachable arms, desk or full length swing away detachable elevating leg rests	Yes
E1092 *		Wide, heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1093 *		Wide heavy-duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1110 *		Semi-reclining wheelchair, detachable arms, (desk or full length), elevating leg rests	Yes
E1130 *		Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	Yes
E1140 *		Standard wheelchair, detachable arms, (desk or full length), swing away detachable footrests	Yes
E1150 *		Wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1160 *		Standard wheelchair, fixed full length arms, swing away detachable elevating leg rests	Yes
E1180 *		Amputee wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1190 *		Amputee wheelchair, detachable arms (desk or full length), swing away detachable elevating leg rests	Yes
E1200 *		Amputee wheelchair, fixed full length arms, swing away detachable footrest	Yes
E1230	ZN	Power operated vehicle (three or four wheel non-highway), specify brand name & model number	Yes
E1240 *		Lightweight wheelchair, detachable arms, (desk or full length), swing away detachable elevating leg rests	Yes
E1280 *		Heavy duty wheelchair, detachable arms (desk or full length), elevating leg rests	Yes
E1285 *		Heavy duty wheelchair, fixed full length arms, swing away detachable footrests	Yes
E1290 *		Heavy duty wheelchair, detachable arms (desk or full length), swing away detachable footrests	Yes
E1375	ZN	Nebulizer portable with small compressor, with limited flow (Medimyst)	Yes
E1399		DME, not otherwise classified • Heat moisture exchanger • Right angle adapter for gastronomy tube • Spring steel catheter clamp • Suction filter (for internal use with suction pump) • 10lb sand weight bag • Trach tube holder • Twill tape (72' roll)	

Procedure Code	***Modifier***	***Description of Item***	***PA Required***
E1399	ZN	DME, not otherwise classified • Aerosol drainage system • BIPAP machine • Bubble humidifier • Clinitest kit (includes dropper tubes, & 5 or 6 Clinitest tabs) • Davol mucus specimen trap (Delee) • Disposable jet nebulizer • Donut heater • Drain bag for trach, 750cc • Enviracare model EV-35 with HEPA filter • Exhalation manifold • Enviracare model EV-35 replacement filters 2 per pack • Face masks, 50 count • Filter cabinet • Manual resuscitator with oxygen accumulator • Mushroom valve • Nebulizer adapters with 750 ml sterile water • Nitrazine paper with dispenser • Non-molded pediatric helmet • Padded tub transfer bench • Peak flow meter • Peep valves for ventilator • Pulse oximetry (per encounter) • Pulse oximeter machine (Note: load specific number of units) • Respiguard II • Swan neck splint index finger size 4/1 • Swan neck splint (l) middle size 3 1/2/1 • VOL pump set, pancreatic 78”	Yes
K0007 *		Extra Heavy Duty Wheelchair (weight capacity up to 600 pounds)	Yes
K0108		Wheelchair component or accessory not otherwise specified	Yes
K0135 *		Intermittent urinary catheter, reusable straight tip **If an EPSDT recipient uses catheters beyond the 30 per month limit, the K0135 code should be used. The recipient must be referred through the EPSDT program and this information must be included on the billing claim form when billing K0135**.	No
K0456		Hospital bed heavy duty, extra wide, semi-electric (head and foot adjustment) with any type rails, with mattress.	Yes
L1900 *		Ankle-foot orthosis (AFO), spring wire, dorsiflexion assist calf band	No
L1940 *		AFO, molded to patient, plastic	No
L1990 *		AFO, double upright free plantar dorsiflexion, solid, stirrup, calf band/cuff (double bar “BK” orthosis)	No
L8100 *		Elastic support, elastic stocking, below knee, medium weight	No
L8130 *		Elastic support, elastic stocking, above knee, medium weight	No
L8501		Tracheostomy speaking valve	No
S9120		Home phototherapy	Yes
X2015 *		Skin gel	No
X2045 *		Karaya Powder (2.5 oz)	No
Z5117 *		Reclining (fully) wheelchair with fixed arms, swing-away detachable footrests	Yes
Z5119 *		Catheters, suction	No
Z5120 *		Trays, tracheostomy	No
Z5121 *		Tubes, tracheostomy	No
Z5122 *		Hospital crib with mattress	Yes
Z5124 *		Travel chair (transporter) child’s	Yes
Z5129 *		Narrow wheelchair & detachable arms swing-away detachable armrest	Yes

Procedure Code	*Modifier*	*Description of Item*	*PA Required*
Z5130 *		One-arm drive wheelchair, with detachable arms, swing-away detachable footrests	Yes
Z5131 *		One-arm drive wheelchair, with detachable arms & elevating leg rests	Yes
Z5133 *		Junior sized standard wheelchair	Yes
Z5134 *		Child's standard wheelchair	Yes
Z5220 *		Auto-syringe infusion pump for iron chelation	Yes
Z5221 *		Infusion tubing for iron chelation therapy (box)	No
Z5222 *		Battery (5.6 volt) for iron chelation therapy	No
Z5223 *		Auto-syringe infusion pump repair for iron chelation therapy	Yes
Z5311		Catheter care kit, orifice of an indwelling catheter (A4350ZN)	Yes
Z5312		Decubitus care mattress, includes flotation or gel mattress	Yes
Z5313		Respiratory therapist visit (H5010)	Yes
Z5314		Primary surgical dressing kit, e.g. Sterile dressings, pads, etc. (A4555)	No
Z5315 *		IV administration kit including tubing, filters, IV start kit, administration set, Y connector (HOME IV ONLY)	No
Z5400 *		Augmentative Communication Devices (portable electronic or non-electronic aids, devices, or systems)	Yes
Z5439		Custom wheelchairs	Yes

Oxygen

Procedure Code	*Modifier*	*Description of Item*	*PA Required*
E0424 *		Stationary compressed gaseous oxygen system, rental; includes contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes
E0431 *		Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask, tubing. (Medicaid billing includes 4 refills)	Yes
E0441 *		Oxygen contents, gaseous, (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned)	Yes
E0443		Portable oxygen contents, gaseous, per unit for use only with portable gaseous systems when no stationary gas or liquid system is used.	Yes
E1390 *		Oxygen concentrator capable of delivering 85% or greater oxygen concentration at the prescribed flow rate	Yes

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.

Orthotic Devices

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.

Orthotic - Upper Limb

Procedure Code	*Description*
L0100	Cervical, craniostenosis, helmet, molded to patient model
L0110	Cervical, craniostenosis, helmet, non-molded
L0120	Cervical, flexible, non-adjustable (foam collar)
L0130	Cervical, flexible, thermoplastic collar, molded to patient
L0140	Cervical, semi-rigid, adjustable (plastic collar)
L0150	Cervical, semi-rigid, adjustable molded chin cup (plastic collar, with mandibular/occipital piece)

Orthotic - Upper Limb

L0160	Cervical, semi-rigid, wire frame occipital/mandibular support
L0170	Cervical, collar, molded to patient model
L0172	Cervical, collar, semi-rigid thermoplastic foam, two piece
L0174	Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension
L0180	Cervical, multiple post collar, occipital/mandibular supports, adjustable
L0190	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (Somi, Guilford, Taylor types)
L0200	Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension
L0210	Thoracic rib belt, custom fitted
L0220	Thoracic rib belt, custom fabricated
L0300	Thoracic-lumbar-sacral-orthosis (TLSO), flexible (dorso-lumbar surgical support)
L0310	TLSO, flexible (dorso-lumbar surgical support), custom fabricated
L0315	TLSO, flexible (dorso-lumbar surgical support), elastic type, with rigid posterior panel
L0317	TLSO, flexible (dorso-lumbar surgical support), hyperextension, elastic type, with rigid posterior panel
L0320	TLSO, anterior-posterior control, (Taylor type), with apron front
L0330	TLSO, anterior-posterior-lateral control, (Knight-Taylor type), with apron front
L0340	TLSO, anterior-posterior-lateral-rotary control (Arnold, Magnuson, Steindler types), with apron front
L0350	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, custom fitted
L0360	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, molded to patient model
L0370	TLSO, anterior-posterior-lateral-rotary control, hyperextension, (Jewett, Lennox, Baker, Cash types)
L0380	TLSO, anterior-posterior-lateral-rotary control, with extensions
L0390	TLSO, anterior-posterior-lateral control, molded to patient model
L0400	TLSO, anterior-posterior-lateral control, molded to patient model, with interface material
L0410	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model
L0420	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model, with interface material
L0430	TLSO, anterior-posterior-lateral control, with interface material, custom fitted
L0440	TLSO, anterior-posterior-lateral control, with overlapping front section, spring steel front, custom fitted
L0500	Lumbar-sacral-orthosis (LSO), flexible (lumbo-sacral surgical support)
L0510	LSO, flexible, (lumbar-sacral surgical support), custom fabricated
L0515	LSO, flexible, (lumbar-sacral surgical support) elastic type, with rigid posterior panel
L0520	LSO, anterior-posterior-lateral control, (Knight, Wilcox types), with apron front
L0530	LSO, anterior-posterior control, (MacAusland type), with apron front
L0540	LSO, lumbar flexion, (Williams flexion type)
L0550	LSO, anterior-posterior-lateral control, molded to patient model
L0560	LSO, anterior-posterior-lateral control, molded to patient model, with interface material
L0565	LSO, anterior-posterior-lateral control, custom fitted
L0600	Sacroiliac, flexible (sacroiliac surgical support)
L0610	Sacroiliac, flexible, (sacroiliac surgical support), custom fabricated
L0620	Sacroiliac, semi-rigid (Goldthwaite, Osgood types), with apron front
L0700	Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model, (Minerva type)
L0710	CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material, (Minerva type)
L0810	Halo procedure, cervical halo incorporated into jacket vest
L0820	Halo procedure, cervical halo incorporated into plaster body jacket
L0830	Halo procedure, cervical halo incorporated into Milwaukee type orthosis
L0860	Addition to halo procedures, magnetic resonance image compatible system

Orthotic - Lower Limb

Procedure Code	***Description***
L0900	Torso support, ptosis support
L0910	Torso support, ptosis support, custom fabricated
L0920	Torso support, pendulous abdomen support
L0930	Torso support, pendulous abdomen support, custom fabricated
L0940	Torso support, post surgical support
L0950	Torso support, post-surgical support, custom fabricated
L0960	Torso support, post-surgical support, pads for post-surgical support
L0970	TLSO, corset front
L0972	LSO, corset front
L0974	TLSO, full corset
L0976	LSO, full corset
L0978	Axillary crutch extension
L0980	Peroneal straps, pair
L0982	Stocking supporter grips, set of 4
L0984	Protective body sock, each

Orthotic - Upper Limb

Procedure Code	***Description***
L0999	Addition to spinal orthosis, not otherwise specified
L1000	Cervical-thoracic-lumbar-sacral orthosis (CTLSO), inclusive of furnishing initial orthosis, including model
L1010	Addition to CTLSO or scoliosis orthosis, axilla sling
L1020	Addition to CTLSO or scoliosis orthosis, kyphosis pad
L1025	Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating
L1030	Addition to CTLSO or scoliosis orthosis, lumbar bolster pad
L1040	Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad
L1050	Addition to CTLSO or scoliosis orthosis, sternal pad
L1060	Addition to CTLSO or scoliosis orthosis, thoracic pad
L1070	Addition to CTLSO or scoliosis orthosis, trapezius sling
L1080	Addition to CTLSO or scoliosis orthosis, outrigger
L1085	Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions
L1090	Addition to CTLSO or scoliosis orthosis, lumbar sling
L1100	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather
L1110	Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model
L1120	Addition to CTLSO, scoliosis orthosis, cover for upright, each
L1200	Thoracic-lumbar-sacral orthosis (TLSO), inclusive of furnishing initial orthosis only
L1210	Addition to TLSO, (low profile), lateral thoracic extension
L1220	Addition to TLSO, (low profile), anterior thoracic extension
L1230	Addition to TLSO, (low profile), Milwaukee type superstructure
L1240	Addition to TLSO, (low profile), lumbar derotation pad
L1250	Addition to TLSO, (low profile), anterior asis pad
L1260	Addition to TLSO, (low profile), anterior thoracic derogation pad
L1270	Addition to TLSO, (low profile), abdominal pad
L1280	Addition to TLSO, (low profile), rib gusset (elastic), each
L1290	Addition to TLSO, (low profile), lateral trochanteric pad
L1300	Other scoliosis procedure, body jacket molded to patient model
L1310	Other scoliosis procedure, post-operative body jacket
L1499	Spinal orthosis, not otherwise specified

Orthotic - Lower Limb

Procedure Code	***Description***
L1500	Thoracic-hip-knee-ankle orthosis, (THKAO), mobility frame (Newington, Parapodium types)
L1510	THKAO, standing frame
L1520	THKAO, swivel walker
L1600	Hip orthosis, (HO), abduction control of hip joints, flexible, Frejka type with cover
L1610	HO, abduction control of hip joints, flexible, Frejka cover only
L1620	HO, abduction control of hip joints, flexible, Pavlik harness
L1630	HO, abduction control of hip joints, semi-flexible (Von Rosen type)
L1640	HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs
L1650	HO, abduction control of hip joints, static, adjustable, (Ilfled type)
L1660	HO, abduction control of hip joints, static, plastic
L1680	HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thighcuffs, (Rancho hip action type)
L1685	HO, abduction control of hip joints, post-operative hip abduction type, custom fabricated
L1686	HO, Abduction control of hip joint, post-operative hip abduction type
L1700	Legg Perthes orthosis, (Toronto type)
L1710	Legg Perthes orthosis, (Newington type)
L1720	Legg Perthes orthosis, trilateral, (Tachdijan type)
L1730	Legg Perthes orthosis, (Scottish rite type)
L1750	Legg Perthes orthosis, Legg Perthes sling, (Sam Brown type)
L1755	Legg Perthes orthosis, (Patten bottom type)
L1800	Knee orthosis, (KO), elastic with stays
L1810	KO, elastic with joints
L1815	KO, elastic or other elastic type material with condylar pad(s)
L1820	KO, elastic or other elastic type material with condylar pads and joints
L1825	KO, elastic knee cap
L1830	KO, immobilizer, canvas longitudinal
L1832	KO, adjustable knee joints, positional orthosis, rigid support
L1834	KO, without knee joint, rigid, molded to patient model
L1840	KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated to patient model
L1843	KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted
L1844	KO, single upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model
L1845	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted
L1846	KO, double upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, molded to patient model

Prosthetic - Lower Limb

Procedure Code	***Description***
L1850	KO, Swedish type
L1855	KO, molded plastic, thigh and calf sections, with double upright knee joints, molded to patient model
L1858	KO, molded plastic, polycentric knee joints, pneumatic knee pads (CTI)
L1860	KO, modification of supracondylar prosthetic socket, molded to patient model,(SK)
L1870	KO, double upright, thigh and calf lacers, molded to patient model, with knee joints
L1880	KO, double upright, non-molded thigh and calf cuffs/lacers, with knee joints
L1885	KO, single or double upright, thigh and calf, with functional active resistance control
L1900 *	Ankle-foot orthosis, (AFO), spring wire, dorsiflexion assist calf band
L1902	AFO, ankle gauntlet, custom fitted

Procedure Code	***Description***
L1904	AFO, molded ankle gauntlet, molded to patient model
L1906	AFO, multiligamentus ankle support
L1910	AFO, posterior, single bar, clasp attachment to shoe counter
L1920	AFO, single upright with static or adjustable stop, (Phelps or Perlstein type)
L1930 *	AFO, plastic
L1940 *	AFO, molded to patient model, plastic
L1945	AFO, molded to patient model, plastic, rigid interior tibial section (floor reaction)
L1950	AFO, spiral, molded to patient model, (IRM type), plastic
L1960	AFO, posterior solid ankle, molded to patient model, plastic
L1970	AFO, plastic, molded to patient model, with ankle joint
L1980	AFO, single upright, free plantar dorsiflexion, solid stirrup, calf band/cuff, (single bar “BK” orthosis)
L1990 *	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff, (double bar “BK” orthosis)
L2000	Knee-ankle-foot orthosis, (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs, (single bar “AK” orthosis)
L2010	KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (single bar “AK” orthosis), without knee joint
L2020	KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis)
L2030	KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis), without knee joint
L2035	KAFO, full plastic, static, prefabricated (pediatric size)
L2036	KAFO, full plastic, double upright, free knee, molded to patient model
L2037	KAFO, full plastic, single upright, free-knee, molded to patient model
L2038	KAFO, full plastic, without knee joint, multiaxis ankle, molded to patient model (Lively orthosis or equal)
L2039	KAFO, full plastic, single upright, poly-axial hinge, medial lateral rotation control, molded to patient model
L2040	HKAFO, torsion control, bilateral rotation straps, pelvic band/belt
L2050	HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt
L2060	HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt
L2070	HKAFO, torsion control, unilateral rotation straps, pelvic band/belt
L2080	HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt
L2090	HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt
L2102	AFO, fracture orthosis, tibial fracture cast orthosis, plaster type casting material, molded to patient
L2104	AFO, fracture orthosis, tibial fracture cast orthosis, synthetic type casting material, molded to patient
L2106	AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient
L2108	AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid
L2122	KAFO, fracture orthosis, femoral fracture cast orthosis, plaster type casting material, molded to patient
L2124	KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient
L2126	KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, molded to patient
L2128	KAFO, fracture orthosis, femoral fracture cast orthosis, molded to patient model
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid
L2180	Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints

Procedure Code	***Description***
L2182	Addition to lower extremity fracture orthosis, drop lock knee joint
L2184	Addition to lower extremity fracture orthosis, limited motion knee joint
L2186	Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman Type
L2188	Addition to lower extremity fracture orthosis, quadrilateral brim
L2190	Addition to lower extremity fracture orthosis, waist belt
L2192	Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt
L2200	Addition to lower extremity, limited ankle motion, each joint
L2210	Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint
L2220	Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint
L2230	Addition to lower extremity, split flat caliper stirrups and plate attachment
L2240	Addition to lower extremity, round caliper and plate attachment
L2250	Addition to lower extremity, foot plate, molded to patient model, stirrup attachment
L2260	Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)
L2265	Addition to lower extremity, long tongue stirrup
L2270	Addition to lower extremity, varus, vulgus correction (“T”) strap, padded/lined or malleolus pad
L2275	Addition to lower extremity, varus, vulgus correction, plastic modification, padded/lined
L2280	Addition to lower extremity, molded inner boot
L2300	Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable
L2310	Addition to lower extremity, abduction bar, straight
L2320	Addition to lower extremity, non-molded lacer
L2330	Addition to lower extremity, lacer molded to patient model
L2335	Addition to lower extremity, anterior swing band
L2340	Addition to lower extremity, pre-tibial shell, molded to patient model
L2350	Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for “PTB” or “AFO” orthoses)
L2360	Addition to lower extremity, extended steel shank
L2370	Addition to lower extremity, Patten bottom
L2375	Addition to lower extremity, torsion control, ankle joint and half solid stirrup
L2380	Addition to lower extremity, torsion control, straight knee joint, each joint
L2385	Addition to lower extremity, straight knee joint, heavy duty, each joint
L2390	Addition to lower extremity, offset knee joint, each joint
L2395	Addition to lower extremity, offset knee joint, heavy duty, each joint
L2397	Addition to lower extremity orthosis, suspension sleeve
L2405	Addition to knee joint, drop lock, each joint
L2415	Addition to knee joint, cam lock (Swiss, French, Bail types) each joint
L2425	Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint
L2430	Addition to knee joint, ratchet lock for active and progressive knee extension, each joint
L2435	Addition to knee joint, polycentric joint, each joint
L2492	Addition to knee joint, lift loop for drop lock ring
L2500	Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring
L2510	Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model
L2520	Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted
L2525	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model
L2526	Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted
L2530	Addition to lower extremity, thigh/weight bearing, lacer, non-molded
L2540	Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model
L2550	Addition to lower extremity, thigh/weight bearing, high roll cuff
L2570	Addition to lower extremity, pelvic control, hip joint, Clevis type, two position joint, each
L2580	Addition to lower extremity, pelvic control, pelvic sling

Procedure Code	Description
L2600	Addition to lower extremity, pelvic control, hip joint, Clevis type or thrust bearing, free, each
L2610	Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each
L2620	Addition to lower extremity, pelvic control, hip joint, heavy duty, each
L2622	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each
L2624	Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each
L2627	Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables
L2628	Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables
L2630	Addition to lower extremity, pelvic control, band and belt, unilateral
L2640	Addition to lower extremity, pelvic control, band and belt, bilateral
L2650	Addition to lower extremity, pelvic and thoracic control, gluteal pad, each

Orthotic - Upper Limb

Procedure Code	Description
L2660	Addition to lower extremity, thoracic control, thoracic band
L2670	Addition to lower extremity, thoracic control, paraspinal uprights
L2680	Addition to lower extremity, thoracic control, lateral support uprights

Orthotic - Lower Limb

Procedure Code	Description
L2750	Addition to lower extremity orthosis, plating chrome or nickel, per bar
L2755	Addition to lower extremity orthosis, carbon graphite lamination
L2760	Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)
L2770	Addition to lower extremity orthosis, stainless steel, per bar or joint
L2780	Addition to lower extremity orthosis, non-corrosive finish, per bar
L2785	Addition to lower extremity orthosis, drop lock retainer, each
L2795	Addition to lower extremity orthosis, knee control, full kneecap
L2800	Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull
L2810	Addition to lower extremity orthosis, knee control, condylar pad
L2820	Addition to lower extremity orthosis, soft interface for molded plastic, below knee section
L2830	Addition to lower extremity orthosis, soft interface for molded plastic, above knee section
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L2860	Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism, each
L2999	Lower extremity orthosis, not otherwise specified
L3000	Foot, insert, removable, molded to patient model, UCBll type, Berkeley Shell, each
L3001	Foot, insert, removable, molded to patient model, Spenco, each
L3002	Foot, insert, removable, molded to patient model, Plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model, silicone gel, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
L3030	Foot, insert, removable, formed to patient foot, each
L3040	Foot, arch support, removable, pre-molded, longitudinal, each
L3050	Foot, arch support, removable, pre-molded, metatarsal, each
L3060	Foot, arch support, removable, pre-molded, longitudinal/metatarsal, each
L3070	Foot, arch support, non-removable, attached to shoe, longitudinal, each
L3080	Foot, arch support, non-removable, attached to shoe, metatarsal, each

Procedure Code	***Description***
L3090	Foot arch support, non-removable, attached to shoe, longitudinal/metatarsal, each
L3100	Hallus-valgus night dynamic splint
L3140	Foot, abduction rotation bar, including shoes
L3150	Foot, abduction rotation bar, without shoes
L3160	Foot, adjustable shoe-styled positioning device
L3170	Foot, plastic heel stabilizer
L3201	Orthopedic shoe, oxford with supinator or pronator, infant
L3202	Orthopedic shoe, oxford with supinator or pronator, child
L3203	Orthopedic shoe, oxford with supinator or pronator, junior
L3204	Orthopedic shoe, hightop with supinator or pronator, infant
L3206	Orthopedic shoe, hightop with supinator or pronator, child
L3207	Orthopedic shoe, hightop with supinator or pronator, junior
L3208	Surgical boot, each, infant
L3209	Surgical boot, each, child
L3211	Surgical boot, each, junior
L3212	Benesch boot, pair, infant
L3213	Benesch boot, pair, child
L3214	Benesch boot, pair, junior
L3215	Orthopedic footwear, ladies shoes, oxford
L3216	Orthopedic footwear, ladies shoes, depth inlay
L3217	Orthopedic footwear, ladies shoes, hightop, depth inlay
L3218	Orthopedic footwear, ladies surgical boot, each
L3219	Orthopedic footwear, men’s shoes, oxford
L3221	Orthopedic footwear, men’s shoes, depth inlay
L3222	Orthopedic footwear, men’s shoes, hightop, depth inlay
L3223	Orthopedic footwear, men’s surgical boot, each
L3224	Orthopedic footwear, woman’s shoe, oxford, used as an integral part of a brace (orthosis)
L3225	Orthopedic footwear, man’s shoe, oxford, used as an integral part of a brace (orthosis)
L3230	Orthopedic footwear, custom shoes, depth inlay
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each
L3251	Foot, shoe molded to patient model, silicone shoe, each
L3252	Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each
L3253	Foot, molded shoe, plastazote (or similar), custom fitted, each
L3254	Non-standard size or width
L3255	Non-standard size or length
L3257	Orthopedic footwear, additional charge for split size
L3260	Ambulatory surgical boot, each
L3265	Plastazote sandal, each
L3300	Lift, elevation, heel, tapered to metatarsals, per inch
L3310	Lift, elevation, heel and sole, neoprene, per inch
L3320	Lift, elevation, heel and sole, cork, per inch
L3330	Lift, elevation, metal extension, (skate)
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch
L3334	Lift, elevation, heel, per inch
L3340	Heel wedge, Sach
L3350	Heel wedge
L3360	Sole wedge, outside sole
L3370	Sole wedge, between sole
L3380	Clubfoot wedge
L3390	Out flare wedge
L3400	Metatarsal bar wedge, rocker
L3410	Metatarsal bar wedge, between sole
L3420	Full sole and heel wedge, between sole

Procedure Code	***Description***
L3430	Heel, counter, plastic reinforced
L3440	Heel, counter, leather reinforced
L3450	Heel, Sach cushion type
L3455	Heel, new leather, standard
L3460	Heel, new rubber, standard
L3465	Heel, Thomas with wedge
L3470	Heel, Thomas extended to ball
L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur
L3500	Miscellaneous shoe addition, insole, leather
L3510	Miscellaneous shoe addition, insole, rubber
L3520	Miscellaneous shoe addition, insole, felt covered with leather
L3530	Miscellaneous shoe addition, sole, half
L3540	Miscellaneous shoe addition, sole, full
L3550	Miscellaneous shoe addition, toe tap, standard
L3560	Orthopedic shoe addition, toe tap, horseshoe
L3570	Miscellaneous shoe addition, special extension to instep, (leather with eyelets)
L3580	Miscellaneous shoe addition, convert instep to Velcro closure
L3590	Miscellaneous shoe addition, convert firm shoe counter to soft counter
L3595	Miscellaneous shoe addition, March bar
L3600	Transfer of an orthosis from one shoe to another, caliper plate, existing
L3610	Transfer of an orthosis from one shoe to another, caliper plate, new
L3620	Transfer of an orthosis from one shoe to another, solid stirrup, existing
L3630	Transfer of an orthosis from one shoe to another, solid stirrup, new
L3640	Transfer of an orthosis from one shoe to another, Dennis Browns splint (Riveton), both shoes
L3649	Unlisted procedures for foot orthopedic shoes, shoe modifications and transfers
L3650	Shoulder orthosis, (SO), figure 8 design abduction restrainer
L3660	SO, figure 8 design abduction restrainer, canvas and webbing
L3670	SO, acromio/clavicular, (canvas and webbing type)

Orthotic - Upper Limb

Procedure Code	***Description***
L3700	Elbow orthoses, (EO), elastic with stays
L3710	EO, elastic with metal joints
L3720	EO, double upright, with forearm/arm cuffs, free motion
L3730	EO, double upright, with forearm/arm cuffs, extension/ flexion assist
L3740	EO, double upright, with forearm/arm cuffs, adjustable position lock with active control
L3800	Wrist-hand-finger orthoses, (WHFO), short opponens, no attachments
L3805	WHFO, long opponens, no attachment
L3810	WHFO, addition to short and long opponens, thumb abduction ib Cld bar
L3815	WHFO, addition to short and long opponens, second M.P. abduction assist
L3820	WHFO, addition to short and long opponens, I.P. extension assist, with M.P. extension stop
L3825	WHFO, addition to long and short opponens, M.P. extension stop
L3830	WHFO, addition to short and long opponens, M.P. extension assist
L3835	WHFO, addition to short and long opponens, M.P. spring extension assist
L3840	WHFO, addition to short and long opponens, spring swivel thumb
L3845	WHFO, addition to short and long opponens, thumb I.P. extension assist, with M.P. stop
L3850	WHFO, addition to short and long opponens, action wrist, with dorsiflexion assist
L3855	WHFO, addition to short and long opponens, adjustable M.P. flexion control
L3860	WHFO, addition to short and long opponens, adjustable M.P. flexion control and I.P.

Procedure Code	***Description***
L3890	Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism, each
L3900	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven
L3901	WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion extension, cable driven
L3902	WHFO, external powered, compressed gas
L3904	WHFO, external powered, electric
L3906	WHFO, wrist, (gauntlet), molded to patient model
L3907	WHFO, wrist gauntlet with thumb spica, molded to patient model
L3908	WHFO, wrist extension control (cock-up), non-molded
L3910	WHFO, Swanson design
L3912	WHFO, flexion glove, with elastic finger control
L3914	WHFO, wrist extension (cock-up)
L3916	WHFO, wrist extension (cock-up), with outrigger
L3918	WHFO, knuckle bender
L3920	WHFO, knuckle bender, with outrigger
L3922	WHFO, knuckle bender, two-segment to flex joints
L3924	WHFO, Oppenheimer
L3926	WHFO, Thomas suspension
L3928	WHFO, finger extension, with clock spring
L3930	WHFO, finger extension, with wrist support
L3932	WHFO, safety pin, spring wire
L3934	WHFO, safety pin, modified
L3936	WHFO, Palmer
L3938	WHFO, dorsal wrist
L3940	WHFO, dorsal wrist, with outrigger attachment
L3942	WHFO, reverse knuckle bender
L3944	WHFO, reverse knuckle bender, with outrigger
L3946	WHFO, composite elastic
L3948	WHFO, finger knuckle bender
L3950	WHFO, combination Oppenheimer, with knuckle bender, and two attachments
L3952	WHFO, combination Oppenheimer, with reverse knuckle bender and two attachments
L3954	WHFO, spreading hand
L3956	Addition of joint to upper extremity orthosis, any material, per joint
L3960	Shoulder-elbow-wrist-hand orthosis, (SEWHO), abduction positioning, airplane design
L3962	SEWHO, abduction positioning, Erbs Palsey design
L3963	SEWHO, molded shoulder, arm, forearm, and wrist, with articulating elbow joint
L3964	SEO, mobile arm support attached to wheelchair, balanced, adjustable 1
L3965	SEO, mobile arm support attached to wheelchair, balanced, adjustable, rancho type 1
L3966	SEO, mobile arm support attached to wheelchair, balanced, reclining 1
L3968	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) 1
L3969	SEWHO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support 1
L3970	SEWHO, addition to mobile arm support, elevating proximal arm 1
L3972	SEWHO, addition to mobile arm support, offset or lateral rocker arm, with elastic balance control 1
L3974	SEWHO, addition to mobile arm support, supinator 1
L3980	Upper extremity fracture orthosis, humeral
L3982	Upper extremity fracture orthosis, radius/ulnar
L3984	Upper extremity fracture orthosis, wrist
L3985	Upper extremity fracture orthosis, forearm, hand with wrist hinge

Procedure Code	Description
L3986	Upper extremity fracture orthosis, combination of humeral, radius ulnar, wrist (e.g., Colles fracture)
L3995	Addition to upper extremity orthosis, sock, fracture or equal, each
L3999	Upper extremity orthosis, not otherwise specified
L4000	Replace girdle for Milwaukee orthosis
L4010	Replace trilateral socket brim
L4020	Replace quadrilateral socket brim, molded to patient model
L4030	Replace quadrilateral socket brim, custom fitted

Orthotic - Lower Limb

Procedure Code	Description
L4040	Replace molded thigh lacer
L4045	Replace non-molded thigh lacer
L4050	Replace molded calf lacer
L4055	Replace non-molded calf lacer
L4060	Replace high roll cuff
L4070	Replace proximal and distal upright for KAFO
L4080	Replace metal bands KAFO, proximal thigh
L4090	Replace metal bands KAFO-AFO, calf or distal thigh
L4100	Replace leather cuff KAFO, proximal thigh
L4110	Replace leather cuff KAFO-AFO, calf or distal thigh
L4130	Replace pretibial shell

Repair Codes

Procedure Code	Description
L4205	Repair of orthotic device, labor component, per 15 minutes (Effective 1/1/97 this replaces HCPCS code L4200)
L4210	Repair of orthotic device, repair or replace minor parts
L4310	Multi-podus or equal orthotic preparatory management system for lower extremities

Orthotic - Lower Limb

Procedure Code	Description
L4320	Addition to AFO, multi-podus (or equal) orthotic preparatory management system for lower extremities, Flexible foot positioner with soft interface for AFO, with Velcro closure
L4350	Pneumatic ankle control splint (aircast or equal)
L4360	Pneumatic walking splint (aircast or equal)
L4370	Pneumatic full leg splint (aircast or equal)
L4380	Pneumatic knee splint (aircast or equal)
L4390	Replace soft interface material, multi-podus type splint (Effective 1/1/97 this replaces HCPCS code K0126)
L4392	Replace soft interface material, ankle contracture splint (Effective 1/1/97 this replaces HCPCS code K0127)
L4394	Replace soft interface material, foot drop, splint (Effective 1/1/97 this replaces HCPCS code K0128)
L4396	Ankle contracture splint (Effective 1/1/97 this replaces HCPCS code K0129)
L4398	Foot drop splint, recumbent positioning device (Effective 1/1/97 this replaces HCPCS code K0130)
L5000	Partial foot, shoe insert, with longitudinal arch, toe filler

Prosthetic - Lower Limb

Procedure Code	***Description***
L5010	Partial foot, molded socket, ankle height, with toe filler
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler
L5050	Ankle, Symes, molded socket, SACH foot
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
L5100	Below knee, molded socket, shin, SACH foot
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	Above knee, short prosthesis, no knee joint (“stubbies”), with foot blocks, no ankle joints, each
L5220	Above knee, short prosthesis, no knee joint (“stubbies”), with articulated ankle/foot, dynamically aligned, each
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
L5250	Hip disarticulation, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	Hip disarticulation, tilt table type, molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
L5280	Hemipelvectomy, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5300	Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5310	Knee disarticulation (or through knee), molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5320	Above knee, molded socket, open end, SACH foot, single axis knee, endoskeletal system, including soft cover and finishing
L5330	Hip disarticulation, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5340	Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing

Orthotic - Lower Limb

Procedure Code	***Description***
L5400	Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee
L5410	Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, below knee, each additional cast change and realignment
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
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
L5450	Immediate post-surgical or early fitting, application of non-weight bearing rigid dressing, below knee
L5460	Immediate post-surgical or early fitting, application of non-weight bearing rigid dressing, above knee

Prosthetic - Lower Limb

Procedure Code	***Description***
L5500	Initial, below knee, “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, direct formed
L5505	Initial, above-knee or knee disarticulation ischial level socket, USMC or equal pylon, no cover, Sach foot, plaster socket, direct formed
L5510	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, molded to model
L5520	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5530	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee in “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee “PTB” type socket, “USMC” or equal pylon, no cover, SACH foot, laminated socket, molded to model
L5560	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, plaster socket, molded to model
L5570	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee-knee disarticulation, ischial level socket, “USMC” or equal pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee-knee disarticulation ischial level socket, “USMC” or equal pylon, no cover, SACH foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model
L5600	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient
L5610	Addition to lower extremity, above knee, Hydracadence system
L5611	Addition to lower extremity, above knee-knee disarticulation, 4-bar linkage, with friction swing phase control
L5613	Addition to lower extremity, above knee-knee disarticulation, 4-bar linkage, with hydraulic swing phase control
L5614	Addition to lower extremity, above knee-knee disarticulation, 4-bar linkage, with pneumatic swing phase control
L5616	Addition to lower extremity, above knee, Universal Multiplex system, friction swing phase control
L5617	Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each
L5618	Addition to lower extremity, test socket, Symes
L5620	Addition to lower extremity, test socket, below knee
L5622	Addition to lower extremity, test socket, knee disarticulation
L5624	Addition to lower extremity, test socket, above knee
L5626	Addition to lower extremity, test socket, hip disarticulation
L5628	Addition to lower extremity, test socket, hemipelvectomy
L5629	Addition to lower extremity, below knee, acrylic socket
L5630	Addition to lower extremity, Symes type, expandable wall socket
L5631	Addition to lower extremity, above knee or knee disarticulation, Acrylic socket
L5632	Addition to lower extremity, Symes type, PTBl, brim design socket
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636	Addition to lower extremity, Symes type, medial opening socket
L5637	Addition to lower extremity, below knee, total contact
L5638	Addition to lower extremity, below knee, leather socket
L5639	Addition to lower extremity, below knee, wood socket

Procedure Code	***Description***
L5640	Addition to lower extremity, knee disarticulation, leather socket
L5642	Addition to lower extremity, above knee, leather socket
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	Addition to lower extremity, above knee, wood socket
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	Addition to lower extremity, below knee, air cushion socket
L5647	Addition to lower extremity, below knee suction socket
L5648	Addition to lower extremity, above knee, air cushion socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket
L5654	Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5655	Addition to lower extremity, socket insert, below knee, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5656	Addition to lower extremity, socket insert, knee disarticulation, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5658	Addition to lower extremity, socket insert, above knee, (Kemblo, Pelite, Aliplast, Plastozote, or equal)
L5660	Addition to lower extremity, socket insert, Symes, silicone gel or equal
L5661	Addition to lower extremity, socket insert, multidurometer symes
L5662	Addition to lower extremity, socket insert, below knee, silicone gel or equal
L5663	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal
L5664	Addition to lower extremity, socket insert, above knee, silicone gel or equal
L5665	Addition to lower extremity, socket insert, multidurometer, below knee
L5666	Addition to lower extremity, below knee, cuff suspension
L5667	Addition to lower extremity, below knee/above knee, socket insert, suction suspension with locking mechanism
L5668	Addition to lower extremity, below knee, molded distal cushion
L5669	Addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism
L5670	Addition to lower extremity, below knee, molded supracondylar suspension (“PTS” or similar)
L5672	Addition to lower extremity, below knee, removable medial brim suspension
L5674	Addition to lower extremity, below knee, latex sleeve suspension or equal, each
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair
L5677	Additions to lower extremity, below knee, knee joints, polycentric, pair
L5678	Additions to lower extremity, below knee, joint covers, pair

Orthotic - Lower Limb

Procedure Code	***Description***
L5680	Addition to lower extremity, below knee, thigh lacer, non-molded
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5684	Addition to lower extremity, below knee, fork strap
L5686	Addition to lower extremity, below knee, back check, (extension control)
L5688	Addition to lower extremity, below knee, waist belt, webbing
L5690	Addition to lower extremity, below knee, waist belt, padded and lined
L5692	Addition to lower extremity, above knee, pelvic control belt, light
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	All lower extremity prostheses, shoulder harness

Prosthetic - Lower Limb

Procedure Code	***Description***
L5700	Replacement, socket, below knee, molded to patient model
L5701	Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5704	Replacement, custom shaped protective cover, below knee
L5705	Replacement, custom shaped protective cover, above knee
L5706	Replacement, custom shaped protective cover, knee disarticulation
L5707	Replacement, custom shaped protective cover, hip disarticulation
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	Addition, exoskeletal knee shin system, polycentric, mechanical stance phase lock
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber, or equal)
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)

Procedure Code	***Description***
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control
L5840	Addition, endoskeletal knee-shin system, multi-axial, pneumatic swing phase control
L5845	Addition, endoskeletal, knee-shin system, stance, flexion feature, adjustable
L5846	Addition, endoskeletal, knee-shin system, microprocessor control feature, swing phase only
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
L5910	Addition, endoskeletal system, below knee, alignable system
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5930	Addition, endoskeletal system, high activity knee control frame
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5970	All lower extremity prostheses, foot, external keel, SACH foot
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)
L5974	All lower extremity prostheses, foot, single axis ankle/foot
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)
L5978	All lower extremity prostheses, foot, multi-axial ankle/foot
L5979	All lower extremity prostheses, multi-axial ankle/foot, dynamic response
L5980	All lower extremity prostheses, flex-foot system
L5981	All lower extremity prostheses, flex-walk system or equal
L5982	All exoskeletal lower extremity prostheses, axial rotation unit
L5984	All endoskeletal lower extremity prostheses, axial rotation unit
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986	All lower extremity prostheses, multi-axial rotation unit (ii MCPlt or equal)
L5987	All lower extremity prosthesis, shank foot system with vertical loading pylon
L5999	Lower extremity prosthesis, not otherwise specified

Prosthetic - Upper Limb

Procedure Code	***Description***
L6000	Partial hand, Robin-Aids, thumb remaining, (or equal)
L6010	Partial hand, Robin-Aids, little and/or ring finger remaining, (or equal)
L6020	Partial hand, Robin-Aids, no finger remaining, (or equal)
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110	Below elbow, molded socket, (Muenster or Northwestern suspension types)
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310	Shoulder disarticulation, passive restoration, (complete prosthesis)
L6320	Shoulder disarticulation, passive restoration, (shoulder cap only)
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360	Interscapular thoracic, passive restoration (complete prosthesis)
L6370	Interscapular thoracic, passive restoration, (shoulder cap only)
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
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
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
L6386	Immediate post surgical or early fitting, each additional cast change and realignment
L6388	Immediate post surgical or early fitting, application of rigid dressing only
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
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
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
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
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

Procedure Code	***Description***
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
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
L6600	Upper extremity additions, polycentric hinge, pair
L6605	Upper extremity additions, single pivot hinge, pair
L6610	Upper extremity additions, flexible metal hinge, pair
L6615	Upper extremity addition, disconnect locking wrist unit
L6616	Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620	Upper extremity addition, flexion-friction wrist unit
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release
L6625	Upper extremity addition, rotation wrist unit with cable lock
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630	Upper extremity addition, stainless steel, any wrist
L6632	Upper extremity addition, latex suspension sleeve, each
L6635	Upper extremity addition, lift assist for elbow
L6637	Upper extremity addition, nudge control elbow lock
L6640	Upper extremity additions, shoulder abduction joint, pair
L6641	Upper extremity addition, excursion amplifier, pulley type
L6642	Upper extremity addition, excursion amplifier, lever type
L6645	Upper extremity addition, shoulder flexion/abduction joint, each
L6650	Upper extremity addition, shoulder universal joint, each
L6655	Upper extremity addition, standard control cable, extra
L6660	Upper extremity addition, heavy duty control cable
L6665	Upper extremity addition, Teflon or equal, cable lining
L6670	Upper extremity addition, hook to hand, cable adapter
L6672	Upper extremity addition, harness, chest or shoulder, saddle type
L6675	Upper extremity addition, harness, figure-(ib 8lg) eight type, for single control
L6676	Upper extremity addition, harness, figure-(ib 8lg) eight type, for dual control
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682	Upper extremity addition, test socket, elbow disarticulation or above elbow
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686	Upper extremity addition, suction socket
L6687	Upper extremity addition, frame type socket, below elbow or wrist disarticulation
L6688	Upper extremity addition, frame type socket, above elbow or wrist disarticulation
L6689	Upper extremity addition, frame type socket, shoulder disarticulation
L6690	Upper extremity addition, frame type socket, interscapular-thoracic
L6691	Upper extremity addition, removable insert, each
L6692	Upper extremity addition, silicone gel insert or equal, each
L6700	Terminal device, hook, Dorrance, or equal, model #
L6705	Terminal device, hook, Dorrance, or equal, model # 5
L6710	Terminal device, hook, Dorrance, or equal, model # 5X
L6715	Terminal device, hook, Dorrance, or equal, model # 5XA
L6720	Terminal device, hook, Dorrance, or equal, model # 6
L6725	Terminal device, hook, Dorrance, or equal, model # 7
L6730	Terminal device, hook, Dorrance, or equal, model # 7LO
L6735	Terminal device, hook, Dorrance, or equal, model # 8
L6740	Terminal device, hook, Dorrance, or equal, model # 8X
L6745	Terminal device, hook, Dorrance, or equal, model # 88X
L6750	Terminal device, hook, Dorrance, or equal, model # 10P

Procedure Code	***Description***
L6755	Terminal device, hook, Dorrance, or equal, model # 10X
L6765	Terminal device, hook, Dorrance, or equal, model # 12P
L6770	Terminal device, hook, Dorrance, or equal, model # 99X
L6775	Terminal device, hook, Dorrance, or equal, model # 555
L6780	Terminal device, hook, Dorrance, or equal, model # SS555
L6790	Terminal device, hook, Accu-hook, or equal
L6795	Terminal device, hook, 2-load, or equal
L6800	Terminal device, hook, APRLVC, or equal
L6805	Terminal device, modifier wrist flexion unit
L6806	Terminal device, hook, TRS Grip, Grip III, VC or equal
L6807	Terminal device, hook, Grip I, Grip II, VC, or equal
L6808	Terminal device, hook, TRS Adept, infant or child, VC or equal
L6809	Terminal device, hook, TRS Super Sport, passive
L6810	Terminal device, pincher tool, Otto Bock or equal
L6825	Terminal device, hand, Dorrance, VO
L6830	Terminal device, hand, APRL, VC
L6835	Terminal device, hand, Sierra, VO
L6840	Terminal device, hand, Becker Imperial
L6845	Terminal device, hand, Becker Lock Grip
L6850	Terminal device, hand, Becker Plylite
L6855	Terminal device, hand, Robin-Aids, VO
L6860	Terminal device, hand, Robin-Aids, VO Soft
L6865	Terminal device, hand, passive hand
L6867	Terminal device, hand, Detroit Infant Hand (mechanical)
L6868	Terminal device, hand, passive infant hand, Steeper, Hosmer or equal
L6870	Terminal device, hand, child mitt
L6872	Terminal device, hand, NYU child hand
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal
L6875	Terminal device, hand, Bock, VC
L6880	Terminal device, hand, Bock, VO
L6890	Terminal device, glove for above hands, production glove
L6895	Terminal device, glove for above hands, custom glove
L6900	Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining
L6905	Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining
L6910	Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining
L6915	Hand restoration (shading and measurements included), replacement glove for above
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
L6925	Wrist disarticulation, external power, self suspended inner socket, removable forearm shell, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
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
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
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

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
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
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
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
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
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
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
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled
L7015	Electronic hand, System Teknik, Variety Village or equal, switch controlled
L7020	Electronic greifer, Otto Bock or equal, switch controlled
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled
L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled
L7035	Electronic hand greifer, Otto Bock or equal, myoelectronically controlled
L7040	Prehensile actuator, Hosmer or equal, switch controlled
L7045	Electronic hook, child, Michigan or equal, switch controlled
L7170	Electronic elbow, Hosmer or equal, switch controlled
L7180	Electronic elbow, Boston, Utah or equal, myoelectronically controlled
L7185	Electronic elbow, Variety Village or equal, switch controlled
L7186	Electronic elbow, child, variety village or equal, switch controlled
L7190	Electronic elbow, Variety Village or equal, myoelectronically controlled
L7191	Electronic elbow, child, variety village or equal, myoelectronically controlled
L7260	Electronic wrist rotator, Otto Bock or equal
L7261	Electronic wrist rotator, for Utah arm
L7266	Servo control, Steeper or equal
L7272	Analogue control, UNB or equal
L7274	Proportional control, 6-12 volt, Liberty, Utah or equal

Battery

Procedure Code	***Description***
L7360	Six volt battery, Otto Bock or equal
L7362	Battery charger, six volt, Otto Bock or equal
L7364	Twelve volt battery, Utah or equal, each
L7366	Battery charger, twelve volt, Utah or equal
L7499	Upper extremity prosthesis, not otherwise specified

Prosthetic - Upper Limb

Procedure Code	***Description***
L7500	Repair of prosthetic device, hourly rate (Excludes V5335 repair of oral or laryngeal prosthesis or Artificial larynx)
L7510	Repair of prosthetic device, repair or replace minor parts (Excludes V5335 repair of oral or laryngeal prothesis or artificial larynx)
L7520	Repair prosthetic device, labor component, per 15 minutes (Effective 1/1/97 this replaces HCPCS code K0285)
L7900	Vacuum erection system (Effective 1/1/97 this replaces HCPCS code K0163)

Orthotic - Lower Limb

Procedure Code	***Description***
L8100	Elastic support, elastic stocking, below knee, medium weight, each
L8110	Elastic support, elastic stocking, below knee, heavy weight, each
L8120	Elastic support, elastic stocking, below knee, surgical weight, (Linton type or equal), each
L8130	Elastic support, elastic stocking, above knee, medium weight, each
L8140	Elastic support, elastic stocking, above knee, heavy weight, each
L8150	Elastic support, elastic stocking, above knee, surgical weight, (Linton type or equal), each
L8160	Elastic support, elastic stocking, full length, medium weight, each Elastic support, elastic stocking, full length, heavy weight, each
L8170	Elastic support, elastic stocking, full length, heavy weight, each
L8180	Elastic support, elastic stocking, full length, heavy surgical weight, (Linton type or equal), each
L8190	Elastic support, elastic stocking, leotards, medium weight, each
L8200	Elastic support, elastic stocking, leotards, surgical weight, (Linton type or equal), each
L8210	Elastic support, elastic stocking, custom made
L8220	Elastic support, elastic stocking, lymphedema
L8230	Elastic support, elastic stocking, garter belt
L8239	Elastic support, not otherwise specified
L8300	Truss, single, with standard pad
L8310	Truss, double, with standard pads
L8320	Truss, addition to standard pad, water pad
L8330	Truss, addition to standard pad, scrotal pad
L8400	Prosthetic sheath, below knee, each

Prosthetic - Lower Limb

Procedure Code	***Description***
L8410	Prosthetic sheath, above knee, each
L8415	Prosthetic sheath, Wool, upper limb, each
L8417	Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each (Effective 1/1/97 this replaces HCPCS code XX015)
L8420	Prosthetic sock, wool, below knee, each
L8430	Prosthetic sock, wool, above knee, each
L8435	Prosthetic sock, wool, upper limb, each
L8440	Prosthetic shrinker, below knee, each
L8460	Prosthetic shrinker, above knee, each
L8465	Prosthetic shrinker, upper limb, each
L8470	Stump sock, single ply, fitting, below knee, each
L8480	Stump sock, single ply, fitting, above knee, each
L8485	Stump sock, single ply, fitting, upper limb, each
L8490	Addition to prosthetic sheath/sock, air seal suction retention system

L8499	Unlisted procedure for miscellaneous prosthetic services
L8500	Artificial Larynx, any type
L8501	Tracheotomy speaking valve
L8600	Implantable breast prosthesis, silicone or equal
L8603	Collagen implant, urinary tract, per 2.5 cc syringe, includes shipping and necessary supplies
L8610	Ocular implant
L8612	Aqueous shunt
L8613	Ossicula implant
L8614	Cochlear device/system
L8619	Cochlear implant external speech processor, replacement
L8630	Metacarpophalangeal joint implant
L8641	Matatarsal joint implant
L8642	Hallux implant
L8658	Interphalangeal joint implant
L8670	Vascular graft material, synthetic, implant

14.5.4 Place of Service Codes

The following place of service code applies when filing claims for DME:

POS Code	***Description***
12	Home

14.5.5 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 HCFA-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

14.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-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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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. Currently, the Central Source contractor is Classic Optical.

The policy provisions for eye care providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 17.

15.1 Enrollment

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Eye Care provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for eye care related claims.

NOTE:

All nine digits are required when filing a claim.

Opticians and Optometrists are assigned a provider type of 22 (Optician/Optometrist). Valid specialties for Eye Care providers include the following:

- Optician (X3)
- Optometrist (X4)

Ophthalmologists are enrolled with a provider type of 01 (Physician). The valid specialty is Ophthalmologist (18).

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.

To prescribe therapeutic agents for the eye, the optometrist must be licensed by the Alabama Board of Optometry.

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.

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 only
- 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 Only

Medicaid recipients 21 years of age and older are authorized one complete eye examination every two calendar years. Recipients under 21 years of age are authorized the same service each calendar year, or more often if documented medical necessity indicates.

A complete eye examination and 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 refractive error findings to indicate the diagnosis.

NOTE:

For children, examine eye tension and visual fields only if indicated.

Optometrist Services

Optometrists may provide services other than correction of refractive error as follows:

- During an optometric 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 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.
- Orthoptics (eye exercises) require prior authorization.
- Photochromic lenses and UV400 coating 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.

Physician Services

Physicians may provide the following eye care services when diseases, injuries, or congenital defects are present:

- Contact lenses (when medically necessary for 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.

15.2.2 Eyeglasses

If a Medicaid recipient requires eyeglasses, services include verification of prescription, dispensing of eyeglasses (including laboratory selection), frame selection, procurement of eyeglasses, and fitting and adjustment of the eyeglasses to the patient.

Recipients 21 years of age and older are authorized one pair of eyeglasses each two calendar years if indicated by an examination. Prior authorization is required for additional glasses within same benefit period. Recipients under 21 years of age are authorized the same service each calendar year, or more often if documented medical necessity indicates. These limitations also apply to fittings and adjustments.

At the option of the provider taking the frame measurements, either the central Medicaid 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.

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 or clear plastic unless prior authorized by Medicaid because of unusual conditions. All lenses must meet FDS impact-resistant regulations.

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 lenses 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. Medicaid will pay for the frame only.

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, or significant prescription change. The provider should forward a letter to Medicaid justifying medical necessity prior to ordering the eyeglasses.

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

Photochromic lenses

UV 400 lens coating

Contact lenses (for keratoconus, aphakia, and high magnification difference between lenses)

Refer to Section 15.5.3, Procedure Codes and Modifiers, for the appropriate procedure codes for services requiring prior authorization.

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	HCFA Assignment of Vision Services
Z5135-Z5144	Eyeglasses
Z5151-Z5152, Z5159-Z5173	Eyeglasses
Z5180, Z5193	Eyeglasses
Z5196-Z5198, Z5273-Z5293	Eyeglasses
Z5321	Eyeglasses
Z5392	Eyeglasses
Z5397-Z5399	Eyeglasses
Z5443-Z5448, 92002-92015	Ophthalmological services for new patients
92313	Corneoscleral lens
92315-92317	Corneal lens/Corneoscleral lens
92325-92326	Modification of lens/Replacement of lens

Refer to Appendix D, Managed Care, 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 ten-digit prior authorization number.

15.4 Cost Sharing (Copayment)

The copayment amount for optometric office visits is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.
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

➢ 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.

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 HCFA-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
- Other situations

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. Refer to 15.5.3, Procedure Codes and Modifiers, for a list of possible procedure codes. Send this claim directly to EDS.

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 Medicaid source contractor provides the eyeglasses.

1. The examiner completes the HCFA-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 EDS.

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 EDS. 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 EDS.

Post-Operative Care

Medicaid will deny post-operative claims when the surgeon (ophthalmologist) receives payment for the global amount. Medicaid will not process post-operative management claims until the referring ophthalmologist has received payment for surgery. It is the responsibility of the optometrist to confer with the surgeon for appropriate claim corrections and/or submissions.

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.

Completing the Eyeglasses Prescription Form

Use the Medicaid Eyeglasses Prescription Form to order frames and lenses for eyeglasses. The Central Source contractor supplies these forms supplied upon request. When the contractor provides eyeglasses, the provider cannot bill Medicaid for lenses and frames. Only the contractor may submit claims for these services.

Field on Form	***Information To Enter***
Provider Number	Enter ordering provider number.
Date	Enter only the date of service or date of prior authorization letter. Do not enter any other dates.
Eyeglasses Prescription Information	Enter the prescription in the appropriate fields provided.
P.D. Far-Near	Indicate as appropriate.
Eye	Enter appropriate measurement.
Bridge	Enter appropriate measurement.
Seg Height	Enter appropriate measurement.
Type Lenses	Indicate plastic or glass.
Temple Length	Enter appropriate measurement.
SV	Check appropriate block.
Frame	Enter appropriate frame name and color.
Special Instructions	Indicate as applicable.
Insurer's ID Number or RID number	Enter the 13-digit RID number from the recipient's plastic Medicaid card. Please verify this information. The Eyeglass Central Source is dependent upon the examiner for this vital information. Failure to furnish accurate information may delay or deny payment to the Medicaid Central Source.
Patient name	Enter the patient's last name, first name, and middle initial as it appears on the plastic Medicaid card.
Date of Birth	Enter patient's date of birth.
Patient's Address	Enter address
Patient or Authorized Person's Signature/Doctor's Signature	Have patient or patient's authorized representative sign and indicate the doctor's signature.
Prior Authorization	If services performed require prior authorization, indicate the ten-digit number supplied by Medicaid.
Provider	Enter the provider name and address to which the Central Source will deliver the completed eyeglasses.

The provider keeps the pink copy and forwards the other copies to the Central Source. The remainder of the form will be completed by the Central Source.

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 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

15.5.2 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

15.5.3 Procedure Codes and 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, and pose no limitations on other related procedure codes.

Procedure Code	*Description*
92002	New Patient Ophthalmologic Service, Intermediate: Examination and evaluation with initiation of diagnostic and treatment program.
92004	New Patient Optometric Service: Complete comprehensive examination and evaluation. (Does not include refraction, which should be billed separately.)
92012	Established Patient Ophthalmological Service, Intermediate
92014	Established Patient Optometric Service: Complete comprehensive examination and evaluation. (Does not include refraction, which should be billed separately.)
92015	Determination of refractive state (Bill as an add-on charge with complete eye exam when refraction is accomplished)
99201	New Patient: Office or other outpatient visit for the evaluation and management of a new patient that requires these three key components: • A problem-focused history • A problem-focused examination • Straightforward medical decision making
99202	New Patient: Office or other outpatient visit for the evaluation and management of a new patient that requires these three key components • An expanded problem-focused history • An expanded problem-focused examination • Straightforward medical decision making

Procedure Code	***Description***
99203	New Patient: Office or other outpatient visit for the evaluation and management of a new patient that requires these three key components: • A detailed history • A detailed examination • Medical decision making of low complexity
99204	New Patient: Office or other outpatient visit for the evaluation and management of a new patient that requires these three key components: • A comprehensive history • A comprehensive examination • Medical decision making of moderate complexity
99205	New Patient: Office or other outpatient visit for the evaluation and management of a new patient that requires these three key components: • A comprehensive history • A comprehensive examination • 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 problem or problems are minimal.)
99212	Established Patient: Office or other outpatient visit for the evaluation and management of an established patient that 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 that 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 that 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 that 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*
99311	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity
99312	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity
99313	Subsequent Nursing Facility Care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: • A detailed interval history • A detailed examination • Medical decision making of moderate to high complexity
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	Initial 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	Initial 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
99261	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: • A problem focused interval history • A problem focused examination • Medical decision making that is straightforward or of low complexity
99262	Follow-up inpatient consultation for an established patient, which requires at least two of these three key components: • An expanded problem focused interval history • An expanded problem focused examination • Medical decision making of moderate complexity

Special Optometric Services

Procedure Code	*Description*	*PA Required*
92065	Orthoptic training (requires prior authorization from Medicaid)	Yes
92081	Visual field examination	No
92082	Visual field examination, intermediate	No
92083	Visual field examination, extended	No
92100	Tonometry	No
92225	Ophthalmoscopy, extended, initial	No
92226	Ophthalmoscopy, subsequent	No
92250	Ophthalmoscopy, with Fundus photography	No
92285	External ocular photography for documentation	No
92330	Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation	No
92340	Fitting and/or adjustment	No
92370	Repair of frames	No

Surgical Procedures

Procedure Code	*Description*
65205	Removal of Foreign Body
65210	Removal of Foreign Body, conjunctival embedded
65220	Removal of Foreign Body, corneal, without slit lamp
65222	Removal of Foreign Body, corneal, with slit lamp
68801	Lacrimal Function
68810	Probing

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, 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***
V2510		Contact lens, gas permeable, spherical	Yes
V2511		Contact lens, gas permeable, toric	Yes
V2513		Contact lens, gas permeable, extended wear	Yes
V2520		Contact lens, hydrophilic, spherical	Yes
V2521		Contact lens, hydrophilic, toric	Yes
V2523		Contact lens, hydrophilic, extended wear	Yes
92310		Fitting of contact lens for both eyes, except aphakia	Yes
92310	52	Fitting of contact lens for one eye, except aphakia	Yes
92311		Fitting, for aphakia, one eye	Yes
92312		Fitting, for aphakia, both eyes	Yes

Eyeglasses Codes

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 FDS 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
- Bifocal sphere
- Bifocal spherocylinder cylinder
- Other lenses
- Lenses requiring prior authorization from Medicaid before ordering

Frame Codes

- Women’s frames
- Girls’ frames
- Men’s frames
- Boys’ frames
- Unisex frames for men or women
- Unisex frames for boys or girls
- Special frame (size, type) other than above

Single Vision Spherocylinder (Plus or Minus)

Single Vision (Plus or Minus)	*Price Per Lens*
V2100 – Plano – 4.00	$ 5.23
V2101 – 4.25 – 7.00	5.72
V2102 – 7.25 – 12.00	7.95
V2103 – Plano – 4.00/0.25 – 2.00 cylinder	5.52
V2104 – Plano – 4.00/2.25 – 4.00 cylinder	5.43
V2105 – Plano – 4.00/4.25 – 6.00 cylinder	7.26
V2106 – Plano – 4.00/over 6.00 cylinder	7.35
V2107 – 4.25 – 7.00/0.25 – 2.00 cylinder	5.63
V2108 – 4.25 – 7.00/2.25 – 4.00 cylinder	7.14
V2109 – 4.25 – 7.00/4.25 – 6.00 cylinder	7.52
V2110 – 4.25 – 7.00/over 6.00 cylinder	7.85
V2111 – 7.25 – 12.00/0.25 – 2.25 cylinder	7.74
V2112 – 7.25 – 12.00/2.25 – 4.00 cylinder	7.78
V2113 – 7.25 – 12.00/4.25 – 6.00 cylinder	8.70
Z5062 – 7.25 – 12.00/over 6.00 cylinder	15.57

Bifocal Sphere (Plus or Minus)

Bifocal Sphere (Plus or Minus)	*Price Per Lens*
V2200 – Plano – 4.00	$ 7.31
V2201 – 4.25 – 7.00	8.20
V2202 – 7.25 – 12.00	9.12

Bifocal Spherocylinder (Plus or Minus)

Bifocal Spherocylinder (Plus or Minus) Cylinder	*Price Per Lens*
V2203 – Plano – 4.00/0.25 – 2.00 cylinder	$ 7.31
V2204 – Plano – 4.00/2.25 – 4.00 cylinder	7.64
V2205 – Plano – 4.00/4.25 – 6.00 cylinder	8.05
V2206 – Plano – 4.00/over 6.00 cylinder	8.84
V2207 – 4.25 – 7.00/0.25 – 2.00 cylinder	8.25
V2208 – 4.25 – 7.00/2.25 – 4.00 cylinder	8.32
V2209 – 4.25 – 7.00/4.25 – 6.00 cylinder	8.69
V2210 – 4.25 – 7.00/over 6.00 cylinder	8.80
V2211 – 7.25 – 12.00/0.25 – 2.25 cylinder	9.18
V2212 – 7.25 – 12.00/2.25 – 4.00 cylinder	9.85
V2213 – 7.25 – 12.00/4.25 – 6.00 cylinder	10.42
Z5061 – 7.25 – 12.00/over 6.00 cylinder	10.42
V2199 – Over plus or minus 12.00 diopters	18.80
V2700 – Balance lens	5.15

NOTE:

Procedure Code V2199 may be used to bill for "add power".

Other

Other	*Price Per Lens*
V2115 – Lenticular (Myodisc) * (stand alone)	$ 31.56
V2117 – Aspheric Lenticular * (stand alone)	13.69
V2299 – Executive Bifocals * (stand alone)	9.85
V2399 – Trifocals * (stand alone)	10.28
V2499 – Aspheric * (stand alone cost)	11.69
V2710 – Slab-off Prism * (stand alone)	30.90
V2715 – Prism Add ** (add-on)	1.50
V2718 – Press On Fresnell Prisms ** (add on)	11.18
V2743 – Tinted Lenses ** (add-on)	3.00
V2799 – Polycarbonate Lenses * (stand alone)	12.36

Lenses Requiring Prior Authorization from Medicaid Before Ordering

Lens	*Price per Lens*
V2744 – Photocromic ** (add-on cost)	$ 6.38
V2755 – UV 400 Coating ** (add-on cost)	3.00

* Stand Alone Cost: This item is all-inclusive, billed with no other lens code.

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

Women's Frames

Frame	*Price*
Z5273 – BI - 224 Limited Edition	$ 11.95
Z5321 – B - 216 Limited Edition	11.95
Z5276 – Hart: Looking Glass Model 7037	13.95
Z5279 – Bacara 277 (Metal)	11.95
Z5280 – Regina (Metal)	9.45
Z5292 – Oretha	10.95
Z5445 – LG6021	11.95
Z5446 – Marla	9.40
V2020 – LG9039	12.95
Z5293 - IG - 4 Philip Optics	12.95

Girls' Frames

Frame	*Price*
Z5137 – Betty Springs	$ 10.95
Z5160 – Mianstreet 415	12.50
Z5165 – IG - 27 Philip Optics	11.70
Z5398 – IG - 25 Philip Optics	11.70
Z5397 – Nino	6.95

Men's Frames

Frame	*Price*
Z5136 – Hart: Mainstreet 3025	$ 8.45
Z5138 – Hart: Looking Glass 8002	13.50
Z5291 – Manchester Limited Edition	11.95
Z5172 – Hart: Looking Glass 8025	13.50
Z5275 – Elay	11.95
Z5284 – Hart: Mainstreet 876 – Metal	10.35
Z5285 – Hart: Boulevard 3017 – Metal	10.35
Z5287 – Raymond	5.95
Z5291 – Bacara 212 (Metal)	11.95
Z5447 – Stinger	11.95
Z5448 – Barry	7.95
Z5170 - Uptown	6.95

Boys' Frames

Frame	*Price*
Z5165 – Mainstreet 415	$ 12.50
Z5169 – Nick	5.95
Z5281 – Hart: Looking Glass 8023 – Metal	12.95
Z5288 – SST-1 (Metal)	10.95
Z5289 – Hart: Boulevard 3014 – Metal	8.75
Z5136 – Mainstreet 302S	10.95
Z5399 – Chuckles	12.95

Unisex Frames for Men, Women, Boys, Girls

Frame	*Price*
Z5135 – Hart: Boulevard 3112 – Metal	$ 11.15
Z5159 – Hart: Boulevard 4017 – Metal	11.15
Z5198 – Boulevard 1104	8.95
Z5392 – Robby	11.95
Z5286 – Overlook	4.95
Z5321 – Bacara 226	11.95
Z5392 – Bacara 207	11.95
Z5443 – Ontario	10.95
Z5444 – Stanford	9.50
Z5290 - Oden	11.95
Z5151 – Boulevard 4502	10.95
Z5152 – Boulevard 4508	10.95
Z5164 – Bella Italia 23 Limited Edition	11.95
Z5193 – Boulevard 4509	10.95
Z5196 – Boulevard 4511	10.95
Z5197 – Boulevard 4517	10.95
Z5168 – Benji Limited Edition	11.95

Special Frame (Size, Type) Other Than Above

Frame	*Price*
Z5180 – Special Order Frames ***(PA REQUIRED)***	$ 25.00

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.

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-1500 claim form must be submitted.

Refer to Section 5.7, 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
HCFA-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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16

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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a FQHC provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for FQHC-related claims.

NOTE:

All nine digits are required when filing a claim.

FQHC facilities are assigned a provider type of 49 (FQHC). The valid specialty is F2 (Federally Qualified Health Center). Registered nurses should bill using the clinic number as the performing provider number (Block 24K) on the HCFA-1500 claim form.

Physicians, Nurse Midwives, Certified Registered Nurse Practitioners, and Physician Assistants affiliated with the FQHC are issued individual Medicaid provider numbers that are linked to the FQHC number. Each of these providers is assigned a provider type of 49 (FQHC). Valid specialties are as follows:

- All valid specialties associated with physicians (refer to specialty table below)
- N2 (Nurse Midwife)
- N3 (Certified Registered Nurse Practitioner)
- N6 (Physician Assistant)

Specialty (Applicable for physicians only)	***Code***
Allergy/Immunology	03
Anesthesiology	05
Cardiac surgery and cardiovascular disease	S1
Cochlear implant team	C9
Colon and rectal surgery	S2
Dermatology	07
EENT	XA
Emergency medicine	E1
Endocrinology	E2
EPSDT	E3
Family practice	08
Gastroenterology	10
General practice	01
General surgery	02
Geriatrics	38
Hand surgery	21
Hematology	H2
Infectious diseases	55
Internal medicine	11
Mammography	M7
Neonatology	NI
Nephrology	39
Neurological surgery	14
Neurology	13
Nuclear medicine	36
Nutrition	40
Obstetrics/Gynecology	16
Oncology	XI
Ophthalmology	18
Optometry	X4
Oral and maxillofacial surgery	SE
Orthopedic	X6
Orthopedic surgery	20
Otorhinolaryngology	X9
Pathology	22
Pediatrics	37
Plastic, reconstructive, cosmetic surgery	24
Primary care provider (not a screening provider but can refer patients)	AE
Proctology	28
Psychiatry	26
Pulmonary disease	29
Radiology	30
Rheumatology	R4
Thoracic surgery	33
Urology	34
Vascular surgery	S4

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 and thereafter an annual cost report
- 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 are met.

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:

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 EDS 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.

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.

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

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.

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 EDS 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 EDS 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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

16.4 Cost Sharing (Copayment)

The copayment amount is $1.00 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.

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 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.

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 HCFA-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 provider number on Block 24K of the HCFA-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, HCFA-1500 Claim Filing Instructions, for more information.

16.5.1 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.

16.5.2 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

16.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z’.

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 HCFA level codes will be recognized.

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*
Z5181	Family Planning, initial visit
Z5182	Family Planning, annual visit
Z5183	Family Planning, periodic revisit
Z5190	Family Planning, expanded counseling visit
99401	Family Planning, HIV pre-test counseling
99402	Family Planning, HIV post-test counseling
*Z5115	EPSDT Screening normal findings
*Z5116	EPSDT Screening abnormal findings
*Z5154	Periodic EPSDT Screening normal findings
*Z5155	Periodic EPSDT Screening abnormal findings
*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 70 years
*Z5316	EPSDT Vision Screen
*Z5317	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.

NOTE:

VFC codes must be billed under the FQHC's VFC number.

16.5.4 Place of Service Codes

The following place of service codes apply when filing claims for FQHC services:

POS	*Description*
11	Office
12	Home
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.

16.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

16.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-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

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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 leave home under normal circumstances. Leaving home requires a considerable and taxing effort by the recipient, and absences from the home are infrequent, of relatively short duration, and for medical reasons.
- 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a home health provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for home health-related claims.

NOTE:

All eight characters are required when filing a claim.

Home health providers are assigned a provider type of 14 (Home Health). The valid specialty for home health providers is H3 (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
- Submit a copy of the agency's most recent cost report

For continued participation as a Medicaid home health care provider, an annual Medicare cost report for the home health agency's fiscal year must be submitted to Medicaid within 30 calendar days after the report is submitted to Medicare. A copy of any Medicare audit adjustment or settlement must be submitted to Medicaid within 30 calendar days of receipt by the home health agency.

NOTE:

If the cost report is not provided as required, the home health agency's contract may be terminated for noncompliance.

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.

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.

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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

17.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

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.

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-92 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

17.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z’.

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 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	97020	microwave
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	97139	unlisted therapeutic procedure (specify)
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
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	97545	Work hardening/conditioning; initial 2 hours
420	97546	each additional hour (List separately in addition to code for primary procedure)

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

Orthotics

Revenue Code	*Procedure Code*	*Description*
420 or 430	L3650 – L3995	Orthotics
420 or 430	L4205 – L4210	Orthotics repair

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

Other Home Health Services

Revenue Code	*Procedure Code*	*Description*
551	Z5414	Skilled Nursing Visit
571	Z5415	Home Health Aide Visit

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-92 claim form.

17.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim 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-92 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-92 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, social 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.

The policy provisions for Hospice providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 51.

18.1 Enrollment

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hospice provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hospice-related claims.

NOTE:

All eight characters are required when filing a claim.

Hospice providers are assigned a provider type of 47 (Hospice). Valid specialties for hospice providers include Hospice (H6).

Enrollment Policy for Hospice Providers

To participate in Medicaid, hospice providers must meet the following requirements:

- Receive certification from the Health Care Financing Administration 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 copy of the notification to the hospice showing the approved Medicare reimbursement rate, the fiscal year end, and the Medicare provider number

Only hospice programs physically located within Alabama or within 30 miles of the state line may participate.

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.

The hospice must submit required hospice election and physician certification documentation to Medicaid for coverage of hospice care.

18.2.1 Physician Certification

The hospice must obtain physician certification that the individual recipient is terminally ill.

For the first period, the hospice 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 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 eight calendar days after care begins.

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.

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 any one of four periods in a person's lifetime during 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. 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
- Election is re-certified when there is a break in care

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. 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.

If an individual is eligible for Medicare as well as Medicaid, the individual must elect or revoke the hospice benefit simultaneously under both programs.

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 hospice retains medical records for at least three years after the current year.

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

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 a copy of the form used 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.

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 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 Therapy	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 must conform to the methodology and amounts calculated by the Health Care Financing Administration (HCFA). 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 HCFA 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.

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, with the hospice provider indicated as the payee.
- 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 the LTC-2 discharging the resident from the nursing facility. The LTC-2 is the form generated when a recipient is approved for Hospice. The bottom portion of this form should be filled out by the provider to indicate discharge from the nursing facility to the Hospice. The form should indicate the admission to the hospice program with the provider name and date of discharge. The hospice provider should follow the usual procedure for prior authorization stated in 18.3, Prior Authorization and Referral Requirements.

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 would continue to be 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 amount required to be paid from claimant’s income.

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.

Medicare/Medicaid Eligibility

All recipients who are Medicaid eligible should send a completed election statement to Medicaid. If an individual is eligible for Medicare as well as Medicaid, the individual must elect or revoke the hospice benefit simultaneously under both programs. 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. The Medicaid Prior Approval Unit must receive Form 165 on dually eligible recipients even though Medicare reimburses the provider for the hospice 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.

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.

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.

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-92 claim form. See Section 5.6.2, Institutional Medicaid/Medicare Related Claim Filing Instructions, for instructions on completing the crossover claim form.

18.3 Prior Authorization and Referral Requirements

The hospice must send Medicaid a copy of the Medicaid Hospice Election and Physician's Certification form (Form 165). This form must be filled out completely and legibly. The hospice maintains the original of this form for each recipient. One copy of the form must be given to the patient, one copy must be given to the physician, and one copy must be sent to the Alabama Medicaid Long Term Care Admissions (LTC ADM) Records Unit, P. O. Box 5624, Montgomery, Alabama 36103.

On receipt, the LTC ADM Records nurse reviews submitted information. If appropriate, the nurse approves or denies the service and generates a notification. This notification indicates the date(s) of authorization for payment, if approved. The hospice should not bill EDS for payment until a notification form has been received for the recipient.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

18.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by a Hospice provider.

18.5 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.

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-92 claim form is required. Medicare-related claims should 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.

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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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.

Payment of hospice services is limited to the following codes:

Revenue Code	Procedure Code	Description
651	Z5424	Routine home care, per day
652	Z5425	Continuous home care, per day
655	Z5426	Inpatient respite care, per day
656	Z5427	General inpatient care, per day
659	Z5428 Z5429 Z5430	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

18.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 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-92 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-92 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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19

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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a hospital is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for hospital-related claims.

NOTE:

All eight characters are required when filing a claim.

Hospitals are assigned a provider type of 05 (Hospital). Valid specialties for hospitals include the following:

- Post-extended care hospital (WC)
- General hospital (W6)
- Inpatient psychiatric hospital under 21 (W3)
- Inpatient psychiatric hospital over 65 (W2)
- Lithotripsy (L2)
- Mammography (M7)
- Organ transplants (W8)
- Swing bed hospitals (WD)

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 Request for Certification in the Medicare/Medicaid Program (HCFA-1514) or its successor.
- 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 HCFA, 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 EDS Provider Enrollment, P.O. Box 244035, Montgomery, AL 36124.

All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility.

Enrollment Policy for Lithotripsy

In order to participate in the Title XIX Medicaid Program as an ESWL provider, the following requirements must be met:

- Submit documentation that the lithotripsy machine is FDA approved
- Provide documentation to indicate the lithotripsy machine is being operated under the authority of a valid Certificate of Need (CON). Documentation can be a copy of the valid CON or a copy of the contract between the provider of care and the holder of the CON.

In order for Medicaid to reimburse the facility for ESWL treatment, the facility must have a signed contract with the Alabama Medicaid Agency.

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
19.2.2	Post-hospital Extended Care (PEC) Services	• General Information • PEC Provider Number • 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 Eligible 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 Lab and Radiology • Outpatient Chemotherapy and Radiation • Outpatient Physical Therapy • Prior Authorization for Outpatient Service • Payment of Outpatient Hospital Services
19.2.6	Electracorporeal Shock Wave Lithotripsy (ESWL)	Describes program benefits and limitations for lithotripsy-related services
19.2.7	Outpatient and Inpatient Tests	Describes program benefits and limitations for tests
19.2.8	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.)

Inpatient benefits for Medicaid recipients are limited to 16 days per calendar year. The number of days of care charged to a recipient 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.

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.

All hospitals should contact Quality Assurance (QA) personnel at (334) 242-5187 for authorization of these deliveries. 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

Newborns delivered in the hospital are covered by an eligible mother's claim for up to ten days of well-baby nursery care if the mother is in the hospital and is otherwise entitled to Medicaid coverage.

For routine hospital delivery of newborns, use revenue codes 170 (Nursery) and 171 (Nursery/Newborn). These revenue codes are reflected on the mother's claims in conjunction with her inpatient stay. The hospital per diem rate includes charges for the mother and newborn.

For recipients living in a maternity care district, no additional newborn nursery care may be billed during the time that has been covered by the global fee (2 days for vaginal and 4 days for C-section deliveries).

Infants delivered outside the hospital, those remaining after the mother is discharged, and those admitted to accommodations other than well-baby must be eligible for benefits in their own right, and a claim for services must be filed under the infant's number. Please note the following examples:

- If an infant is admitted to an intensive care or other specialty care nursery, the claim must be billed under the infant's recipient number even if the mother is still a patient.
- A claim for three days filed under the mother's name and recipient number receiving six nursery days, will be returned to the hospital with instructions to bill the last three days under the baby's name and recipient number, who must be eligible in his own right.

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.

Medicaid routinely monitors the coding of neonatal intensive care claims through post-payment review.

Unless the newborn infant needs medically necessary, specialized care as defined by Medicaid, no additional billings by the hospital for inpatient services are allowed while the mother is an inpatient.

To bill Medicaid utilizing revenue codes 172 (Nursery/Preemie), 175 (Nursery/ICU), and 179 (Nursery/Other), the infant must meet the criteria established by Medicaid. These services should be billed on a separate UB-92 claim form under the infant's name and recipient number. The claim must indicate the ICD-9-CM diagnosis codes identifying the conditions that required the higher level of care.

When the diagnosis code V30 appears on the claim, a secondary diagnosis denoting the infant's condition must be included. The secondary diagnosis indicated should identify the reason for the higher level of care.

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 Program Management Unit at (334) 242-5050 for contractor information.

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
- Pancreas

- Pancreas/Kidney

For Medicaid-eligible children under the age of 21, 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, food and lodging for caretaker/guardian of minor (if applicable), and home health.

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 EDS. 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 require prior authorization with the exception of children aged five and under.

Inpatient Noncovered 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 physician 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 Inpatient Care criteria as defined in the *Alabama Medicaid Agency Administrative Code,* Chapter 44.

Refer to Sections 19.5.2, Procedure Codes and Modifiers, for noncovered inpatient revenue codes.

Payment for Inpatient Hospital Services

Payment for all inpatient hospital services will be from approved per diem rates established by Medicaid or the Partnership Hospital Program (PHP). The PHP is the payer for all in-state hospital acute care days with the exception of recipients with Medicare Part A coverage, Maternity Care, and DYS-CHIP-eligible recipients.

19.2.2 Post-Hospital Extended Care (PEC) Services

General Information

Inpatient hospital services rendered at an inappropriate level of care (lower than acute) are considered post-hospital 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 Provider Number

In order to receive reimbursement for PEC, the hospital must enroll with EDS to receive a provider number. The provider number 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' provider number (the number uses the 'PECXXXXH' format).**

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 noninfected, 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 furnished 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 provider number 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 provider number (HOSXXXXH).
- Pharmaceutical items, to include over-the-counter products and prescription drugs should be billed separately under the hospital's pharmacy provider number (100XXXXXX).
- Some hospital pharmacies choose not to be enrolled as a Medicaid provider. A Medicaid pharmacy provider outside of the hospital may fill the prescriptions.

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 Eligible Medicaid Recipients

Providers may bill eligible recipients for noncovered services, for example, excessive days beyond benefit limitations, 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 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.

In the event that the Alabama Medicaid Agency's retrospective review determines that the admission did not meet the Inpatient Care criteria, Medicaid recipients may not be billed for inpatient stays that were initially approved by the hospital's utilization review committee.

Medicaid recipients may not be billed for inpatient care because the hospital failed to obtain the required admission and continued stay authorization.

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.

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 listed in Appendix I, Outpatient Hospital/ASC Procedures List, are covered on an outpatient basis. Surgeries listed on the surgical procedures list are reimbursable when provided on an inpatient basis if utilization review criteria are met.

NOTE:

Claims for outpatient surgical procedures that are discontinued prior to completion must be submitted with modifier 73 or 74 to be reimbursed.

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.

Surgical procedures that are routinely performed in a physician's office and are not listed on the surgical procedures list may be considered for prior approval to be performed in the outpatient setting if medically necessary and if Medicaid approves the procedure.

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.

Multiple surgical procedures on the claim that are not considered mutually exclusive or incidental are reimbursed at the lesser of actual charges or 100% of the fee on the pricing file for the initial procedure, plus the lesser of actual charges or 50% of the fee on the pricing file for subsequent procedures. The primary procedure should be listed first. Bilateral procedures should be billed with modifier 50. If you have questions concerning procedures not listed in Appendix I, contact the Institutional Services Unit at Medicaid at (334) 242-5587.

NOTE:

Procedures not listed in Appendix I could 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. Refer to Appendix H, Injectable Drug Listing.

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 Section D.1.3 of the Managed Care appendix 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 78 on the UB-92 claim form.

UB-92 claims for emergency department services must be coded according to the criteria established by Medicaid to be considered for payment. Refer to Section 19.5.3, Procedure Codes, and Modifiers, for level of care codes for emergency department services.

These procedure codes may be billed only for services rendered in a hospital emergency department and must be listed on the UB-92 claim form with revenue code 450. Claims for emergency department services containing these procedure codes and any revenue code other than 450 will be subject to denial or recoupment.

Non-certified visits to the emergency room are considered outpatient visits and count against the three outpatient hospital visits allowed per calendar year.

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. Medicaid may approve additional ultrasounds if a patient’s documented medical condition meets the established criteria. 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 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 limit 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 less than 24 hours.

Outpatient observation charges must be billed in conjunction with the appropriate facility fee (99281 - 99284).

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 - 99284) with units of one.
- Procedure code 99218 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:

  - A detailed or comprehensive history

  - A detailed or comprehensive examination

  - Medical decision-making that is straightforward or of low complexity

  The problem(s) requiring admission to “observation status” is usually of low severity.
- Procedure code 99219 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history

  - A comprehensive examination

  - Medical decision-making of moderate complexity

  The problem(s) requiring admission to “observation status” is usually of moderate severity.
- Procedure code 99220 should be used to bill the 4th through the 23rd hour for the evaluation and management of a patient in outpatient observation, which requires these three key components:

  - A comprehensive history

  - A comprehensive examination

  - Medical decision-making of high complexity

  The problem(s) requiring admission to “observation status” is of high severity.

Providers should bill the appropriate CPT code based on the severity of the patient’s condition. Providers may bill up to twenty (20) units of each procedure code. Units are equal to the number of hours. These codes must be billed with a facility fee (99281-99284). The facility fee is billed with units of one and covers the first three hours. The applicable CPT code would then be billed for the 4th up to the 23rd hour.

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 or critical care.

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

Outpatient Lab and Radiology

Outpatient visits made solely for lab and radiology procedures do not count against 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. See Section 19.5.3, Procedure Codes, and Modifiers, for procedure codes to be used for these services. 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.

Physical 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.

Physical therapy 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.

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(es)
- 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 physical 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.

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, Outpatient Hospital/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.

Payment of Outpatient Hospital Services

Payment for all outpatient hospital services will be from approved rates as established by Medicaid.

Publicly owned hospitals and hospitals that predominately treat children under the age of 18 years may be paid at an enhanced rate. These payments will not exceed combined payments for providing comparable services under comparable circumstances under Medicare.

19.2.6 Electracorporeal Shock Wave Lithotripsy (ESWL)

Electracoporeal 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.

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.

Anesthesiologist services are not included in the facility's or physician's reimbursement rate and can be billed separately.

19.2.7 Outpatient and Inpatient Tests

Medicaid pays for medically necessary laboratory tests, x-rays, or other types of tests provided in inpatient or outpatient hospital facilities that have been ordered by the attending physician or other staff physician.

19.2.8 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 but are not subject to the outpatient limitation of three visits a calendar year.

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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

In the case of out-of-state referrals, prior authorization is required for select surgical procedures.

Medicaid issues a 10-digit prior authorization number for those stays. This number must appear in form locator 91 on the hospital claim form.

19.4 Cost Sharing (Copayment)

The copayment amount for an inpatient admission (including crossovers) is $50.00 per admission.

The copayment amount for an outpatient hospital visit is $3.00 per visit or $3.00 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.

The copayment amount for an ESWL visit is $3.00 per visit.

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).

NOTE:

Medicaid's copayment is not a third party resource. Do not record copayment on the UB-92.

19.5 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.

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:

When filing a claim on paper, a UB-92 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.

All inpatient and outpatient claims must contain a valid physician's license number in field 82 of the UB-92 claim form.

Certified Emergency Outpatient Visits

If the Emergency Room visit is for a true emergency as defined in Section 19.2.5, Outpatient Hospital Services, 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 visits do not count against the yearly outpatient visits. An “E” in field 78 indicates that the visit has been properly certified. Certified emergency claims are also exempt from requiring the Patient 1st referral.

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-92 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 October 1 of any year should be split billed due to PHP year-end.

Claims that span a Medicaid per diem rate change must be split billed in order for the hospital to receive the correct reimbursement.

19.5.1 Time Limit for Filing Claims

All in-state inpatient hospital claims follow Partnership Hospital Program (PHP) payment guidelines. PHP requires all claims to be filed within 120 days from the end of the fiscal year. The fiscal year begins October 1 and ends September 30. The filing deadline is the last day of February of the following year.

Listed below are examples of filing deadlines:

- Any inpatient claims with dates of service from 10/1/97 through 9/30/98 that are filed after 2/28/99 will be denied by EDS as exceeding the PHP filing limit. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims for retroactive coverage with dates of service from 10/1/97 through 9/30/98 that are filed after 2/28/99 will be denied by EDS. Hospitals must seek payment, if any, from PHPs. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service from 10/1/97 through 9/30/98 that are filed after 2/28/99 with third party liability action (either paid or denied) will be denied by EDS. The usual third party filing limits will not apply. Recipients may not be billed if a claim is denied for this reason.
- Any inpatient claims with dates of service prior to 10/1/97 are considered outdated. Recipients may not be billed.

Medicaid requires all claims for out-of-state inpatient and outpatient services and psychiatric hospitals 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.

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 Alabama UB-92 Billing Manual published by the Alabama Hospital Association for a complete listing of valid revenue codes and procedure codes.

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z’.

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:

- Noncovered inpatient revenue codes
- Emergency department
- Pharmacy
- Laboratory services
- Radiation therapy
- Respiratory services
- Occupational therapy
- Speech therapy
- Miscellaneous procedures
- Noncovered outpatient revenue codes
- Outpatient observation
- Esophagus
- Radiology
- Blood
- Physical therapy
- Orthotics
- ESWL

Noncovered Inpatient Revenue Codes

The following revenue codes are noncovered on a UB-92 claim form for inpatient services. If covered charges for any of the following revenue codes are indicated on the UB-92 claim form, the claim will be denied.

10X	253	374	54X	610	911
14X	254	38X	55X	65X	917
18X	256	403	56X	82X	96X
22X	273	49X	57X	83X	97X
23X	277	52X	58X	84X	98X
24X	29X	53X	59X	85X	99X

Noncovered Outpatient Revenue Codes

For outpatient claims, the following revenue codes are noncovered services. If covered charges for any of the following revenue codes are indicated on the UB-92 claim form, the line item(s) with the noncovered revenue code will denied.

10X	19X	273	510	610	90X
11X	20X	274	52X	65X	91X
12X	21X	277	53X	710	94X
13X	22X	29X	54X	80X	96X
14X	23X	374	55X	81X	97X
15X	24X	38X	56X	84X	98X
16X	253	43X	57X	85X	99X
17X	254	44X	58X	88X	
18X	256	47X	59X	89X	

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.

Effective for dates of service beginning January 1, 2000, hospital providers should use the following procedure codes when billing for emergency department services:

New Code	***Revenue Code***	***Old Code***	***Description***
99281	450	Z5299	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	450	Z5299	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	450	Z5299	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	450	Z5300	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	450	Z5301	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-92 claim form with revenue code 450. Claims for emergency room services containing these procedure codes and any revenue code other than 450 will be denied.

When billing for Medicaid/Medicare crossover claims, the CPT codes will be accepted for any dates of service.

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, 99282, and 99283 (brief), and 99284 (limited).

Outpatient observation is limited to 23 hours. It can only be billed in conjunction with procedure codes 99281, 99282, 99283, and 99284, not with 99285. It also cannot 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. (Each hour is one unit.)

Revenue Code	***Procedure Code***	***Description***
760	99218	Each hour, 4th hour through 23rd hour (maximum units 20), low severity
760	99219	Each hour, 4th hour through 23rd hour (maximum units 20), moderate severity
760	99220	Each hour, 4th hour through 23rd hour (maximum units 20), high severity

Pharmacy

Revenue code 250 applies to Pharmacy - Injectable Drugs (includes immunization).

See Appendix H, Alabama Medicaid Injectable Drug List, of this manual.

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-92 Billing Instructions, for information on span billing.

Radiology

Use revenue codes 320-331 with valid CPT codes for radiology.

Radiation Therapy

Use revenue code 333 with procedure codes 77261-77790 for radiation therapy.

Blood

Administration and processing per unit of blood and/or blood components. Lab charges will be billed according to procedure.

Revenue Code	***Procedure Code***	***Description***
390	36430	Blood

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

Annual limit for physical therapy means per calendar year.

Revenue Code	Procedure Code	Physical Therapy	See Note	Max Units	Annual Limit
421	97010	Application of a modality to one or more areas; hot or cold pack	1	1	12
42X	95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	1	1	12
	95832	Hand, with or without comparison to other side		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	Physical therapy evaluation		1	
	97002	Physical therapy re-evaluation		1	
	97010	Application of a modality to one or more areas; hot or cold packs*		1	
	97012	Traction, mechanical*		1	
42X	97014	Electrical stimulation, unattended*	3	4	
	97016	Vasopnuematic device*	2	1	
	97018	Paraffin bath*	2	1	
	97022	Whirlpool	2	1	24
	97024	Diathermy*		1	
	97026	Infrared*		1	
	97028	Ultraviolet		1	
	97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	2	4	96
	97034	Contrast baths, each 15 minutes		4	96

Revenue Code	Procedure Code	Physical Therapy	See Note	Max Units	Annual Limit
	97035	Ultrasound, each 15 minutes	2	4	96
	97036	Hubbard tank, each 15 minutes	2	4	96
	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility	2	4	96
	97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	2	1	24
	97113	Aquatic therapy with therapeutic exercises*	2	1	
	97116	Gait training (includes stair climbing)		1	18
	97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)		1 w/PA	8
	97140	Manual therapy techniques (e.g., mobilization, manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	4
	97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
	97504	Orthotics fitting & training, upper and/or lower extremities, each 15 minutes		4	16
	97520	Prosthetic training, upper and/or lower extremities, each 15 minutes		4	16
42X	97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	2	4	96
	97535	Self care/home management training (for example, 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 minutes	4	4	36
	97542	Wheelchair management/propulsion training, each 15 minutes		4	24
	97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes		4	12
	97750	Physical performance test or measurement, (for example, muscoloskeletal, functional capacity) with written report, each 15 minutes		4	12

* With therapeutic procedure codes only (97110 through 97546)

NOTE:

1. Restricted to one procedure per date of service (cannot bill two together for the same date of service).
2. If additional services are needed, the provider of service must use modifier 22. Medicaid monitors use of this modifier. Documentation in medical record must support use of modifier 22 by reflecting continued improvement of condition for which physical therapy is ordered.
3. 97014 cannot be billed on same date of service as procedure code 20974 or 20975.
4. Requires PA.

Occupational Therapy

The revenue code for occupational therapy is 43X.

NOTE:

Occupational Therapy is covered only when service is rendered to a recipient as a result of an EPSDT screening or to a QMB recipient.

Hospitals may bill the following CPT codes for EPSDT referral OT services:

97003	97022	97118	97128	97500	97530	97700
97004	97110	97120	97145	97501	97531	97720
97010	97112	97124	97240	97520	97540	97721
97018	97114	97126	97241	97521	97541	97752

Orthotics

Orthotics provided by Hospitals are limited to procedure codes within the following ranges:

L3650 to L3995	L4200 to L4210

Speech Therapy

Revenue Code	*Procedure Codes*	*Description*
44X	92506-92508	Speech Therapy
44X	92597	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.

ESWL

Revenue Code	*Procedure Code*	*Description*
790	50590	Lithotripsy, electracorporeal shock wave

Miscellaneous Procedures

Revenue Code	*Procedure Codes*	*Description*
320	93307	Echocardiography, real-time with image documentation (2D); with or without M-mode recording; complete
320	93308	Echocardiography, real-time with image documentation (2D); with or without M-mode recording; follow-up; limited study
320	93320	Doppler echocardiography
329	51736	Simple Uroflometry
329	51741	Complex Uroflometry
331	96400	Chemotherapy
331	96408	Chemotherapy Administration (may be span billed for one calendar month)
331	96410	Infusion technique
331	96412	Infusion technique
331	96414	Infusion technique
331	96450	Chemotherapy administration

Revenue Code	***Procedure Codes***	***Description***
331	96520	Refilling and maintenance of portable pump
331	96530	Refilling and maintenance of implantable pump or reservoir
331	99195	Phlebotomy, therapeutic
481	93875 through 93979	Non-invasive studies of the cerebral arteries duplex scans of the extracranial arteries doppler studies of the intracranial arteries
481	95869	Electromyography limited study of muscles
481	95935	"H" or "F" reflex study by electrodiagnostic testing
611	70551	Magnetic resonance imaging, brain (including brain stem); without contrast material
611	70552	Magnetic resonance imaging, brain (including brain stem) with contrast material cervical
611	70553	Magnetic resonance imaging, brain, with and without contrast
612	72141	Magnetic resonance imaging, spinal canal and contents; without contrast material
612	72142	Magnetic resonance imaging, spinal canal and contents, cervical with contrast material(s)
612	72146	Magnetic resonance imaging, spinal canal and contents; thoracic; without contrast material
612	72147	With contrast material(s)
612	72148	Magnetic resonance imaging, spinal canal and contents; lumbar; without contrast material
612	72149	With contrast material(s)
612	72156	Magnetic resonance imaging, spinal canal and contents, cervical with and without contrast
612	72157	Magnetic resonance imaging, thoracic, with and without contrast
612	72158	Magnetic resonance imaging, lumbar, with and without contrast
619	73221	Magnetic resonance imaging, any joint, upper extremity
619	73721	Magnetic resonance imaging, any joint, lower extremity
700	29065	Shoulder to hand (long arm cast)
700	29125	Application of short arm splint (forearm to hand), static
700	29365	Application of cylinder cast (thigh to ankle)
700	29405	Application of short leg cast (below knee to toes)
729	59025	Fetal non-stress test
730	93041	Rhythm Electrocardiogram, tracing
730	93005	EKG (Code 93000 has been deleted)
730	93012	Telephonic or telemetric transmission of EKG rhythm strip
730	93017	Cardiovascular Stress test
731	93225	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning
731	93231	Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, without superimposition scanning utilizing a device capable of a full miniaturized printout recording
740	95805	Multiple sleep latency test
740	95816	EEG; same facility
740	95819	EEG – Electroencephalogram
741	92585	Evoked response (EEG) audiometry
750	91030	Esophagus acid perfusion (Bernstein) test for esophagitis

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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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-92 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:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 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-92 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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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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an independent laboratory is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for laboratory-related claims.

NOTE:

All nine digits are required when filing a claim.

Independent laboratory providers are assigned a provider type of 09 (Independent Laboratory). The valid specialties for Independent Lab providers include the following:

- Independent Lab (69)
- Department of Public Health Lab (L3)

NOTE:

Independent Laboratories assigned specialty L3 should refer to Chapter 9, County Health Department, in the *Alabama Medicaid Provider Manual* for State Agencies.

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 HCFA 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 are 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.

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) 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.hcfa.gov/medicaid/clia/waivetbl.htm.

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

The following sections describe the only tests Independent labs may perform:

Waiver Certificate – Level 2 Certification

Holders of a Waiver certificate are authorized to perform only the following tests:

Procedure Code	***Description***
80061	Lipid Panel, including the following components: • Cholesterol, serum, total (82465) • Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) • Triglycerides (84478)
80101	Drug, screen; single drug class, each drug class
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
81007	Urinalysis; qualitative or semiqualitative, bacteriuria screen, commercial kit (specify type)
81025	Urine pregnancy test, by visual color comparison methods
82009	Acetone or other ketone bodies, serum; qualitative
82044	Albumin; urine, microalbumin, semiqualitative (eg, reagent strip assay)
82055	Alcohol (ethanol); any specimen except breath
82120	Qualitative test of a vaginal fluid sample for elevated pH (pH greater than or equal to 4.7) and the presence of volatile amines
82270	Blood, occult; feces, 1-3 simultaneous determinations
82273	Blood, occult; other sources, qualitative
82465	Cholesterol, serum, total
82947	Glucose, quantitative
82950	Glucose, post glucose dose (includes glucose)
82951	Glucose tolerance test (GTT), three specimens (includes glucose)
82952	Glucose tolerance test, each additional beyond three specimens
82962	Glucose, blood by glucose monitoring device(s) cleared by FDA specifically for home use
82985	Glycated protein

Procedure Code	*Description*
83026	Hemoglobin, by copper sulfate method, non-automated
83036	Hemoglobin, by copper sulfate method, non-automated, glycated
83518	Immunoassay or analyte other than infectious agent antibody or infectious agent antigen, qualitative or semi-qualitative; single step agent (eg, reagent strip)
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83986	pH, body fluid, except blood
84478	Triglycerides
84703	Gonadotropin, chorionic (hCG); qualitative
84830	Ovulation tesats, by visual color comparison methods for human luteinizing hormone
85013	Blood count; spun microhematocrit
85014	Blood count; other than spun hematocrit
85018	Blood count; hemoglobin
85610	Prothrombin time
85651	Sedimentation rate, erythrocyte; non-automated
86308	Heterophile antibodies; screening
86318	Immunoassay for infectious agent antibody, qualitative or semiquantitative, single step method (eg, reagent strip)
87072	Culture or direct bacterial identification method, each organism, by commercial kit, any source except urine
87880	Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A

Provider Performed Microscopy Procedure (PPMP) Certificates – Level 4 Certification

Holders of PPMP certificates are authorized to perform **ALL** the procedures under the Waiver Certificate – Level 2 Certification **AND** the following tests:

Procedure Code	*Description*
81000	Urinalysis, by dipstick or tablet reagent for billirubin, glucose, hemoblobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobillinogen, any number of these constituents; nonautomated without microscopy
81001	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy (NOTE: May only be used when the lab is using an automated dipstick urinalysis instrument approved as waived.)
81015	Urinalysis; microscopic only
81020	Urinalysis; two or three glass test
89190	Nasal smears for eosinophils
G0026	Fecal leukocyte examination
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner
Q0111	Wet mount, including preparations of vaginal, cervical, or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examination
Q0114	FERN test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous

20.3 Prior Authorization and Referral Requirements

Laboratory 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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

20.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided for laboratory services.

20.5 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.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

20.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z’.

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 following sections describe procedure codes that apply when filing claims for independent lab services.

Blood Specimens

If an Independent Lab performs lab work at the same site where the specimen was drawn or in a lab owned, operated, and financially associated with the site it was drawn, the Independent Lab provider cannot bill a collection fee.

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 are 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.

Hematology - Claims for the same recipient from the same provider for the same date of service that contain two or more of the following services (85021, 85022, 85023, 85024, 85025, 85027) will be considered an unbundled service and will be denied.

- Procedure codes 85022 and 85023 billed on the same date of service as 85077 (platelet count manual differential) will be denied
- Procedure codes 85023, 85024, 85025, and 85027 billed on the same date of service as 85590 (manual count) and 85595 (automated count) will be denied
- Procedure codes 85021 through 85027 billed on the same date of service as 85041 (red blood cell only), 85048 (white blood cell only), 85018 (hemoglobin only), or 85014 (other than spun hematocrit) will be denied

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, 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	***Description***	***Note***
26	Professional Component	Labs providing professional component services include modifier 26 with the procedure code on the claim
77	Repeat Procedure by another physician	To indicate that a basic procedure performed by another physician had to be repeated
GB	Distinct Procedure Service	To indicate that a procedure or crossover only service was distinct or separate from other services performed on the same day. This service may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury in extensive injuries). GB does not replace any existing modifiers. GB should not be confused with modifiers for repeat procedures. GB should be used to indicate a separate distinct service.
TC	Technical Component	
Y2	First repeat procedure, same date, same provider	
Y3	Second repeat procedure, same date, same provider	
Y4	Third repeat procedure, same date, same provider	
Y5	Fourth repeat procedure, same date, same provider	
Y6	Fifth repeat procedure, same date, same provider	
Y7	Sixth repeat procedure, same date, same provider	
Y8	Seventh repeat procedure, same date, same provider	
Y9	Eighth repeat procedure, same date, same provider	
Z2	Ninth repeat procedure, same date, same provider	
Z3	Tenth repeat procedure, same date, same provider	

NOTE:

Claims submitted for a repeat of the same procedure on the same date of service without modifiers will be denied as duplicate services.

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 HCFA-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
HCFA-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
Medicaid Acronym Dictionary	Appendix O

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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, or neonatal nurse 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Independent CRNP is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for CRNP-related claims.

NOTE:

All nine digits are required when filing a claim.

Independent CRNPs are assigned a provider type of 58 (Independent Nurse Practitioner). Valid specialties for Independent CRNPs include the following:

- EPSDT Screening (E3)
- Family Practice (08)
- Neonatology (NI)
- Nurse Practitioner (N3)
- Pediatrics (37)

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 below, 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 can not make physician required visits to hospitals or other institutional settings. Also, the CRNP cannot provide services in the emergency department or assist at surgery for Medicaid reimbursement.

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 Section D.1.3 of the Managed Care appendix 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 for Services form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program.

21.4 Cost Sharing (Copayment)

The copayment amount is $1.00 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.

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.

21.5 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.

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.

NOTE:

When filing a claim on paper, a HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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 found in Appendix H, Alabama Medicaid Injectable Drug Listing, and all laboratory services, which are CLIA certified.

Refer to Appendix A, EPSDT, for procedure codes for Vaccines for Children (VFC).

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:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-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

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

EDS 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*.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Independent Radiology provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for radiology-related claims.

NOTE:

All nine digits are required when filing a claim.

Independent Radiology providers are assigned a provider type of 10 (Independent Radiology). Valid specialties for Independent Radiology providers include the following:

- Mammography (M7)
- Nuclear Medicine (36)
- Physiological Lab (Independent Diagnostic Testing Facility) (66)
- Portable X-Ray Equipment (63)
- Radiology (30)

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 that are 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; 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 76090 and 76091.

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 code 76092.

22.3 Prior Authorization and Referral Requirements

Radiology 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.

Services performed by an independent radiologist for those recipients enrolled in the Patient 1st Program **do not require a referral** from the Primary Medical Provider (PMP).

Procedure codes performed as a result of an EPSDT screening require an EPSDT screening referral form in the patient's medical record. Refer to Appendix A, EPSDT, for more information on obtaining a referral through the EPSDT Program.

22.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Independent Radiology providers.

22.5 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.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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.

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.

22.5.4 Place of Service Codes

The following place of service code applies when filing claims for radiology services:

POS Code	*Description*
99	Other Unlisted Facility

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 HCFA-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
HCFA-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

23

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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Licensed Social Worker is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for social work-related claims.

NOTE:

All nine digits are required when filing a claim.

Licensed Social Workers are assigned a provider type of 41 (Crossovers Only). The valid specialty for Licensed Social Workers is Medicare/Medicaid Crossover Only (M4).

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
- Submit a copy of current certification as a licensed social worker from the Board of Social Work Examiners

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

➢ 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.

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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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.

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:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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 pregnant woman has access to medical care, with the goal of lowering Alabama's high infant mortality rate and improving maternal and infant health overall.

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 *Maternity Care Operational Manual* published by the Alabama Medicaid Agency and in the *Alabama Medicaid Agency Administrative Code,* Chapter 45.

24.1 Enrollment

The Alabama Medicaid Agency selects Primary Contractors for the Maternity Care Program through a competitive bid process. Contractors must meet the licensure certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Provider Number, Type, and Specialty

Primary Contractors are enrolled by Medicaid's Managed Care Division as maternity care providers and issued a nine-digit Alabama Medicaid provider number that enables them to submit requests and receive reimbursements for maternity care services.

NOTE:

All nine digits are required when filing a claim.

Maternity care providers are assigned a provider type of Maternity Care (87). The valid specialty for maternity care providers is Maternity Care Program (M6).

Districts

Medicaid has established 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. Claire, 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

Contact information for primary care contractors for each district displays below:

District	***Primary Contractor***	***Phone Number For Recipients***	***Phone Number For Providers***	***1-800 Phone Number***	***Start Date***
District 1	HealthGroup of Alabama	(256) 517-6604	(256) 517-6604 Laura Thompson	1-888-500-7343	10/1/99
District 2	HealthGroup of Alabama	(256) 517-6604	(256) 517-6604 Laura Thompson	1-888-500-7343	8/1/99
District 3	Quality of Life	(256) 492- 0131	(256) 492-0131 Amelia Wofford	1-888-490-0131	8/1/99
District 4	Alabama Health Network	(205) 348- 1247	(205) 348-0749 Becky Henderson	1-800-736-6231	8/1/99
District 5	Alabama Maternity, Inc.	(205) 930-1427	(205) 930-1364 Connie Arnwine	1-877-997-8377	8/1/99
District 6	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Rhonda Boswell	1-877-826-2229	7/1/99
District 7	Alabama Health Network	(205) 348-1247	(205) 348-0749 Becky Henderson	1-800-736-6231	8/1/99
District 8	Bryan Whitfield Memorial Hospital	(334) 287-2675	(334) 287-2675 Marcia Lankster	1-888-531-6262	10/1/99
District 9	Neighborhood Health Services	(205) 345-2510	(205) 345-2510 Charlotte Jamison	1-800-820-7630	6/1/99
District 10	Gift of Life Foundation	(334) 272-1820	(334) 272-1820 Martha Jinright	1-877-826-2229	7/1/99
District 11	Maternity Services of District 11	(334) 291-0180	(334)291-0180 Sharon Lee	1-877-503-2259	10/1/99
District 12	Southwest Alabama Maternity Care Program	(334) 743-7498	(334) 743-7498 Jeanette Gibson	1-877-826-2229	8/1/99
District 13	Southeast Alabama Maternity Care Program	(334) 712-3784	(334) 712-3784 Gary Bennett	1-800-735-4998	10/1/99

NOTE:

Maternity care services provided to recipients who reside in Mobile county will be reimbursed on a fee-for-service basis.

24.2 Benefits and Limitations

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

24.2.1 Eligibility

The following recipients are required to participate in the Maternity Care Program:

- Those certified through the SOBRA Program
- Those certified through the Medicaid for Low Income Families (MLIF) Program (formerly AFDC)
- Refugees
- SSI eligible women 19 and over

The following recipients are not required to participate:

- Dual recipients (Medicare/Medicaid)
- Indians who are members of a federally recognized tribe
- Children under the age of 19 who meet any of the following criteria:
  - Persons eligible for SSI under Title XIX
  - Persons in foster care or other out of home placement, such as Department of Youth Services (DYS)
  - Persons receiving foster care or adoption assistance
  - Persons receiving services through a family centered, community based, coordinated system of care receiving grant funds (Special Needs)
- Recipients residing in Mobile county
- Women enrolled in a private HMO
- Those persons described in Section 1902(e)(3) of the Act

Medicaid recipients who are not required to participate may participate on a voluntary basis with the exception of Mobile county residents. If the recipient elects to participate in the program, Medicaid pays for services through the Maternity Care Program.

24.2.2 Covered Services

The Primary Contractor is responsible for all pregnancy-related care including high risk care 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. This section contains information about the following services covered under the global fee:

- Antepartum care
- Outpatient care (except emergencies)
- Delivery
- Hospitalization
- 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, hospitalization, routine newborn care, and professional services, such as anesthesiology. Any non-routine newborn care must be billed under the baby's Medicaid number.

Hospitalization

Hospitalization includes delivery as well as any pregnancy-related hospitalizations, as defined in the *Maternity Care Operational Manual*, that occur in the antepartum period or postpartum period. Hospitalization includes all charges that are normally submitted on the uniform billing claim form (UB-92), 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

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.

Outpatient

Outpatient includes any pregnancy-related outpatient visits to the emergency room or labor and delivery suite for pregnancy-related care (for example, non-stress tests and false labor). Certified emergencies are covered on a fee-for-service basis.

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. Refer to the *Maternity Care Operational Manual* for specifics on care coordination services requirements.

Assistant Surgeon Fees

The global rate includes assistant surgeon fees for caesarian (c-section) deliveries.

Associated Services

The global fee includes all services associated with treatment of the pregnancy during the antepartum and postpartum period including, but not limited to colposcopy, EKGs, cerclages, and medical services performed in an outpatient setting (except lab and radiology procedures other than ultrasounds).

Anesthesia Services

Anesthesia services include anesthesia services performed by an anesthesiologist or the delivering physician that are not medically contraindicated.

Home Visits

Home visits include home visits that are to be performed in accordance with the priority criteria provided in the *Maternity Care Operational Manual*.

Ultrasounds

Ultrasounds include medically necessary ultrasounds. The Primary Contractor is responsible for up to seven ultrasounds with the option of establishing a system for authorization of ultrasound services. Medicaid may authorize the eighth and later ultrasounds to be paid on a fee-for-service basis after reviewing the patient's clinical condition.

24.2.3 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. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron).
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.
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), genetic counseling, circumcision, routine newborn care, standby, and infant resuscitation may be billed on a fee-for-service basis. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number.
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.
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.
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	Mental health visits for the purpose of outpatient mental health services may be billed on a fee-for-service basis.
Miscarriages less than 21 weeks	All services may be 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 is not considered a specialty provider.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service.
Outlier Policy	The outlier policy is in effect when a Maternity Care Program recipient has an extended stay (or stays) and delivers at a Level III facility (USA, UAB or Huntsville Hospital, or the Medical Center in Columbus, Georgia). Extended stay is defined in excess of seven days but does not have to be consecutive. Days eight and greater (up to the 16 day limit) will be reimbursed directly to the hospital provider.

Separately Billable Service	*Description*
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service.
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

Primary Contractors generally do not require prior authorization for billing covered services to EDS.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

24.4 Cost Sharing (Copayment)

Copayment does not apply to services provided for pregnant women.

24.5 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.

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 HCFA-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 EDS 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

24.5.3 Procedure Codes and Modifiers

Claims for maternity care services are limited to the following seven procedure codes and modifiers:

Code	*Modifier*	*Description*
59400	ZE	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy or forceps) and postpartum care. Patient must have entered care prior to 28 weeks and received a minimum of six (6) prenatal visits and other global components.
59410	ZE	Vaginal delivery and postpartum care only.
59510	ZE	Routine obstetric care including antepartum care, cesarean delivery and postpartum care. Patient must have entered care prior to 28 weeks and received a minimum of six (6) prenatal visits and other global components.
59515	ZE	Cesarean delivery and postpartum care only
Z5225		Primary Contractor Administration Fee. (see note)
Z5226		Care Coordinator Fee Only. (see note)
Z5382		Maternity Care Drop-Out Fee. This fee is payable only to the Primary Contractor and is for care coordination and administration costs. Medical services are to be billed by the actual provider of service following Medicaid program policies. Patient must have received a minimum of two (2) prenatal visits and the initial care coordinator encounter.

The recipient must have entered care prior to 28 weeks and received a minimum of six prenatal visits as well as other global components. If the recipient does not begin care prior to 28 weeks then the Primary Contractor should bill the delivery only fee.

If an eligible woman fails to receive the required number of prenatal visits, the Primary Contractor’s file must contain sufficient documentation to explain why the minimum number of services could not be met. Examples of reasons why women might not be able to receive the minimum required prenatal visits include women who move between districts late in their pregnancy, or women who present late (in their last month) and deliver early. Only with sufficient documentation will the global fee be paid in such cases.

NOTE:

The Administration Fee and Care Coordinator Fee are to be billed only when a recipient has been granted an exemption for third party liability (TPL) and can only be billed by the Primary Contractor.

24.5.4 Associated Codes

The following services are considered associated codes and are included in the global fee:

Procedure Code	*Description*
Z5185	Prenatal Clinic Visit
Z5195	Postpartum Clinic Visit
Z5297	Intermediate service RHC
Z5298	FQHC encounter
Z5369	FQHC Imaging Services (ultrasounds, etc.)
Z5371	Inpatient hospital encounter, per day, to include all services
00940	Anesthesia for vaginal procedures (including biopsy of labia)
00942	Anesthesia for vaginal procedures (including biopsy of labia)
00946	Anesthesia for vaginal procedures (including biopsy of labia)
00948	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix)
00950	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix)
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina)
00955	Continuous epidural analgesia for labor and vaginal delivery
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
49020	Drainage of peritoneal abscess or localized peritonitis
49060	Drainage of retroperitoneal abscess; open
56300	Laparoscopy (peritoneoscopy), diagnostic; (separate procedure)
56304	Laparoscopy surgical; with lysis of adhesions
56306	Laparoscopy, surgical
56405	Incision and drainage of vulva or perineal abscess
57000	Colpotomy; with exploration
57010	Colpotomy
57020	Colpocentesis (separate procedure)
57150	Irrigation of vagina and/or application of medicament
57410	Pelvic examination under anesthesia
59000	Amniocentesis, any method
59012	Cordocentesis (intrauterine), any method
59020	Fetal contraction stress test
59025	Fetal non-stress test
59030	Fetal scalp blood sampling
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
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
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
76805	Echography
76810	Echography
76815	Echography
76816	Echography
76818	Fetal biophysical profile
76825	Echocardiography, fetal
76826	Echocardiography, fetal
76827	Doppler echocardiography, fetal
76828	Doppler echocardiography, fetal
81000	Chemical/routine urinalysis
81002	Chemical/routine urinalysis
81003	Chemical/routine urinalysis
85014	Hematocrit
85018	Hemoglobin
99025	Initial (new patient) visit
99050	Services requested after office hours in addition to basic
99052	Services requested between 10:00 PM and 8:00 AM
99054	Services requested on Sundays and holidays in addition
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
99221	Initial hospital care, per day, for E&M
99222	Initial hospital care, per day, for E&M
99223	Initial hospital care, per day, for E&M
99231	Subsequent hospital care, per day, for E&M
99232	Subsequent hospital care, per day, for E&M
99233	Subsequent hospital care, per day, for E&M
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes

Procedure Code	*Description*
99241	Office consultation for a new or established patient
99242	Office consultation for a new or established patient
99243	Office consultation for a new or established patient
99244	Office consultation for a new or established patient
99245	Office consultation for a new or established patient
99252	Initial inpatient consultation for a new or established patient
99253	Initial inpatient consultation for a new or established patient
99254	Initial inpatient consultation for a new or established patient
99255	Initial inpatient consultation for a new or established patient
99261	Follow-up inpatient consultation for an established patient
99262	Follow-up inpatient consultation for an established patient
99271	Confirmatory consultation for a new or established patient
99272	Confirmatory consultation for a new or established patient
99273	Confirmatory consultation for a new or established patient
99274	Confirmatory consultation for a patient
99275	Confirmatory consultation for a patient
99354	Prolonged physician service in the office or other outpatient setting
99355	Prolonged physician service in the office or other outpatient setting
99356	Prolonged physician service in the inpatient setting
99357	Prolonged physician service in the inpatient setting
99374	Home Health Agency Care Supervisor
99375	Physician supervision of a patient under care of home health agency
99376	Physician supervision of patients under care of home health agencies
99385	Preventive Medicine Services
99386	Preventive Medicine Services
99394	Preventive Medicine Services
99395	Periodic reevaluation and management of a healthy individual
99401	Preventive medicine counseling and/or risk factor reduction
99402	Counseling and/or risk factor reduction interventions provided
99403	Preventive Medicine Services
99404	Preventive Medicine Services

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:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
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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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a nurse midwife is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for claims related to nurse midwifery.

NOTE:

All nine digits are required when filing a claim.

Nurse Midwives are assigned a provider type of 99 (Other). The valid specialty for nurse midwives is Nurse Midwife (N2).

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 College of Nurse-Midwife certificate
- Copy of the current enrollment in the American College of Nurse Midwives Continuing Competency Assessment Program
- 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.

To prevent double payment, a nurse midwife who has a Medicaid provider number should inform Medicaid of the name of the hospital(s) with whom employed, regardless of regularity and frequency.

A nurse midwife who is not employed with and paid by a hospital may bill Medicaid using a HCFA-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 preformed 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 Section D.1.3 of the Managed Care appendix 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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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 may submit claims and receive reimbursements for Family Planning services, excluding sterilization procedures. See Appendix C, Family Planning, for these procedure codes.

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

GYN Services

Nurse midwives may bill office procedure 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
99	Other unlisted facility

25.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
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26 Nursing Facility

Medicaid reimburses medically necessary nursing facility services other than services provided in an institution for tuberculosis. 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, nor 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a nursing facility is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for nursing facility-related claims.

NOTE:

All eight characters are required when filing a claim.

Nursing facility providers are assigned a provider type of 11 (Nursing Facility). The valid specialty for nursing facility providers is Nursing Facility (S5).

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/Patient Agreement with Medicaid

The Provider Agreement presents in detail the requirements imposed on each party to the agreement. It is also the document that requires the execution of the Nursing Facility/Patient Agreement.

The Nursing Facility/Patient Agreement must be executed promptly for each patient on admission. One copy of the agreement is given to the patient/sponsor and a copy is retained by the nursing facility. The completed Nursing Facility/Patient Agreement becomes an audit item by Medicaid.

EDS 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.

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 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 (see below)
- 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
- Bed and bath linens, including linen savers
- Nursing and treatment supplies as ordered by the resident's physician or 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.
- Personal apparel laundry services

NOTE:

Personal services include assistance with eating, dressing, toilet functions, bathing, brushing teeth, combing hair, and shaving; hair and nail hygiene services; basic personal laundry; and incontinence care.

Personal supplies include items necessary to permit the resident to maintain a clean, well-kept personal appearance, including 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, and over-the-counter drugs.

Non-covered Services

The following special services are not ordinarily included in basic nursing facility charges:

- Prosthetic devices, splints, crutches, and traction apparatus for individual residents
- Personal services, when requested by the resident/sponsor, when provided by the facility, and when charges are itemized for the sponsor by services rendered (dry cleaning of personal apparel; beauty and barber services provided by professional barbers and beauticians; radio, television, and telephone services)

- Services of licensed professional physical therapist, speech therapist, or occupational therapist
- Dental services and supplies
- Special duty nurse and/or sitter
- Additional charge for private room
- Special inhalation equipment such as positive pressure treatment and oxygen

NOTE:

These services, drugs, or supplies may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between resident, sponsor, and the nursing facility.

Other services are provided by Medicaid 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 patients, nor their families, nor their sponsor, may be charged for reservation of a bed for the first four days of any period during which a Medicaid patient is temporarily absent due to admission to a hospital. Prior to discharge of the patient to the hospital, the patient, the family of the patient, or the sponsor of the patient 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 patient beyond the covered four-day hospital reservation period. The covered four-day hospital stay reservation policy does not apply to:

- Medicaid-eligible patients 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 patients;
- A patient who has applied for Medicaid but has not yet been approved; provided that if such a patient 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 patient, family of the patient, or sponsor of the patient for the period that would have been within the four covered days policy; or
- Medicaid patients who have received a notice of discharge for non-payment of service.

Therapeutic Visits

Payments to nursing facilities will only be made for therapeutic visits not to exceed three days per visit and eight such visits per patient during any calendar year; limited to two visits per calendar quarter to home, relatives and friends.

The nursing facility must ensure that each therapeutically indicated visit by a patient 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, not to exceed 14 consecutive days at any time.

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 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. Patients 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. No payment will be made by Medicaid 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 should contact the Medicare fiscal intermediary.

Application of Medicare Coverage

Patients 65 years or older 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 while a patient is receiving Medicare 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 a determination of medical eligibility for retroactive Medicaid coverage, the nursing facility should furnish Medicaid with Form MED-54, attaching all physician's orders, physician's progress notes, and nurse's notes for the period of time in question.

Resident Records

Medicaid monitors the admission and discharge system and maintains a record for each active patient in the nursing facility.

An inactive file is kept for three years on each resident who has been discharged or has died.

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

All individuals seeking admission into a nursing facility must be evaluated to determine if there is an indication of mental illness, mental retardation, or a related condition and whether the individual's care and treatment needs would most appropriately be met in the nursing facility or in another setting.

An accurate Level I screening document (LTC-14) must be completed for each person applying for admission to a nursing facility. This document is completed by the referral source, such as the attending physician or the referring agency/hospital.

The Alabama Department of Mental Health and Mental Retardation provides pre-admission screening and resident reviews on all present nursing facility residents with a diagnosis of mental illness and/or mental retardation.

The Alabama Department of Mental Health and Mental Retardation conducts the Level II Screenings on each resident with a primary or secondary diagnosis of MI/MR and determines the resident’s need for active treatment.

For all residents with a primary or secondary diagnosis of MI/MR, the Alabama Department of Mental Health determines appropriate placement in a nursing facility based on the results of the Level II Screening and Medicaid medical criteria.

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 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 an RN and under the general direction of a physician.

A nursing care resident must require **two or more** of the following specific services:

- 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
- 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 and 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 noninfected, post operative, or chronic conditions
- Comatose patient receiving routine medical treatment

NOTE:

The above criteria apply to all 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. These residents need to meet only **one** of the above criteria.

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 bylaws, 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 patient, 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.
- It is advertised as a mental institution.
- More than fifty percent (50%) of the patients 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, Third Edition, International Classification of Diseases*, adopted for use in the United States, 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 patients 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 patients 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 patient'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, 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.
- 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 patient 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

NOTE:

Refer to Appendix E, Medicaid Forms, for the Nursing Facility Statistical Report. This is the recommended analysis sheet; however, providers may use any form of their own design if it provides the same information.

Cost Reports

Each provider is required to file a complete uniform cost report for each fiscal year ending June 30. The complete uniform cost report must be received by Medicaid 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 performs the following reviews of services provided to Medicaid residents in nursing 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 for nursing facility services. Medicaid certifies the resident at the time of admission using the following forms: MDS assessment, Level 1 Screening and Level II Screening where appropriate. Medicaid certifies the resident at the time of readmission. A control number is provided for each new Medicaid resident admitted.
- Review of the effectiveness of discharge planning
- Review for quality assessment and assurance

26.3 Prior Authorization and Referral Requirements

The application to establish medical need for Medicaid benefits is a two-step process consisting of the following:

- For applications that are prior authorized, performing the prior authorization procedure through Medicaid's Long Term Care Admissions Records Unit
- For applications that are not prior authorized, approval or denial of medical eligibility made by Medicaid in-house physician

Providers use the following procedures to obtain prior authorization:

- All Medicaid certified nursing facilities are required to furnish the LTC Admissions Records Unit with an admission application packet 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 in the LTC Admissions Records Unit. All applications with a date greater than 60 days old are assigned an effective date that is 60 days prior to the LTC Admissions Records Unit stamp date. No payment will be made for the days between the requested date and the assigned LTC effective date. The facility will be informed in writing of the assigned effective date.
- A MED 54 (Request for Retroactive Eligibility) may not be used to cover the time lost due to an application over 60 days old. Retroactive Eligibility may be granted for periods prior to the time lost due to the 60-day late period. The family or sponsor may not be charged for the non-covered period.

The admission application packet consists of the following:

- A fully completed written application form XIX-LTC-9 and an LTC-4. The facility and the applicant’s attending physician must provide as much information as exists on each question on the LTC-9 and LTC-4, attaching documentation where such is available. All required medical information must be submitted.
- A fully completed Level 1 Screening for Mental Illness/Retardation/Related Condition (LTC-14)
- For a person with a diagnosis of mental retardation and/or mental illness, a fully completed DMH PSO 1 (Medical and Drug History), DMH PSO 2 (Psychosocial Assessment), DMH PSO 3 (Psychiatric History), and DMH PSO 4 (Pre-admission Screening Report)

A total evaluation of the resident must be made before admission to the nursing facility or authorization for 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:

- Diagnosis
- Summary of present medical, social, and developmental findings
- Medical and social family history
- Mental and physical functional capacity
- Prognosis
- Kinds of services needed
- Evaluation of the resources available in the home, family, and community
- 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

When the Medicaid staff approves an application for medical need through prior authorization, the date the application is processed is documented on the LTC-4.

- In the event the resident does not have a Medicaid number, the facility must contact the appropriate Medicaid Certification District Office and/or SSI office.
- A facility will not be paid for services for a resident until a Medicaid number is on record with Medicaid.

An LTC-2 and/or LTC-2A are generated by Medicaid.

The LTC-2 specifies the dates the Medicaid recipient is eligible for nursing facility care.

When a patient is discharged, dies, or transfers, the facility must complete the information on the bottom of the LTC-2 and return it to Medicaid within 48 hours.

Failure to forward the above information prevents Medicaid from issuing another LTC-2 for readmission to the facility or admission to another facility.

Application Denials

On each denied admission application, Medicaid advises the recipient and/or sponsor, the attending physician, and the facility of the recipient'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 patient and/or sponsor are advised of the patient's right to a fair hearing. If the reconsideration results in a favorable decision, normal admitting procedures are followed.

26.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by nursing facility providers.

26.5 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.

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-92 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.

NOTE:

Providers are required to send a statistical page with the each month's claim submissions for recording purposes. Appendix E, Medicaid Forms, contains a sample statistical reporting form. This form may be faxed to (334) 834-5301 Attn: LTC Division.

26.5.1 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.

26.5.2 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). Medicaid does not cover diagnosis codes preceded by an "E," "M," or "Y." Do not use decimal points in the diagnosis code field.

26.5.3 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

26.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 claim form.

26.5.5 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-92 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

26.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-92 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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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
- Dispensed 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

EDS 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*.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Pharmacy provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for pharmacy-related claims.

NOTE:

All nine digits are required when filing a claim.

Pharmacy providers are assigned a provider type of 07 (Pharmacy). Valid specialties for Pharmacy providers include the following:

- Government Pharmacy (PA)
- Institutional Pharmacy (PB)
- Retail Pharmacy (P2)

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 and invoices must be available for examination.

Out-of-State Pharmacies

Out of state bordering pharmacies, located within 30 miles of the border of the state of Alabama, may be enrolled as a regular Medicaid pharmacy provider. Out of state pharmacies not bordering Alabama, or located more than 30 miles from the state border, will be enrolled on a temporary basis for emergency situations.

Out of state bordering pharmacies may participate in the Alabama Medicaid Program under the following conditions:

- Possess certification from the State Board of Pharmacy in the state where the pharmacy is registered and hold a permit to operate in the state of residence
- Complete an application for out-of-state pharmacies
- Agree to abide by the Alabama state provider tax law.

Alabama Medicaid program limitations apply to both out-of-state and in-state pharmacies. Medicaid uses the same payment methodology to reimburse out-of-state and in-state pharmacies enrolled with the Alabama Medicaid Program for drugs dispensed.

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.

Medicaid will not compensate pharmacy providers for:

- Drugs for anorexia or weight gain
- Drugs to promote fertility
- Drugs for cosmetic purposes or hair growth
- Over the counter drugs, with the exception of those specified on the Alabama Preferred Drug List or those otherwise specified by the Alabama Medicaid Agency
- Covered outpatient drugs when the manufacturer requires as a condition of sale that associated tests and/or monitoring services be purchased exclusively from the manufacturer or designee

- DESI and IRS drugs which may be restricted in accordance with Section 1927(d)(2) of the Social Security Act
- Agents when used for the symptomatic relief of cough and colds except for those specified by the Alabama Medicaid Agency

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 signature of the prescribing physician. Stamped or typewritten signatures are not acceptable. Telephone prescriptions for Schedule II drugs are not allowed.

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.

27.2.2 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 34-day 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 limit, the pharmacist must request an override for the prescribed quantity. If the override is not approved, then the excess number above the limit is noncovered and the pharmacist can charge the recipient for that amount in excess of the Medicaid limit.

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.

27.2.3 Prescription Refill

Prescriptions cannot exceed five refills. Medicaid will deny claims for prescription refills exceeding five. 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.

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.

27.2.4 Reimbursement for Covered Drugs

This section describes reimbursement for multiple source drugs, over-the-counter medications and other drugs, dispensing fees, 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 HCFA, 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
- Calculated State Maximum Allowable Cost (MAC)

NOTE:

AEAC is defined as Medicaid's best estimate of the price providers generally pay for a drug. Medicaid establishes the AEAC for each drug based on the package size providers most frequently purchase.

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases "brand medically necessary" must be indicated on the prescription in the physician's handwriting and the pharmacist must maintain the prescription on file.

Medicaid may recoup payments if the dispensing pharmacist does not have the original or faxed prescription with "brand medically necessary" written in the physician's own handwriting from the pharmacist's record.

Prescription Compounding

Alabama Medicaid pays for prescription drugs through the billing of NDCs. Pharmacists may dispense compounded medications when prescribed and can bill for each ingredient with a valid NDC. In addition, pharmacists will receive a dispensing fee for each valid NDC billed, which constitutes payment in full. Please ensure that any compounding performed is consistent with Public Law 105-115.

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.

Dispensing Fees

Medicaid maintains dispensing fees. A differential dispensing fee will be paid for non-retail providers.

Only one dispensing fee is allowed for a 30-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 (OTC)

Medicaid pays for certain OTC medications. Over-the-counter medications covered through the Medicaid pharmacy program 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 OTC medications.

If a prescribing physician writes a prescription that requires a pharmacist to break a bottle of medication, the pharmacist should bill Medicaid for the package size closest to the amount actually dispensed. For example, a bottle of ibuprofen is packaged with 100 tablets at a cost of $4.50. A recipient has a prescription for 90 tablets. The pharmacist should break the bottle, dispense 90 tablets, and bill $4.50.

Do not dispense more medication than indicated on the prescription unless authorized by the prescribing physician to do so.

Pharmacists must submit the shelf price paid by the general public for Medicaid payment of over-the-counter medications. Do not submit a dispensing fee to Medicaid.

27.2.5 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) 353-5994.

- **DAW Audits** - Use of the Dispense As Written (DAW) code 1 requires “Brand Medically Necessary” (BMN) certification. In absence of certification in the physician’s own handwriting on the prescription, recoupments may be initiated.
- **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.
- **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 -** The prescribing physician must authorize all changes from the original prescription before changes are made.
- **Requirements for Signatures and Prescriptions** - Schedule II and BMN products require original prescription and signature. Other drugs may be called in without the subsequent signature of the physician as allowed by State law.
- **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.

Continued violations of Medicaid claims processing policies may result in recoupment and referral to the Alabama Attorney General’s Office for investigation of fraud.

27.2.6 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 1-800-824-6584. 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 EDS.

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 welrfar 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 EDS 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 prior authorization of drugs requiring prior approval. Only HID can issue prior authorizations.

HID should respond within 24 hours of receipt of requests for prior authorization. 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 after 4:30 p.m. on Fridays until Monday (or the next State working day). Utilization of this code will be strictly monitored and recoupments will be initiated when the code is found to have been used inappropriately.

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**.

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	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

NOTE:

Copayment amount should be collected on the original prescription as well as any refills.

27.5 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.

Pharmacy 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.

Most pharmacy claims are submitted electronically for online adjudication. Claims filed electronically use Provider Electronic Solutions software from EDS 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 EDS for payment. EDS will furnish pharmacy claim forms upon request. Pharmacy claim forms can be purchased from EDS 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

Place of service codes do not apply when filing the pharmacy claim form.

27.5.5 Required Attachments

Attachments are not required for pharmacy claims.

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 5.5
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;

Alabama Pharmacy Association, (APA) fax, (334) 271-5423;

Alabama Independent Drugstore Association (AIDA), fax (334) 213-2406; and

Alabama Pharmacy Cooperative Inc. (APCI), fax (205) 870-1927

Responses will be in the quarterly Medicaid Pharmacy Newsletter, Monthly APA, AIDA, and APCI publications.

Are original prescriptions and signatures required for all drugs?

Medicaid requires original, signed prescriptions for Schedule II drugs and Brand Medically Necessary drugs. Schedule III, IV, and V drugs may be called in, as allowed by state pharmacy regulations.

Can a call-in prescription be accepted for a MAC drug when brand necessary certification is required?

No. The MAC price may only be waived when a pharmacy has a prescription with “Brand Medically Necessary” written in the prescribing physician’s own handwriting. Therefore, a written prescription is necessary. For example, because Zantac is a MAC drug and requires brand medically necessary certification on the prescription, a telephone prescription would not be acceptable in order to receive brand reimbursement.

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 (1-800-748-0130) for consideration of an override.

How long is a prescription valid?

In accordance with state law, controlled substance prescriptions are valid for up to 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. The pharmacist should not request additional requests from the physician.

Why is it important that I bill the exact NDC number dispensed if the product is a generic?

According to Jerry Moore, 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 Program Integrity, Pharmacy Audit Unit** for investigation at **(334) 242-2323**. Also, calls may be made to the **Medicaid Fraud Hotline** at **1-800-824-6584**. 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?

After a recipient has been convicted and is incarcerated, the recipient may no longer receive Medicaid benefits. It is the responsibility of the correction facility to provide medical care. Incarcerated recipients still receiving Medicaid benefits may be referred to the Medicaid Pharmacy Audit Unit at (334) 242-2323.

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 34-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 can not 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.

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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

EDS 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.

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a physician is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursement for physician-related claims.

NOTE:

All nine digits are required when filing a claim.

Physicians are assigned a provider type of 01 (Physician). Physician-Employed Nurse Practitioners or Physician-Employed Physician Assistants are assigned a provider type of 06 (Physician-Employed Practitioners), and Certified Registered Nurse Anesthetists and Anesthesiology Assistants are assigned a provider type of 92 (CRNA).

Valid specialties for physicians and physician-employed practitioners are listed below:

Specialty	***Code***
Allergy/Immunology	03
Anesthesiology	05
Anesthesiology Assistant	N7
Cardiac surgery	S1
Cardiovascular disease	06
Certified Registered Nurse Anesthetist	C3
Cochlear implant team	C9
Colon and rectal surgery	S2
Dermatology	07
EENT	XA
Emergency medicine	E1
Endocrinology	E2
EPSDT	E3
Family practice	08
Gastroenterology	10
General practice	01
General surgery	02
Geriatrics	38
Hand surgery	21
Hematology	H2
Infectious diseases	55
Internal medicine	11
Mammography	M7
Neonatology	N1
Nephrology	39
Neurological surgery	14
Neurology	13
Nuclear medicine	36
Nutrition	40
Obstetrics/Gynecology	16
Oncology	XI
Ophthalmology	18
Oral and maxillofacial surgery	SE
Orthopedic	X6
Orthopedic surgery	20
Otorhinolaryngology	X9
Pathology	22
Pediatrics	37
Physician-Employed Nurse Practitioner	N3
Physician-Employed Physician Assistant	N6
Plastic, reconstructive, cosmetic surgery	24
Primary care provider (not a screening provider but can refer patients)	AE
Proctology	28
Psychiatry	26
Pulmonary disease	29
Radiology	30
Rheumatology	R4
Thoracic surgery	33
Urology	34
Vascular surgery	S4

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 EDS Provider Enrollment, P.O. Box 244035, Montgomery, AL 36124.

EDS 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.

A physician enrolled in and providing services through an approved residency training program will be assigned a pseudo Medicaid license number, but may not bill for services performed as part of the residency training program. A pseudo Medicaid license number is required on written prescriptions issued to Medicaid recipients.

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.

Reimbursement may be made to a physician submitting a claim for services furnished by another physician in the event there is a reciprocal arrangement as long as block 19 on the claim identifies the physician who actually furnished the service. Both physicians should be enrolled as Medicaid providers. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement or 90 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement should be enrolled with the Alabama Medicaid Agency.

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. 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., "no call" or "no show."

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 who is not employed by and paid by a hospital may bill Medicaid using a HCFA-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 HCFA-1500 claim form, or assign their billing rights to the hospital, which shall bill Medicaid on a HCFA-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 provider number 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.

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".

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.

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 Medicaid and receive an Alabama Medicaid provider 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 Alabama Medicaid provider number.

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 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 cannot provide services in the emergency room or as an assistant at surgery for reimbursement by Medicaid.

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), HCPCS or designated by special procedure codes created by Medicaid for its own use

This table contains details on selected covered services.

Service	***Coverage and Conditions***
Anesthesia	Anesthesia is covered. See Chapter 38, Anesthesiology.
Artificial Eyes	Artificial eyes must be prescribed by a physician.
Computerized Axial Tomograph (CAT) Scans	CAT scans are covered as medically necessary.
Chiropractors	Chiropractic services are covered only for QMB recipients and for services referred directly as a result of an EPSDT screening.

Service	***Coverage and Conditions***
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.
Diet Instruction	Diet instruction performed by a physician is considered part of a routine visit.
Drugs	Non-injectable drugs must be billed by a pharmacy to be covered. Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose.
Examinations	Physician visits for examinations are counted as part of each recipient's benefit limit of 14 physician visits per year. 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. The physician must physically see the patient for a visit to be billed. 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 eyecare 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
Hearing Aids	See Chapter 10, Audiology/Hearing Services, for details.
Immunizations	The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program. Medicaid reimburses administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program. Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT-4 codes. Refer to Appendix A, EPSDT, for more information. The single antigen vaccines may be billed only when medically justified and prior authorized. These vaccines are listed below: • Diphtheria - 90719 • Measles - 90705 • Mumps - 90704 • Rubella - 90706 Payment for immunizations against communicable diseases for adults will be made if the physician normally charges his patients for this service.
Infant Resuscitation	Newborn resuscitation (procedure code 99440) 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.

Service	***Coverage and Conditions***
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: 1. Routine newborn care (99431, 99433, and discharge codes 99238 or 99239) 2. Circumcision (54150 or 54160) 3. Newborn resuscitation (99440) 4. Standby services following a caesarian section or a high-risk vaginal delivery. (99360) 5. Attendance at delivery (when requested by delivering physician) and initial stabilization of newborn (99436) 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 caesarian 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.
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.
Obstetrical Services	Refer to Section 28.2.10
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	Post-surgical 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 one day prior to surgery or up to 62 days after surgery.
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. Office visits are not covered when billed in conjunction with psychotherapy codes. Psychiatric services under the Physicians' Program are confined to use with psychiatric diagnosis (290-319) and must be performed by a physician. Hospital visits are not covered when billed in conjunction with psychiatric therapy on the same day. For services rendered by psychologist, see Appendix A, EPSDT, for details. Psychiatric day care is not a covered benefit under the Physicians' Program.
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.

Service	***Coverage and Conditions***
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, through the same incision or separate incisions in the same operative field, 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. • 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. 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.
Surgery, Breast Reconstruction	Breast reconstruction surgery is reimbursable following a medically necessary mastectomy when performed for the removal of cancer. 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 • The recipient is eligible for Medicaid on the date of reconstruction surgery • The recipient elects reconstruction within two years of the mastectomy surgery • The diagnosis codes used are appropriate • The surgery is performed in the manner chosen by the patient and the physician in accordance with guidelines consistent with Medicare and other third party payers • 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.
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 and provided in a hospital setting. Refer to Chapter 19, Hospital, for more information. 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.

Service	Coverage and Conditions
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.
Well Baby Coverage	Well baby coverage is covered only on the initial visit, which must be provided within eight weeks of the birth. When the well-baby checkup is done, the physician should bill procedure code 99432. Only one well-baby checkup can be paid per lifetime, per recipient. Refer to Appendix A, EPSDT, for information on additional preventive services.

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.
Biofeedback	Biofeedback is not covered.
Blood Tests	Blood tests are not covered for marriage licenses.
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.
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.
Oxygen and Compressed Gas	A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program; the cost of the oxygen or gas is not covered.
Post Surgical Visits	Post-surgical 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 one day prior to surgery or up to 62 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. 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.

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.

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.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix 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.

Any physician billing for a professional interpretation for an inpatient may not bill for a hospital visit on the same inpatient day for the same recipient. Medicaid will cover either one hospital visit or professional interpretation(s) up to the allowed benefit limit.

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 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.

28.2.6 Critical Care

When caring for a critically ill patient in which the constant attention of the physician is required, the appropriate critical care procedure code (99291 and 99292) must be billed. 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.

No individual procedures related to critical care may be billed in addition to procedure codes 99291 and 99292, except those procedures listed below:

- Procedure code 99360 and either procedure code 99221, 99222, or 99223 (initial hospital care) may be billed once with each hospital stay and may be billed with critical care.
- 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 can not be billed.
- Procedure code 99082 (transportation or escort of patient), may also be billed with critical care (99291 and/or 99292). Only the attending physician may bill this service and critical care. Residents or nurses who escort a patient may not bill either service.

28.2.7 Neonatal Critical Care

The purpose of the following policy statements is to provide assistance to neonatology providers seeking to bill procedures for critical care. Refer to the CPT Procedure Codes for additional guidance and clarification. Procedures included as part of the global care are specified in the CPT description.

Any procedures that are included in or are typically required, as part of the global descriptor, may not be billed separately. For example, endotracheal intubation includes laryngoscopy, and ventilatory support includes tracheostomy tube change. These codes begin with the day of admission and may be billed once per patient, per day.

Proc Code	*Description*
99295	This code must be used for the initial day of critical care as defined in the CPT billing manual. This code is used only for infants requiring critical care.
99296	This code may be used for patients on a ventilator 20 hours per day or greater or for patients whose weight is less than 1000 grams.
99297	This code may be used for patients that meet one of the following criteria: On CPAP 20 hours per day or more Receive oxygen 20 hours per day or more Weigh less than 1600 grams Receive intravenous fluids and NPO

Once the patient is no longer considered by the attending physician to be critical, the Subsequent Hospital Care codes (99231-99233) should be billed.

Procedures that may be billed in addition to the neonatal critical care global codes (or subsequent hospital care codes) include, but are not limited to:

- Chest tube placement
- Pericardiocentesis or thoracentesis
- Intracranial taps

Services that may be billed in addition to neonatal intensive care unit (NICU) critical care codes are:

- Initial history and physical or EPSDT screen may be billed in conjunction with 99295. Both may not be billed.
- One EPSDT screen for the hospitalization will encompass all diagnoses identified during the hospital stay for referral purposes.
- Standby (99360) resuscitation (99440) or attendance at delivery (99436) 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.

The procedures identified in the NICU global payment codes (99295-99297) may not be billed in conjunction with the Subsequent Hospital Care codes (99231-99233) per day.

Only one unit of 99295, 99296 or 99297 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).

Procedure codes 99295, 99296 and 99297 can only be billed in the NICU or ICU (Intensive Care Unit). If a recipient is readmitted to the NICU/ICU, the neonatologist must be the primary physician in order for NICU critical care codes to be billed again.

Procedure codes 99291 and 99292 may be billed by the neonatologist in place of service 41, Ambulance, if care is personally rendered by the neonatologist. Procedure code 99295 may not be billed in this setting.

Procedure codes 99291 and 99292 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. Procedure code 99295 may not be billed in this setting.

In order for a physician providing care to the neonate to bill 99291 or 99292 in a unit other than NICU (e.g., pediatric unit) all of the following conditions must be met:

- The admission must be a readmission from outside the hospital.
- The patient must meet critical care criteria.
- The physician providing care to the neonate must be the attending physician, not a consultant.

In these instances 99291 and 99292 may be used but will be reviewed retrospectively by Medicaid for appropriateness of billing for critical care.

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. Neonatologists may not do 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 neonatologist 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 neonatologist 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 neonatologist is assuming total responsibility for care of the patient and is the primary attending physician for the patient. Consultation and critical care cannot be billed on the same patient on the same day.

Procedure codes 99296 and 99297 may be used for infants up to one year of age. For infants who remain in the NICU after they are one year of age and continue to be critically ill, 99291 and 99292 may be billed. Medicaid will review medical records for 99291 and 99292 billings to ensure that the critical care was rendered.

28.2.8 End-Stage Renal Disease (ESRD)

All physician services rendered to each outpatient maintenance dialysis patient (regardless of the patient's mode of/or setting for dialysis) shall be billed on a monthly capitation basis. 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) 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
- 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.)

Refer to Chapter 35, Renal Dialysis Facility, for further details.

28.2.9 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 in Rule No. 540-X-7-.34 of the Alabama Board of Medical Examiners. The AA must enroll and receive a provider number to bill the Alabama Medicaid Program. Refer to Chapter 38, Anesthesiology, for more information.

28.2.10 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. 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 meet 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 chronic 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 EDS, 1-800-727-7848.

28.2.11 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.

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.

28.2.12 Lab Services

Physicians will not be paid for and should not submit claims for laboratory work done for them by independent laboratories or by hospital laboratories. Physicians may submit claims for laboratory work done by them in their own offices or own laboratory facilities. Physicians 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. Routine venipuncture for collection of laboratory specimens may be billed only when sending blood specimens to another site for analysis. The collection fee may not be billed if the lab work is done at the same site where the specimen was drawn.

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

84434 Thyroxine; total requiring elution (e.g., neonatal)

28.2.13 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.

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.

28.4 Cost Sharing (Copayment)

The copayment amount for physician office visit (including crossovers, and optometric) is $1.00 per visit. Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning.

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.

28.5 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.

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 HCFA-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.

28.5.1 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.

28.5.2 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). Medicaid does not cover diagnosis codes preceded by an "E," "M," or "Y." Do not use decimal points in the diagnosis code field.

28.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z’.

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.

Specimen Collection Code

Pap Smear

When sending a pap smear specimen to another site for analysis, use nonstandard code Q0091 when billing the collection of a pap smear.

Blood Specimens

When sending blood specimens to another site for analysis, use CPT Code 36415 with modifier 90 to bill for the collection fee.

Physician-Employed Physician Assistants (PA) and Certified Registered Nurse Practitioners (CRNP)

Payment will be made only for injectable drugs identified in Appendix H, Alabama Medicaid Injectable Drug List, CPT codes identified in Appendix O, CRNP and PA Services, and laboratory services, which are 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 visits to nursing facilities. However, physician required visits to hospitals or other institutional settings cannot be made by a PA or CRNP. Also, the PA or CRNP cannot provide services in the emergency room or assist at surgery for Medicaid reimbursement.

The “ZO” modifier, which has been utilized by physician-employed nurse practitioners, will not be accepted for dates of service beginning July 1, 1998 and thereafter. For dates of service prior to July 1, 1998 the covered services must be billed under the provider number of the supervising physician utilizing a “ZO” modifier.

Surgical Procedure Code Modifiers

When submitting claims for procedures done on the same date of service, a modifier is required to indicate that the repeated service is not a duplicate. If the same provider performs the repeat procedure, the following modifiers should be used.

Modifier	***Description***
Y2	First repeat procedure, same date, same provider
Y3	Second repeat procedure, same date, same provider
Y4	Third repeat procedure, same date, same provider
Y5	Fourth repeat procedure, same date, same provider
Y6	Fifth repeat procedure, same date, same provider
Y7	Sixth repeat procedure, same date, same provider
Y8	Seventh repeat procedure, same date, same provider
Y9	Eighth repeat procedure, same date, same provider
Z2	Ninth repeat procedure, same date, same provider
Z3	Tenth repeat procedure, same date, same provider

Same Date Modifiers

For repeat procedures done on the same date of service by a different provider, use modifier 77. Claims submitted for repeat procedures on the same date of service without modifiers are denied as duplicate services.

Modifier GB should be used to indicate a separate distinct service. Do not confuse modifier GB with modifiers for repeat procedures. Modifier GB does not replace any existing modifiers.

Modifier	*Description*
77	Repeat Procedure By Another Physician modifier indicates that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the five-digit procedure code.
GB	Distinct procedural service modifier indicates that a crossover only service or procedure was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury in extensive injuries).

NOTE:

Modifier GB is not to be used with Physician's Current Procedural Terminology (CPT) codes 99201-99499 or 77419-77430.

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.

28.5.4 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

POS	Description
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
99	Other Unlisted Facility

28.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-1500 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

28.5.6 Consent Forms Required Before Payments Can Be Made

NOTE:

EDS will NOT pay any claims to ANY provider until a correctly completed original of the appropriate form is on file at EDS.

Abortions

EDS **must** have on file one or more (depending on the circumstance) of the forms required by federal law and a copy of the medical records. CPT Codes within this classification are 59840 to 59852. ICD-9 procedure codes within this classification are 75.0, 74.91, 69.51, 69.01 when used in conjunction with ICD-9CM diagnosis codes 635, 636, and 638.

Refer to Appendix E, Medicaid Forms, for a copy of the appropriate abortion consent form.

- The original copy signed by the attending physician must be submitted to EDS.
- The second copy of the signed certification must be placed in the recipient/patient medical record.
- Copies of the signed certification may need to be provided to hospital, laboratory, etc., as applicable in order for these other providers to submit billing for their services.

All claims related to abortions must have a copy of the attending physician's certification and a copy of the medical records on file at EDS prior to payment.

The attending physician's certification and a copy of the medical records are not required when a recipient presents with a "spontaneous" abortion.

In the event that the recipient does not qualify for payment by Medicaid and elects to have the abortion, the provider may bill the recipient for the abortion.

Sterilization

EDS must have on file the Medicaid-approved sterilization form. Refer to Appendix C, Family Planning, for more information.

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

Hysterectomy procedures performed for the sole purpose of rendering an individual incapable of reproducing are no longer 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.

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

EDS must have on file a Medicaid-approved Hysterectomy Consent Form. See Appendix E, Medicaid Forms, for a sample copy of this form. The recipient signature on the consent form may be written either before or after the operation. However, the consent itself, the doctor's explanation to the patient that the operation will make her sterile, and the doctor's signature must precede the operation except in the case of medical emergency.

Exceptions That Do Not Require Consent

If the following situations, the consent form is not required. If consent is not required, **the reason must be stated on the claim.**

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.
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.
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.

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 M, 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
HCFA-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	Appendix H
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
CRNP and PA Services	Appendix O

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

EDS 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*.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a podiatrist is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for podiatry-related claims.

NOTE:

All nine digits are required when filing a claim.

Podiatrists are assigned a provider type of 17 (Podiatrist). Valid specialties for podiatrists include the following:

- Podiatry (48)
- QMB/EPSDT (EQ)

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

For podiatry services to be paid by Medicaid for non-QMB recipients, 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 EPSDT Referral for Services form (Form 167) or Patient 1st EPSDT Referral for Services form (Form 345), which must identify the reason for referral and serve as documentation that the services provided were the result of an EPSDT screening.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

29.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. Copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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.

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. 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
99	Other Unlisted Facility

29.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-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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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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a preventive health education provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for preventive health education-related claims.

NOTE:

All nine digits are required when filing a claim.

Preventive health education providers are assigned a provider type of 99 (Other). The valid specialty for preventive health education providers is Preventive Health Education (P9).

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 Section D.1.3 of the Managed Care appendix 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

➢ 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.

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 HCFA-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 Parenting Education services are limited to diagnosis code V222. Adolescent Pregnancy Prevention Education services are limited to diagnosis code V2509.

30.5.3 Procedure Codes and Modifiers

Services are **limited** to the billing of the following two procedure codes:

Procedure Code	*Description*
Z5267	Prenatal Parenting Education – Limited to pregnant female recipients. Limited to diagnosis code 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

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the Form XIX-TPD-1-76.

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-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

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 age 21 years of age and referred as the result of an EPSDT screening.

The policy provisions for private duty nursing providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

31.1 Enrollment

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a private duty nursing provider is issued a eight-character Medicaid provider number that enables the provider to submit requests and receive reimbursements for nursing-related claims.

NOTE:

All eight characters are required when filing a claim.

Private duty nursing providers are assigned a provider type of 38 (Private Duty Nursing). The valid specialty is Private Duty Nursing (P6).

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.

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 are rendered by a Registered Nurse or Licensed Practical Nurse employed by a Medicaid-enrolled private duty nursing provider.

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. If Medicaid criteria are met, the request is approved in writing for a specific number of hours each day or week. If additional hours are needed, a new prior approval request must be submitted to Medicaid.

Requirements for Recipients

The recipient must be under 21 years of age. Recipients must be eligible for Medicaid for the date the services are provided. EDS will not pay claims for ineligible recipients.

To qualify for private duty nursing services, the recipient must have a life-threatening condition requiring attention around the clock. The need for constant care must exceed the family's ability to care for the recipient without the assistance of at least four hours of continuous skilled nursing care(Rule No. 560-X-11-.14).

Major commitment on the part of the recipient's family and community is mandatory to meet the recipient's extraordinary needs. The recipient must depend upon family members to provide a support mechanism at home for non-medical care, including the following specific components:

- The family must have at least one member trained and fully able to care for the recipient in the home. In life threatening situations, two or more trained adults must be available to ensure medical safety.
- The family must provide evidence of parental or family involvement, proven capability in performing medical and nursing tasks, and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).
- The primary care physician must participate in the development of the recipient care plan prior to the recipient's admission to the private duty nursing program and make a commitment to provide primary care.
- Essential equipment must be portable or available at each site the recipient attends.
- Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

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.

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:

- Any one of the primary conditions and any one of the diagnosis criteria are present.
- Two or more secondary conditions and any one of the diagnosis criteria are present.

Primary Conditions

The following primary conditions are qualifying criteria for nursing recipients:

- Tracheotomy - Coverage up to four months for acute (new) tracheotomy with up to an additional two months with documentation of continuing acute problems
- 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 covered will be a minimum of four continuous hours requiring a skilled nurse for monitoring and treatment. Additional hours may also be approved for secondary criteria conditions listed below in conjunction with the primary criteria conditions.

Secondary Conditions

Any two secondary conditions are 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

Diagnosis Criteria

Technology dependence must be related to any of the following diagnoses:

- Severe neuromuscular, respiratory, or cardiovascular disease not requiring mechanical ventilator support
- Chronic liver or gastrointestinal disorders with associated nutritional compromise
- Multiple congenital anomalies or malignancies with severe involvement of vital body functions
- Serious infections which require prolonged treatment

31.2.2 Criteria for Ventilator-Dependent Recipients

Ventilator dependent recipients may qualify for private duty nursing services if any one of the primary conditions and any one of the diagnosis criteria are present.

Primary Conditions

Any of the following primary conditions are qualifying criteria for nursing recipients:

- Mechanical ventilator support is necessary for at least six hours per day and attempted weaning is in progress at least weekly.
- Frequent ventilator checks are necessary (Daytime versus nighttime settings, weans, parameter checks, every two hours to every shift are dependent on pulmonary complexity).
- Oxygen supplementation for ventilator dependent recipients is at or below an inspired fraction of 40 percent (Fi02 of 0.40).

Diagnosis Criteria

The recipient must have a related diagnosis requiring ventilator support. These diagnoses include the following:

- Neuromuscular disease involving the respiratory muscles
- Brainstem respiratory center dysfunction
- Severe thoracic cage abnormalities
- Intrinsic lung disease
- Lung disease associated with cardiovascular disorders

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.

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) signed by the physician
- Private Duty Nursing Acceptance form
- EPSDT Referral for Services form (Form 167) or Patient 1st EPSDT Referral for Services (Form 345)
- 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 private duty nursing service. The plan of care documents the extensive nursing needs of the recipient. 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 for the following conditions:

- 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 EDS the following forms for consideration of authorization for services:

- Alabama Prior Review and Authorization Request form
- EPSDT Referral for Services form (Form 167) or Patient 1st EPSDT Referral for Services form (Form 345)

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

The EPSDT Referral for Services form (Form 167) or Patient 1st EPSDT Referral for Services form (Form 345) 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) or Patient 1st EPSDT Referral for Services form (Form 345) indicating the current screening date and appropriate information must be submitted.

Re-certification

Every two months, documentation must be submitted to EDS to support the need for continuation of private duty nursing services. Providers must submit re-certification requests to EDS **at least** 14 days prior to the re-certification due date. The request for re-certification will be approved or denied based on Medicaid criteria. EDS denies claims for services rendered after the cancellation date.

31.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by private duty nursing providers.

31.5 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.

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-92 claim form is required. When completing the UB-92, enter type of bill 331. 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.

31.5.1 Time Limit For Filing Claims

Medicaid requires all claims for private duty nurse 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

31.5.3 Procedure Codes

Private duty nurse 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	S9905	Private Duty Nurse/RN
551	S9908	Private Duty Nurse/LPN

31.5.4 Place of Service Codes

Place of services codes do not apply when filing the UB-92 claim form.

31.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-92 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-92 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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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 a fee-for-service basis 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is issued nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for claims.

NOTE:
All nine digits are required when filing a claim.

Rural health clinics are assigned a provider type of 29 (rural health clinics). The valid specialty for provider-based rural health clinics is Provider Based Rural Health Clinic (R2).

NOTE:

Physicians affiliated with rural health clinics are assigned their own Alabama Medicaid provider number, which links them to the clinic. The provider type for the physician is 29 (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 provider number, and are not assigned individual provider numbers.

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.

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 that 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.

A nurse practitioner, physician assistant, or certified nurse midwife must furnish patient care services at least 60 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.

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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

32.4 Cost Sharing (Copayment)

The copayment amount is $1.00 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.

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 HCFA-1500 claim form.

Medicare Deductible and Coinsurance

For provider-based rural health clinic services, Medicaid pays the Medicare deductible and coinsurance according to the lesser of the following amounts:

- Reimbursement under Medicare rules
- Total reimbursement allowed by Medicaid

32.5 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.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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:

PCT code 36415 - Routine Venipuncture for Collection of Specimen. The provider providing the service and sending the blood to an outside laboratory for processing must use Modifier 90.

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
Z5267	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:

- Form XIX-TPD-1-76
- 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
HCFA-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 Facilities for Individuals under Age 21

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.state.al.us.

Inpatient 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 facility 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 on the Child/Adolescent Unit 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 serving Medicaid recipients under age 21 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 for recipients under age 21 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.

Hospitals and RTFs shall 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.state.al.us

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 written on agency or facility letterhead and must include, at a minimum, the recipient's name, Medicaid number, date of birth, and date of admission to the facility.

Written notification shall be provided to Medicaid by the case worker 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a psychiatric hospital or RTF is issued an eight-character Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursements for psychiatric hospital-related services All eight characters are required when filing a claim.

Psychiatric hospitals and RTFs are assigned a provider type of 05 (Hospital). The valid specialty for psychiatric hospitals is (W3) and (WF) 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 using the Medicaid PSY-4 form. Contact the Medicaid Prior Authorization Unit at (334) 242-5141 for a copy of the PSY-4 form. The census report must list the names of all Medicaid children and adolescents who are admitted to and discharged from the Acute Care Adolescent Unit during the calendar month. This report should also list the names of the children and adolescents who remain hospitalized on the Acute Care Adolescent Unit during the calendar month. Medicaid must receive the report by the 10th of the following month. Failure to send the required report within the specified time period will result in the hospital's reimbursement checks being withheld, until the report is received by Medicaid.

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)
- 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, or DYS 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
- Be in compliance with staffing and medical record requirements necessary to carry out a program of active treatment for individuals under age 21
- Submit a budget of costs for residential psychiatric treatment services for the RTF's initial cost reporting period

All correspondence regarding application by Alabama RTFs for participation in the Medicaid program should be mailed to:

Alabama Medicaid Agency
Attention: Institutional Services
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.

33.2.1 Therapeutic Visits

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. Therapeutic visits are subject to the following limitations:

- No more than three days in duration
- No more than two visits per 90 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.

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 admissions and continued stays. Instructions for documenting emergency and non-emergency admissions to RTFs will also be found in Chapter 41.

Reimbursement

Medicaid pays for inpatient services provided by psychiatric facilities for individuals under 21 years of age according to the per diem rate established for the hospital or RTF. 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 and RTFs 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 or RTF shall be charged a penalty of $100.00 per day for each calendar day after the due date.

33.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by inpatient psychiatric hospitals or RTFs.

33.5 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.

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-92 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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-92 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-92 claim 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-92 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-92 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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34 Psychologist

Psychologists are enrolled only for services provided to QMB recipients or to recipients 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Psychology provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for psychology-related claims.

NOTE:

All nine digits are required when filing a claim.

Psychology providers are assigned a provider type of 19 (Psychologist). Valid specialties for Psychology providers include the following:

- Psychology (62)
- QMB/EPSDT (EQ)

Enrollment Policy for Psychology Providers

Psychologists must meet the following requirements for participation in Medicaid:

- Possess a doctoral degree 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 appropriate state's Board of Psychology

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 only bill procedures listed in Section 34.5.3, Procedure Codes and Modifiers.

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 (i.e., service plan, plan of care, etc.) 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 not provided directly by the Agency
- 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 physician or clinical psychologist licensed in the state of Alabama

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 physician or clinical psychologist licensed in the state of Alabama.

The physician or clinical psychologist as described above 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 or near the treatment plan. This review shall note the treatment plan has been reviewed and updated or continued without change.

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 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

When clinical records are audited, the list of required documentation described above will be applied to justify payment by Medicaid. The documentation must be sufficient in detail to support the service billed.

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.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

34.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by psychologist providers.

34.5 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.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

34.5.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for psychologist services. Claims without procedure codes or with invalid codes will be denied. **Daily and annual maximum units become effective January 1, 2000.**

CPT Code	*Description*	*See Note*	*Daily Max*	*Annual Max*
90801	Psychiatric diagnostic interview examination		1	1
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication		1	1
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90805	with medical evaluation and management services	3	2	52
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90807	with medical evaluation and management services	3	1	26
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90809	with medical evaluation and management services	2, 3	1	12
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90811	with medical evaluation and management services	3	2	52

CPT Code	Description	See Note	Daily Max	Annual Max
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90813	with medical evaluation and management services	3	1	26
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90815	with medical evaluation and management services	2, 3	1	12
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital, or residential care setting, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90817	with medical evaluation and management services	3	2	52
90818	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90819	with medical evaluation and management services	3	1	26
90821	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90822	with medical evaluation and management services	2, 3	1	12
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20 to 30 minutes face-to-face with the patient	3	2	52
90824	with medical evaluation and management services	3	2	52
90826	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient	3	1	26
90827	with medical evaluation and management services	3	1	26
90828	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 75 to 80 minutes face-to-face with the patient	2, 3	1	12
90829	with medical evaluation and management services	2, 3	1	12
90847	Family medical psychotherapy (conjoint psychotherapy) with patient present	4	1	12
90849	Multiple-family group psychotherapy	4	1	12
90853	Group psychotherapy (other than of a multiple-family group)	5	1	12
90887	Interpretation of explanation of results of psychiatric data, other medical examinations and procedures, or other accumulated data to family or other responsible persons; or advising them how to assist patient		1	12
96100	Psychological testing (includes psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour	6	5	10
96117	Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour		5	10

Guidelines for Covered Procedure Codes:

1. 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 when another code, such as an E&M or pharmacologic management code, would be more appropriate.
2. Procedure codes 90808, 90809, 90814, 90815, 90821, 90822, 90828, and 90829 (75-80 minutes) should not be routinely used. These codes are reserved for exceptional circumstances. The provider must document in the client's clinical record the medical necessity of these services **and** define the exceptional circumstances.
3. Medicaid will not accept psychiatric therapy procedure codes 90804-90829 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.
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 physician or clinical psychologist licensed in the state of Alabama.
6. Procedure code 96100 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. 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.

NOTE:

Procedure codes 90862, pharmacologic management, and 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes, **are covered for physicians only** and may not be 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

34.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-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 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a Renal Dialysis Facility provider is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for dialysis-related claims.

NOTE:

All eight characters are required when filing a claim.

Renal Dialysis Facility providers are assigned a provider type of 34 (Renal Dialysis Facility). The valid specialty for Renal Dialysis Facility providers is Hemodialysis (H5).

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.

Medicaid limits hemodialysis to 156 sessions per year, which provides three sessions per week.

Medicaid limits Continuous Ambulatory Peritoneal Dialysis (CAPD) to the equivalent of three hemodialysis sessions per week.

Medicaid limits ultrafiltration to three sessions per recipient per year.

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 for a physician provider number that will pay to the facility. The CPT-4 procedure codes for EKG tracing and interpretation may be billed using the physician provider number on the HCFA-1500 claim form.

Laboratory Services

Laboratory tests listed below are considered routine and are included as part of the composite rate of reimbursement. All other medically necessary lab tests are considered nonroutine and must be billed directly by the actual provider of service.

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

The administration fee for injectables is included in the facility's composite rate for dialysis and must not be billed separately under a physician provider number.

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

Physician Services

All physician services rendered for maintenance to each outpatient dialysis patient are billed on a monthly capitation basis, regardless of the patient's mode of dialysis or the setting.

Reimbursable services not covered by the monthly capitation payment (MCP) are limited to the following:

- Declotting of shunts
- Covered physician services furnished to hospital inpatients by a physician who elects not to receive the MCP for these services
- Non-renal related physician services. These services may be furnished either by the physician providing renal care or by another physician. They may not be incidental to services furnished during a dialysis session or office visit necessitated by the renal condition.

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 Section D.1.3 of the Managed Care appendix 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-92 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.

NOTE:

If a dialysis claim receives a denial stating the XIX-TPD-1-76 Accident form is required, please review the recipient's medical record. If the treatment is due to disease, enter an H in block 78 and resubmit the claim.

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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

35.5.3 Procedure Codes, Revenue Codes, and Modifiers

Renal Dialysis Facility providers are limited to the following codes:

Revenue Code	***Procedure Code***	***Description***
821	90935	Hemodialysis procedure with single physician evaluation. Limited to 156 units per year.
821	90937	Hemodialysis procedure requiring repeated evaluations with or without substantial revision of dialysis prescription. Limited to 156 units per year.
831	90945	Dialysis procedure other than hemodialysis (e.g. peritoneal, hemofiltration) with single physician evaluation. Limited to 156 units per year.
831	90947	Dialysis procedure other than hemodialysis (e. g. peritoneal, hemofiltration) requiring repeated evaluations with or without substantial revision of dialysis prescription. Limited to 156 units per year.
831	90989	Dialysis training, patient, including helper. Limited to 12 units per lifetime.
250	Q9920-Q9940	Injection of Epogen
250	Injectable Codes	See Alabama Medicaid Injectable Drug Listing in Appendix H for covered injectable drugs.

35.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-92 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-92 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-92 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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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 the Medicare fiscal intermediary, and do not submit fee-for-service claims.

Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 8, for policy provisions for independent rural health clinic providers

36.1 Enrollment

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a rural health clinic provider is issued nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for claims.

NOTE:

All nine digits are required when filing a claim.

Rural health clinics are assigned a provider type of 29 (rural health clinics). The valid specialty for an independent rural health clinic is Independent Rural Health Clinic (R8).

NOTE:

Physicians affiliated with rural health clinics are assigned their own Alabama Medicaid provider number, which links them to the clinic. The provider type for the physician is 29 (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 provider number, and are not assigned individual provider numbers.

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 Health Care Financing Administration (HCFA) letter assigning the Medicare Provider number, and the letter form the fiscal intermediary establishing the reimbursement rate for the independent rural health clinic.

Submit a copy of the HCFA Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver.

Operate in accordance with applicable federal, state, and local laws.

The effective date of the enrollment of an independent rural health clinic will be date of Medicare certification.

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 solely run by mid-level practitioners, then the FTP equivalent of that 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.

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.

A nurse practitioner, physician assistant, or certified nurse midwife must be available to furnish patient care at least 60 percent of the time the clinic operates

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.

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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

36.4 Cost Sharing (Copayment)

The copayment amount is $1.00 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.

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 HCFA-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. Please refer to Chapter 5, Filing Claims, for additional information.

36.5 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.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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.

Encounters are all-inclusive. All services provided for the encounter are included in the reimbursement rate for the encounter.

The only exception to all-inclusive encounters is Medicare/Medicaid crossover claims for laboratory services. Rural Health Clinic providers should use their regular Medicaid provider number, not their 541XXXXXXX Rural Health Clinic number.

Clinic Visit

Procedure Code	*Description*
Z5297	Medical Encounter

Inpatient Hospital

Procedure Code	*Description*
Z5371	Inpatient Hospital Encounter

EPSDT Codes

Procedure Code	*Description*
Z5115	Initial EPSDT, Normal
Z5116	Initial EPSDT, Abnormal
Z5154	Periodic EPSDT, Normal
Z5155	Periodic EPSDT, Abnormal
Z5316	EPSDT Vision Screen
Z5317	EPSDT Hearing Screen
99391	Interperiodic EPSDT, infant (age under one year)
99392	Interperiodic EPSDT, early childhood (age 1-4)
99393	Interperiodic EPSDT, late childhood (age 5-11)
99394	Interperiodic EPSDT, adolescent (age 12-17)
99395	Interperiodic EPSDT, adult (age 18-20)

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)
11976	Implant Removal (limited to one per 365 days)
11977	Implant Removal with Reinsertion (limited to one every five years)
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
57170	Diaphragm
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.

Procedure Code	*Description*
J1055	Depo-Provera Shots
Z5181	Initial Visit (limited to one per recipient per family planning provider)
Z5182	Annual Visit (limited to one per recipient per calendar year)
Z5183	Periodic Visit (limited to four services per calendar year)
Z5184	Home Visit
Z5190	Extended Family Planning Counseling (limited to one service during 60-day post-partum period)
Z5270	Norplant Capsules Kit
Z5272	Implant Physical with Counseling Visit
Z5319	Hormonal IUD (Progestesert)
Z5320	Mechanical IUD (Paragard)

Prenatal Description

Procedure Code	*Description*
Z5185	Prenatal Clinic Visit
Z5195	Postpartum Clinic Visit

Vaccines For Children (VFC)

Refer to Appendix A, EPSDT, for procedure codes for VFC.

Preventive Health

Procedure Code	*Description*
Z5267	Prenatal Education (limited to 12 classes per recipient within 2-year period)
99412	Adolescent Pregnancy Prevention Education

NOTE:

Medical encounter (Z5297) 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:

Form XIX-TPD-1-76

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
HCFA-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 either an EPSDT Referral form (Form 167) or a Patient 1st/EPSDT Referral form (Form 345) as a result of an abnormality discovered during the EPSDT exam
- Provider treats QMB-only 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

EDS 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*.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a therapy provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for therapy-related claims.

NOTE:

All nine digits are required when filing a claim.

Therapy providers are assigned a provider type of 21 (Therapy). Valid specialties for therapy providers include the following:

- Occupational Therapy (T6)
- Physical Therapy (T1)
- QMB/EPSDT (EQ)
- Speech Therapy (T2)

Therapists that enroll independently and have their own provider number bill on a HCFA-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 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 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 OT must be registered by the American Occupational Therapy Certification Board and licensed by the Alabama State Board of Occupational Therapy.

A qualified PT must be a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. A qualified PT must also 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.

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 ordered by a physician and 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 ordered by a physician and 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 eight hours per month. 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 ordered by a physician and 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. Supervision of licensed PT assistants must include one-to-one on-site supervision at least eight hours per month. Each supervisory visit must be documented and signed by the PT.

Only procedure codes identified in Section 37.5.3, Procedure Codes and Modifiers, are valid procedure codes and reimbursable for physical therapy services.

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 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 Section D.1.3 of the Managed Care appendix 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 records that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped.

There are two Medicaid approved referral for service forms, Form 167 and Form 345.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

37.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z.'

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.

Speech Therapy

Speech therapy providers are limited to the procedure codes listed below:

Procedure Code	*Description*
92506	Medical evaluation speech, language, and/or hearing problems
92507	Speech, language, or hearing therapy, with continuing medical supervision; individual
92508	Speech, language, or hearing therapy, with continuing medical supervision; group
92597	Evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communications device

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. Annual limit means per calendar year.

Procedure Code	***Physical Therapy***	***See Note***	***Max Units Per Day***	***Annual Limit***
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report	2	1	12
95832	Hand, with or without comparison to other side		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	Physical therapy evaluation			
97002	Physical therapy reevaluation			
97010	Application of a modality to one or more areas; hot or cold packs	1	1	
97012	traction, mechanical	1	1	
97014	electrical stimulation, unattended	1, 4	4	
97016	vasopnuematic device	1, 3	1	
97018	paraffin bath	1, 3	1	
97022	whirlpool	3	1	24
97024	diathermy	1	1	
97026	infrared	1	1	
97028	ultraviolet		1	
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	3	4	96
97034	contrast baths, each 15 minutes		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
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception	3	1	24
97113	aquatic therapy with therapeutic exercises	1, 3	1	
97116	gait training (includes stair climbing)		1	18
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion). **This procedure requires prior authorization.**		1	8
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes		1	4
97150	Therapeutic procedure(s), group (2 or more individuals)		1	12
97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes		4	16

Procedure Code	*Physical Therapy*	*See Note*	*Max Units Per Day*	*Annual Limit*
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes		4	16
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	3	4	96
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. **This procedure requires prior authorization.**		4	36
97542	Wheelchair management/propulsion training, each 15 minutes		4	24
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes		4	12
97750	Physical performance test or measurement, (e.g., muscoloskeletal, functional capacity) with written report, each 15 minutes		4	12

NOTE:

1. Valid with therapeutic procedure codes (97100-97546) only.

2. Restricted to one procedure or date of service (cannot bill two together for the same date of service.)

3. 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 physical therapy is ordered.

4. Cannot be billed on same date of service as procedure code 20974 or 20975.

Occupational Therapy

Occupational Therapy providers are limited to the following 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. Individual occupational therapy services are limited to the following codes:

Code	*Description*
97003	Occupational therapy evaluation
97004	Occupational therapy re-evalutation
97010	Application of a modality to one or more areas; hot or cold packs
97018	Paraffin bath
97022	Whirlpool
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Code	*Description*
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense posture, and proprioception
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
97504	Orthotics fitting and training and / or upper lower extremities each visit 15 minutes.
97520	Prosthetic training (upper and lower extremities), each 15 minutes
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes
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. **(This procedure requires prior authorization.)**
97542	Wheelchair management / propulsion training, each 15 minutes
97703	Checkout for orthotic / prosthetic use, established patient, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes

NOTE:

Refer to Chapter 14, Durable Medical Equipment, for L codes.

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
99	Other Unlisted Facility

37.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-1500 claim form must be submitted.

Refer to Section 5.7, 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
HCFA-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

38

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

EDS 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.

EDS also enrolls Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician.

A CRNA or AA 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. In this case, the CRNA or AA services are already being paid through that facility's cost report.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as an Anesthesiologist, CRNA, or AA is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for anesthesia-related claims.

NOTE:

All nine digits are required when filing a claim.

Anesthesiologists are assigned a provider type of 01 (Physician). CRNAs and AAs are assigned a provider type of 92 (Anesthesiology). Valid specialties for include the following:

- Anesthesiology (05)
- Anesthesiology Assistant (N7)
- CRNA (C3)

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 with the Alabama Board of Medical Examiners Certificate of Registration and National Commission for Certification of Anesthesiologist Assistants
- Copy of Medicare certification
- Name of employing physician and Medicaid provider number

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 Rule No. 540-X-7-.34 of the Alabama Board of Medical Examiners. The AA must enroll and receive a provider number to bill the Alabama Medicaid Program.

For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. In order to bill for medical supervision, the anesthesiologist must be physically present and available within the operating suite. "Physically present and available" means the anesthesiologist would not be available to render direct anesthesia services to other patients. However, addressing an emergency of short duration or rendering the requisite CRNA or AA supervision activities 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 supervision ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical supervision 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 physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

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 provider number 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. No qualifying factors or Physical Status Modifiers can be billed.

Anesthesia services may include, but are not limited to the following:

- General anesthesia
- Regional anesthesia
- Supplementation of local anesthesia
- 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, the anesthesia care during the procedure, the administration of any fluids deemed necessary by the attending physician, interpretation of non-invasive monitoring to include EKG, temperature, blood pressure, oximetry, capnography and mass spectrometry. Additional claims for such services should not be submitted.

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 the attending physician during a procedure administers regional anesthesia (i.e., nerve block), 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 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.

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.

Qualifying factors may not be billed separately since their allowance has been included in payment of the procedure.

Medicaid does not cover physical status modifiers.

Standby anesthesia is not payable under Medicaid.

NOTE:

Medicaid cannot pay any claims for services provided in connection to a sterilization procedure or hysterectomy for medical reasons unless an approved consent form has been submitted to EDS.

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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

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

➢ 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.

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.

NOTE:

When filing a claim on paper, a HCFA-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 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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 HCFA-1500 claim form.

EDS 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 autoloaded base unit values. The base unit values are derived from the ASARVG for CPT-4 anesthesia codes.

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 directed 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 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.

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.

38.5.4 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

38.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy HCFA-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
HCFA-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 Billing Manual

The **Patient 1st** Billing Manual has been developed by the Alabama Medicaid Agency to explain the policies and procedures of the Patient 1st Billing program. Every effort has been made to present qualified providers a comprehensive guide to basic information concerning coverage of services and billing procedures. This manual is an important part of the **Patient 1st** Program and should be available during Agency visits for review. Providers should also refer to the EDS Provider Insider and the TIPS newsletter regarding any updates on changes within this program.

This manual is not a legal description of all aspects of Medicaid law. It is a practical guide for those providers who participate in the Medicaid **Patient 1st** Program. Should there be a conflict between material in this manual and the pertinent laws, waivers or Administrative Code governing this program, the latter are controlling.

The Patient 1st Advisory Council made several Patient 1st Program recommendations that will be implemented and made effective on July 1, 2001. These changes are noted throughout the manual with an ** mark/ and shaded areas.

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

39.1 Overview

Patient 1st is a managed care program in which certain Medicaid recipients enroll, or are assigned to a primary medical provider (PMP) who manages their health care needs. The PMP is responsible for the provision of primary care, well child check-ups (EPSDT), immunizations, appropriate referrals for specialty services and authorization of specified Medicaid services. In return, for providing medical case management services, PMPs are paid a monthly medical case management fee (exception: Federally Qualified Health Care Centers [FQHCs]). This fee is in addition to regular fee-for-service payments for services rendered. Enrollment is mandatory for all Medicaid beneficiaries except for dually eligible beneficiaries (Medicaid and Medicare), lock-ins, SOBRA eligible adults, institutionalized eligibles, foster children, DYS (Department of Youth Services), and those in another comprehensive plan (e.g., HMO).

The goal of this managed care program is to improve health care for Medicaid recipients by providing a "medical home" while containing the escalating cost of providing quality healthcare.

Patient 1st operates pursuant to a 1915(b)(1) waiver granted in accordance with Title XIX of the Social Security Act. The program was initiated in January 1997 and is operational in all counties.

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 on a continuous basis who wish to participate in the **Patient 1st** Program. 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 Definitions

"Primary Medical Provider (PMP)" - A Medicaid participating physician who practices as a general practitioner, family practitioner, pediatrician, internist or OB/GYN, and has executed an agreement to participate as a PMP. In some cases, a physician type other than those listed, may serve as the PMP if he/she is willing to meet all contractual requirements. Federally Qualified Health Centers and Rural Health Clinics may also serve in this capacity. For purposes of this document, PMP is construed to mean both individual physicians and clinics.

"Primary Care" - Provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

"Patient Management" - Being responsible for the health care management of the recipient with regard to that group of medical services within **Patient 1st**. If not directly provided, medical services that are necessary should be arranged for through referral or authorization by the PMP.

"Emergency Medical Condition" - A medical condition manifesting itself by acute symptoms of severity (including severe pain) such that a prudent lay person, 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 of bodily functions; or
- serious dysfunction of any bodily organ or part.

39.3 Eligible Providers

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.

All PMPs must be currently enrolled Medicaid Providers in good standing PMPs must have hospital admitting privileges or have a written agreement with a physician who has hospital admitting privileges. ****All PMPs must provide to Medicaid a copy of the written agreement or documentation of admitting privileges and notification of any subsequent changes that may occur.**

A participating physician in a clinic or health center can not 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 and schedules 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.

39.4 PMP PARTICIPATION

The following standards must be met in order for providers to be enrolled as a PMP for the Patient 1st Program:

- The PMP must be a licensed physician, enrolled in the Alabama Medicaid Program, who has not been sanctioned.
- The PMP must sign a PMP agreement that delineates program requirements including, patient management, 24-hour coverage, and other requirements.
- 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).
- In order to be considered to carry a caseload, the physician must be at least a minimum of FTE. If a physician is less than full time, a percentage of a total patient caseload will be allowed, based on availability.
- The physicians may have a maximum caseload of 1200.

The PMP must specify what arrangements have been made for hospital admissions. If the PMP does not have admitting privileges, then a designee must be specified. **** PMPs must have a concurrence letter from the hospital with which privileges have been arranged. ** Direct admitting privileges will be verified on an annual basis via random sampling. PMPs with arrangements made will undergo annual verification.**.

PMPs may serve multiple counties and or sites; however, the maximum panel a PMP can serve collectively is 1200, with the minimum being 25. PMPs may specify the number of **Patient 1st** enrollees they will accept per county and/or site. Physician Extenders (Nurse Practitioners and Physician Assistants) will allow the caseload to be extended by 400 additional patients. Only two Physician extenders per physician will be allowed and may only be counted once in a caseload extension.

NOTE:

If a nontraditional PMP has been assigned, based on a case need. The minimum enrollee or full time requirement will not apply.

The written request from the PMP for an extension of the PMP enrollee cap should address, at a minimum, the following:

- The PMP's name and Medicaid number;
- 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 by contacting the Provider Assistance Center at 1-800-688-7989. Requests to exceed the maximum caseload should be sent in writing to Medicaid's Medical Services/Patient 1st Program.

****A PMP's caseload may be exceeded to accommodate sibling assignment, newborn assignment or assignments for previously established patients (last PMP on file).**

39.4.1 General Changes in Panel

If the PMP wishes to decrease the number of enrollees, he/she must notify EDS Provider Enrollment, in writing, at least sixty (60) 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 EDS Provider Enrollment in writing.

Individual or specific recipient additions or deletions must be made in writing to Medicaid's Medical Services/Patient 1st Program.

39.4.2 PMP Disenrollment

A PMP may request to disenroll from the program by giving sixty (60) days notice. (NOTE: Failure to provide a 60-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 EDS with a copy to Medical Services/Patient 1st Program (Fax [334] 353-5556) 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.
- 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.
- 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.

39.4.3 PMP List

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. The PMP list includes the PMP's county(ies) of participation, the PMP's name, specialty, physical address, and phone numbers (regular and 24 hour). This list is sent to all Medicaid recipients to assist them in selecting physicians/clinics serving their county. The PMP list may also be accessed via the Medicaid web site at www.medicaid.state.al.us.

Regardless of publication, the PMP is included in the assignment process if caseload is available and criteria can be met.

39.5 Provider Reimbursement

The PMP (with the exception of FQHCs) is paid a medical case management fee of $3.00 per month for each recipient the PMP has enrolled, as of the first day of each month. The maximum monthly fee amount that may be paid each PMP is $3000. 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 services provided are reimbursed by the current fee-for-service method.

The PMP will be provided a monthly report of all enrollees assigned to the PMP prior to the first of each month. The case management fee will appear as a "rolled-up" claim on the PMP's **EOB**. A "rolled-up" claim is one in which all case management fees are paid as a lump sum under a pseudo Medicaid number. The provider's **EOB** should contain procedure code Z5385 or Z5395 times the number of patients assigned for the month for a maximum payment of $3000. Procedure Code Z5385 is the code used for the payment of the case management fee for existing Medicaid eligible recipients and procedure code Z5395 is the code used for the payment of the case management fee for recipients eligible under the Children's Health Insurance Program (CHIP).

39.6 Monthly Reports of Enrollees

Each month, the PMP will receive two enrollee listings, the Initial Assignment Listing and the Monthly List.

39.6.1 Initial Assignment Listing

This report will list new patients that the Agency has assigned for a future date (usually 45 days). The PMP should use this list to gauge caseloads, ensure that all patients can be serviced, and to determine if any patients have previously been dismissed. This list is not final, as the patient will have until the 15th of the month proceeding the enrollment date to change.

39.6.2 Monthly Enrollee Listing

This list is broken into four reports: new, continuous, deleted enrollees, and a cover sheet report indicating caseload status. The first of each month, the PMP will receive a listing of all enrollees that are the responsibility of the PMP for the month, as well as those that have been added or deleted. The list of continuous enrollees should be compared to the monthly case management fee. These reports should be reviewed prior to the 1st of the month in which the dates become effective.

NOTE:

This list is not a substitute for eligibility verification. All providers should always verify Medicaid eligibility prior to rendering services.

The Deleted Enrollees list indicates the reason the recipient was deleted from the PMP's Panel. The reason codes are listed below for reference.

- FF - Recipient restricted
- FA - Recipient changed to an ineligible aid category, deprivation reason or age group
- FC - Recipient moved out of an eligible county
- FD - Recipient is deceased
- FE - Recipient is not Medicaid eligible
- FH - Recipient is covered by a private HMO
- FM - Recipient is receiving Medicare
- FN - Authorized by Medicaid

39.7 Monthly Caseload Report

This report will give the PMP an indication of the number of patients currently assigned to their panel and available caseloads per county. This report is helpful to the PMP in making a determination as to whether caseload adjustment is needed. Refer to "General Changes in Panel" for instruction on making caseload changes. This report is used for informational purposes only.

39.8 Eligible 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:

- 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 who have been determined to be Medically Exempt for the Patient 1st Program;
- Recipients with dual eligibility (Medicare and Medicaid).

Recipients are removed from **Patient 1st** participation if they are changed to an excluded aid category, or if they lose eligibility or change county 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 Customer Service Unit at **(334) 242-5524**. An example may be a child who is truly in foster care but who is certified for Medicaid through SSI. This child should not be enrolled but is due to how the system recognizes aid categories.

Eligibility verification indicates enrollment status and assigned PMP name and telephone number.

39.9 Recipient Enrollment/Assignment

39.9.1 Enrollment

To facilitate enrollment into the Patient 1st Program, recipients required to participate are assigned a PMP. Federal law requires that recipients be given 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 B. 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. A second notification will be mailed to recipients approximately 5 days prior to assignment, that will confirm the original assignment if no change is made, or confirming the requested change. Providers will be notified at the same time as recipients of assignments, effective the 1st of the next month. 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.
- **Sibling** Will check 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 sibling will be assigned to the PMP of the youngest sibling.
- **Last PMPon file** will be checked. If caseload and age criteria can be met, then assignment will be made to that PMP.
- **Historical claims history** will be considered for 18 months.
- **Random assignment based on PMPs within the recipient's county** as long as caseload is available and age criteria can be met.
- Random assignment is predicated on lowest available caseload on a rotating basis.

39.9.1.1 Newborns

Mothers of infants who will be required to participate in the program have the opportunity to select prior to assignment by the Agency they want for their child's PMP. 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, the hospital and Medicaid's Outreach and Education Unit. The form must be completed and submitted prior to the Agency's assignment of the infant. At the time of birth, the information is transmitted to EDS to be considered in the assignment process. In order for the request to be granted, age criteria must be met and the PMP must have available caseload for the recipient's county.

NOTE:

Reports should be submitted during the expected month of delivery. ** Newborn assignments, sibling, and last PMP on file assignments may override maximum caseload.

39.9.2 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 Eligibility Verification and Claims Submission (AEVCS) may be accessed by dialing 1-800-727-7848 using a true touch tone telephone. This is an automated telephone system available approximately 21 hours a day, 7 days a week.
- The Provider Communications Unit at EDS can be reached at 1-800-688-7989 from 7:30 am – 5:00 pm, Monday through Friday.

The verification will give contact information for the recipient's assigned PMP.

Patient Recruitment

PMPs are encouraged to educate patients about the PMP's participation in **Patient 1st**. PMPs should not recruit patients, but are encouraged to let patients know of their participation in the program. This includes, but is not limited to, door to door marketing, employment of marketing personnel who work on a commission and payment or reward to those recipients choosing the PMP. The Agency has available outreach material upon request.

Recipients Changes of Primary Medical Providers

Recipients always have the ability to change their PMP to their provider of choice. Recipients can change PMPs by calling the 1-800 line, 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 a 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. ****If changes are not received by the 15th of the month, assurances for an effective date for the first of the following month can not be given.** Please see Appendix E 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.

PMP Request Change/Dismissal of Recipient

A PMP may request removal of a recipient from his panel. All requests for patients to be removed from a PMP's panel should be submitted in writing. The request should contain documentation as to why the PMP does not wish to serve as the patient's PMP. Reasons may include: a mutually undesirable relationship, patient's condition or illness would be better treated by another physician, patient behavior of which intervention has had no positive impact, poor patient compliance of which intervention has had no positive impact, and others as may be identified on a case-by case basis.

A letter of dismissal from the PMP should be included as an attachment to documentation provided to Medicaid. The dismissal letter should be addressed to the patient and signed by the PMP. Medicaid will include that letter along with internal notes to the Customer Service Unit, who will review each request. 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. If a patient has been dismissed three times, the patient will be notified that the Agency will only pay for emergency care. The patient will have the responsibility of finding a physician and notifying the Agency of that physician. The original PMP will also be notified of the change and the effective date.

The original PMP must continue to provide services to the recipient until such time the reassignment is complete. All reassignments will be made effective the 1st of a month.

Mass Reassignment

Patient 1st enrollees are 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. Another Scenario for Reassignment is two Locations in Same Area. 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 and private practice site.

PMP Leaves Group Practice

If it is a situation of a PMP leaving the area, then patients will be reassigned to the remaining practitioner.

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.

39.9.3 Referral and Authorization Process

PMPs may make referrals to any practitioner that can best meet the patient’s needs. Every effort should be made; however, to refer patients to Medicaid enrolled physicians to facilitate the reimbursement process.

Authorization Number

Access to services is authorized through use of the PMP's nine digit Medicaid Provider Number. To facilitate the process, and lessen the administrative burden for the physician, the following process are used when processing claims:

Step One (Billing Provider)

- The **PMP** provider number on the claim is compared against the **PMP** provider number 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.

- The unique number of the provider on the claim is compared against the unique number on the PMP file. If they match, the claim continues through Medicaid edits.

Step Two (Referring Provider)

- The referring **PMP** provider number indicated on the claim is compared against the provider number 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.
- The referring **PMP** unique number on the claim is matched against the unique 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 **107**. A **107** denial code means 'Recipient enrolled in the **Patient 1st** Program, services require referral from PMP'.

****When making referrals, the PMP must provide the nine digit Medicaid provider number 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.**

****In extenuating circumstances, on a case by case basis, and after thorough review, Medicaid may determine that an override process may be prudent in some situations. Requests for overrides should be fully explanatory and sent in writing to Medicaid.**

Referral Form

The referral form, included in Appendix E, Medicaid forms, must be used to facilitate the referral. Medicaid requires that the written referral form be used **for each referral authorization given**. The new referral form combines all previous referral forms.

Referral authorization from the PMP must be given prior to patient treatment and the **written referral form must be transmitted to the requesting provider within a 72-hours of the verbal approval. Referrals can be for a 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 provider number. If the PMP is with a Clinic, the referral number is the Clinic's provider number.

****Physician services provided in the inpatient setting will not require a referral. However, the PMP is to be notified when an assigned recipient is admitted to the hospital for coordination and continuity of care concerns.**

The recipient does not have to be seen by the PMP prior to the PMP issuing/approving a referral. Documentation of the referral in the patient's medical record is imperative. When a physician is providing coverage for the PMP (outside of a formal group practice) and services are rendered, the covering physician must provide the PMP with the nature of the services with any follow-up needed for the patient's medical record.

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. No referral can last more than twelve months **(EPSDT Referrals)**. 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.

NOTE:

If the enrollee's PMP changes during the course of a referral, referrals already in place, six (6) months prior, by the former PMP will be honored without obtaining a new referral from the current PMP unless conditions previously mentioned require a new referral be given. For EPSDT referrals already in place, there is a "look back" period of twelve (12) months.

EPSDT Screening

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 EPSDT 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.

39.10 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.

39.10.1 Billing for Referred Services

The nine digit PMP number must be reflected on either the HCFA-1500 by the specialty physician or on the UB-92 if a hospital or outpatient clinic is providing the specialty services. If this field is not properly coded, Medicaid will reject the claim. Please refer to the above section for details on how to bill for referred services.

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.

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 provider number 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.

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 to another **Patient 1st** county and selects another PMP. If the recipient needs medical care and his/her county 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.

Example 3
If an enrollee changes or is changed to another PMP, the PMP, whose name is supplied by calling the Medicaid Automated Eligibility Verification and Claims Submission (AEVCS); Swiping the Medicaid card using the point of service eligibility verification system, or utilizing Provider Electronic Solutions (PES), must continue to provide **Patient 1st** medical case management and authorization of services until the change is effective.

39.10.2 Review of Referred Services Rendered to Patient 1st Enrollees Reports

Each PMP will receive a report of paid services received by his/her enrollees that have been authorized by using the PMP's Medicaid provider number. This report contains: Recipients last name, first initial, Medicaid #, first DOS, Procedure code, Diagnosis code, Consulting provider.

The PMP is responsible for reviewing the services provided to each recipient. If any service was not approved and/or is determined not to be medically necessary, the PMP must report this finding to Medicaid's Quality Assurance Division. Appropriate action will be taken upon further investigation of the claim.

39.10.3 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 service that require a referral and services that **do not** require a referral.

39.11 Complaint / Grievance Process

39.11.1 Filing a Complaint or Grievance

Enrollees can file complaints or grievances through the 1-800 Recipient Inquiry telephone line or in writing. Providers can file complaints or grievances through Medicaid's Customer Service Unit at (334) 242-5524 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 Medical Services/Patient 1st 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.

39.11.2 Grievance Log

Medicaid will maintain a log of the grievances received and their disposition. Grievances will be "categorized" (e.g., provider assignment, lack of access, travel hardships, etc.) as a tool by which to assess program impact.

39.12 Medicaid Benefits

39.12.1 Benefits

Patient 1st enrollees have the same range scope, amount of services and copayments 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. The **Patient 1st** Program does not extend or supersede any existing program benefit or program requirement. Appendix E is a matrix of what services **will** and **will not** require referrals.

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.

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PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL 5/02/01

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
Dental	M DE	Dentists & Federally Qualified Health Centers (Claim Type DE only), Clinics- Children's Dental/Orthodontia and Orthodontists Procedure Codes: 08080 (Comprehensive orthodontal treatment of adolescent dentition), 08680 (Orthontic retention-removal of appliances, construction/placement of retainers), 09430 (Office visit for obs services during regular hours)
Dialysis	OP	Dialysis Centers
EEG/EKG Related Services	M OP	Procedure Codes: 93000-93278 (Routine ECG w/at least 12 leads w/interpretation & report), 95805-95827 (EEG related services)
End Stage Renal Disease	M	Nephrologists Diagnosis Code: 585 (End Stage Renal Disease)
EPSDT Intensive Evaluation	M	Procedure Codes: Z5199-Z5200 (EPSDT Assessment-Normal/Abnormal Findings); 96110 & 96111 (EPSDT Intensive Development Screenings) eff 1/1/01 **NOTE: Other EPSDT requires referral**
Eye Exams, non-medical	M	Optometrists Procedure Codes: 92002-92015, 92313 (Corneoscleral lens) NOTE: Opthalmological 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 (HCFA Assignment of Vision Services), Z5392 (Bacara 207), Z5321 (Bacara 226), Z5159-Z5172 (Hart: Blvd 4017 Metal), Z5164, Z5165, Z5168 deleted 11/15/00; Z5135-Z5144(Hart: Blvd 3112 Metal), Z5151-Z5152 (Blvd 4502/4508), Z5397-Z5399 (Nino Girls), Z5273-Z5293 (Bacara III Women), Z5283, Z5398 deleted 11/15/00, Z5180 (Special Order Frames), Z5193 (Blvd 4509), Z5196-Z5198-Men (Blvd 4511/4517/1104), 92315-92317 (Corneal Lens/Corneosclera Lens) 92325-92326 (Modification/replacement of Lens), 92370 (Repair of spectacles)
Factor 8	ANY	Procedure Codes: Z3277 (Anti-Inhibitor Coagulant Complex), Z3282 (Factor IX Complex-Per IU)

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL 5/02/01

Service	Claim Type	System Identification
Family Planning • Inpatient Hospital • Medical Outpatient	M IP O	Inpatient Hospital: Family Planning Indicator (Y) - Procedure Codes: 6651-6652 (Removal of fallopian tubes), 6663 (Bilateral partial salpingect), 6621-6639 (Bilateral endoscop ligat & crushing of fallopian tubes), 6370-6373 (vasectomy), 9771 (removal of contraceptive device), 9773 (removal of diaphragm), 697 (insertion of contraceptive device), 9617 (insertion of diaphragm), 9724 (replacement/refitting of diaphragm) Diagnosis Codes: V25-V2590 (Contraceptive Management) 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), Z5181-Z5184 (Initial visit), Z5189-Z5190 (Birth control pills), Z5269-Z5272 (Adolescent pregnancy prevention education), Z5319-Z5320 (Hormonal IUD), 11975-11977 (Insertion/Removal of contraceptive capsule), 55250 (Vasectomy), 55450 (Ligation: vas deferens), 58670-58671 (Laproscopy), 57170 (Diaphragm fitting), Z3208 (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), A4259 (Lancets, per box) NOTE: Requires prior authorization
Gynecology/Obstetrics	M OP	OBGYN-Any service performed by this specialty is exempt from referral requirement.
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
Hospice	OP	Hospice
Immunizations	M OP	Administrative Fees for Procedure Codes: 90700-90748 (Immunization, Active DTAP for intramuscular use), 90645 (HIB Vaccine), 90647-90648 (HIB Vaccine), 90657-90658 (HIB Vaccine), Z3282 (Factor IX Complex, per IU), Z1501 (Rhogham Serum), Z2439 (Pneumovax 23), Z2545-Z2546 (Pnu-Imune 23), Z2708 (Fluzone), Z2771-Z2798 (DT Toxoid), Z2894 (Fluzone-Subviron), Z2901-Z2902 (Recombivax-Hep B), Z2906-Z2908 (Haemoph B Prohibit), Z3013-Z3014 (Hepatitis B-Energix B), Z3276-Z3277 (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	IP	Hospital NOTE: Effective 7/1/01 physician hospital visit codes for inpatient care do not require PMP referral

PATIENT 1ST SERVICES NOT REQUIRING PMP REFERRAL 5/02/01

Service	Claim Type	System Identification
Laboratory	M	Independent Labs & Hospitals-(Claim Type OP) - Outpatient Hospital Lab Services-Procedure codes: 36415 (Routine Venipuncture), 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	IP	Nursing Homes & ICF-MR Facilities
Maternity Care Program	M	Maternity Care Program-Primary Caregiver
Maternity Services	M IP OP	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
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 IP OP	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);
Targeted Case Management	M	Targeted Case Management EXCEPTION: Targeted Case Management for the Medically at risk

PATIENT 1ST SERVICES REQUIRING PMP REFERRAL 5/02/01

Service	Claim Type	System Identification
Ambulatory Surgical Center	OP	Lithotripsy other than physicians and centers NOTE: Includes Ambulatory Surgical Centers and Lithotripsy
Anesthesia	M	Physicians EXCEPTION: Anesthesiologists
Audiologists' Services	M	Audiologists
Chiropractor Services	M	Chiropractors
Clinics	M DE	Clinics EXCEPTION: Children's Dental & Children's Orthodontia (Orthodontist) Procedure Codes: 08080 (Comprehensive orthodontal 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
EPSDT Screenings	M	Procedure Codes: Z5115-Z5116 (EPSDT Screening-normal), Z5154-Z5155 (Periodic EPSDT Screening-normal), Z5316-Z5317 (EPSDT Vision Screening), 99391-99395 (Preventive Medicine Svcs)
FQHC Services (Federally Qualified Health Center)	M	FQHCs EXCEPTION: Family Planning Indicator (Y)
Home Health	IP	Home Health Providers
Independent Nurse	M	Independent Nurses
Nephrology	M	EXCEPTION: Nephrologists-Diagnosis Code: 585 (End Stage Renal Disease (ESRD))
Optometrist/Optician Svcs	M	Optometrists/Opticians), for medical diagnosis.
Other	M	Provider Type: 99
Other Medical Services	M	Type of service: 09
Outpatient Hospital Services	M OP	Hospitals-Procedure Codes: 99281-99285, outpatient surgical procedures and therapies (PT, ST and OT) and observation beds (non-certified) EXCEPTION: Outpatient Hospital Radiology (procedure codes: 70010-79999); Outpatient Hospital Lab Services (procedure codes: 36415, 80048-89399); Outpatient Hospital Chemotherapy (procedure codes: 96400-96549)
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 Phyisicians
Podiatrists' Services	M	Podiatrists
Private Duty Nurse	OP	Private Duty Nurses
Psychologists' Services	M	Psychologists
Rural Health Clinics	M	Rural Health Clinics
Targeted Case Management for the Medically at Risk	M	Procedure Codes: Z5413 (medical), Z5449 (dental) NOTE: Requires referral from PMP or dental provider
Therapists' Services	M	Physical Therapists, Occupational Therapists and Speech Therapists

39.12.2 Emergency Services

Access to emergency services will not be restricted by the **Patient 1st** Program. Certified emergencies in outpatient emergency room settings do not require prior authorization by the PMP. However, documentation should be maintained by the provider of service to support emergency certification.

39.12.3 EPSDT Services

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.

In situations where a PMP has authorized another provider to perform EPSDT services, the patient's medical record must contain documentation of such services. Documentation must include: the date the service was provided, nature of the service, who provided the service and the findings. In Appendix E there is a form that can be used to document such services. Actual service documentation (e.g., weight, height, etc.) should be maintained in the medical records of the actual provider of service.

PMP's are required to have a tracking system in place to ensure that EPSDT services are being rendered appropriately and within the specified timeframes. If a PMP has requested that another provider perform the screening then documentation must be maintained by the screener and the PMPs for tracking of service to assure that the child is up to date on screenings. The attachment can also be used for this purpose. Please refer to Agency oversight procedures.

39.12.4 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**. Please refer to for Agency oversight procedures.

39.13 Targeted Case Management for Medically at Risk

Targeted case management (TCM) supports, supplements and enhances the full and appropriate use of the services provided by the PMP by assisting the recipients to comply with their medical regime and by removing barriers to care in order to promote more positive health outcomes and avoid adverse responses, behaviors, and conditions.

Targeted case management services are provided under the Alabama Medicaid State Plan in accordance with 42 CFR Part 433; Section 1915(g) Social Security Act, Title XIX. Section 1915(g) of the Social Security Act defines case management services as "Services which will assist individuals, eligible under the Plan, in gaining access to needed medical, social, educational and other services."

TCMs do not treat or medically manage patients. Medical management and treatment of patients is the responsibility of the PMP. Social workers and nurses serving as TCMs enhance the medical care being provided by the PMP by utilizing their assessment and therapeutic skills to address social, emotional, behavioral, and environmental circumstances which are barriers to health care.

The following are the core elements of case management services:

- Needs Assessment
- Case Planning
- Service Arrangement
- Social Support
- Reassessment/follow-up
- Monitoring

Targeted case management is based on a comprehensive assessment of the patient/family's ability to address their health conditions. This assessment looks at individual/family strengths and needs and leads to the identification of risks that are relevant to full and appropriate use of primary health care services and the practice of healthy behaviors. Targeted case management helps ensure that patients/families have access to health care services and get the maximum benefit from those health care services.

If you are interested in accessing these services for your patient, please contact your local health department

39.14 Patient 1st Billing Instructions

This section provides billing instructions specific to Patient 1st and EPSDT referred services. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

- Enter referring PMP's nine-digit provider number in block 2
- Enter **"X2"** indicating Patient 1st in block 24

If you file electronically on the **UB-92** using EDS Provider Electronic Solutions software, you must enter **"A1"** in Condition Code field on the Header 3 tab and the PMP's Medicaid number in the Referring Physician field on the Header 2 tab.

If you file hard copy claims on the **HCFA-1500**, you must complete the following fields:

- Enter the name of the referring Primary Medical Provider (PMP) in block 17.
- Enter referring PMP's nine-digit provider number in block 17a.
- Enter **"3"** indicating Managed Care in block 24h.

If you file electronically on the **HCFA-1500** using EDS Provider Electronic Solutions software, you must enter **"E"** in the EPSDT/Family Planning field on the Services tab and the PMP's Medicaid number in the Referring ID # field on the Header 2 tab.

EPSDT and Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

- Enter referring PMP's nine-digit provider number in block 2.
- Enter **"X3"**indicating EPSDT and Managed Care in block 24

If you file electronically on the UB-92 using EDS Provider Electronic Solutions software, you must enter **"A1"** in Condition Code field on the Header 3 tab and the screening provider's Medicaid number in the Referring Physician field on the Header 2 tab.

If you file hard copy claims on the **HCFA-1500**, you must complete the following fields:

- Enter the name of the referring Primary Medical Provider (PMP) in block 17.
- Enter referring PMP's nine-digit provider number in block 17a.
- Enter **"4"** indicating EPSDT and Managed Care in block 24h.

If you file electronically on the **HCFA-1500** using EDS Provider Electronic Solutions software, you must enter **"B"** in the EPSDT/Family Planning field on the Services tab and the PMP's Medicaid number in the Referring ID # field on the Header 2 tab.

If you have program or policy questions about Patient 1st, contact Medicaid's Medical Services Division's Customer Services at (334) 242-5524.

39.14.1 *Agency Monitoring*

Activities

Quality Assurance oversight of the **Patient 1st** Program will be coordinated by the Medical Services/Patient 1st Program of Medicaid. The Quality Assurance Process is an integral component of the program to ensure its qualitative and quantitative nature. All providers are required to participate in the Quality Assurance Process.

This Program will utilize a variety of sources from both inside and outside the Agency in monitoring the delivery of care, impact of services and overall effectiveness of the **Patient 1st** Program. Major sources of data to be utilized include utilization management reports, client surveys, medical record reviews and other Agency activities.

The Program Manager of Medicaid's Quality Assurance Program will provide the Medical Services/Patient 1st Program with referral reports and enrollee utilization reports to review data. In addition, the Medical Services/Patient 1st Program will periodically use information available from Medicaid's Surveillance and Utilization Review System (SURS), Drug Utilization Review System (DURS) and the Claims Payment System to enhance its review of Patient 1st Physician utilization patterns, and when warranted, to provide feedback to the provider and, in some cases, the enrollee, with regard to inappropriate usage and treatment patterns.

The Medical Services/Patient 1st Program will closely review physician access by monitoring 24 hours, 7 days a week phone coverage, waiting times for appointments**,** complaints, and grievances from providers and recipients. Particular attention will be given to the 24/7-call coverage.

Progressive penalties may be imposed on PMPs who exhibit continuous non-compliant behavior. Specific non-performance language may be found in the Patient 1st Provider Agreement.

39.14.2 Outreach and Education

The outreach and education efforts are coordinated and supported by the Outreach and Education Unit within the Office of the Associate Medical Director. This unit is responsible for coordination and disseminating education materials to both providers and recipients, performing provider visits, provider recruitment, working with communities to identify recipient educational needs and any other activities that supports education efforts.

The Outreach and Education Unit is also responsible for keeping the PMPs apprised of the **Patient 1st** Program through the TIPS newsletter which is published on a quarterly basis.

A PMP may request to schedule an inservice training with the Outreach and Education Unit at any time if the PMP is experiencing billing problems or needs further guidance/training on program procedures and policies in order to ensure that proper Medicaid reimbursement is being made. To request an inservice, the PMP should contact the Medicaid's Outreach and Education Program at (334) 353-5203.

Recipient education has and will continue to be done 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.

Educational efforts undertaken by the Agency will be outlined in the *Medicaid TIPS*. The *Medicaid TIPS* is the newsletter published by the Agency's Outreach and Education Unit to keep managed care providers apprised of the issues related to the Patient 1st Program. In addition, continuous updates will be made to the Medicaid Provider Manual and the *Provider Insider*.

39.15 Obtaining Forms / Educational Materials

To request **Patient 1st** forms, please complete the order form (Appendix E Medicaid forms) and fax to (334) 353-5027 or
Mail the form to:

Alabama Medicaid Agency
Outreach and Education Unit
P. O. Box 5624
Montgomery, Alabama 36103-5624

39.15.1 Medicaid Forms

See Appendix E for the following Medicaid Forms:

Attachment One	Immunization Record
Attachment Two	Alabama Medicaid Agency Referral Forms
Attachment Three	EPSDT Documentation
Attachment Four	Patient 1st Medical Record Review Form
Attachment Five	PMP Change Form
Attachment Six	Newborn PMP Request Form
Attachment Seven	Request For Educational Material

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:

Amputee
Arthritis
Augmentative Communication
Cerebral Palsy
Child Development
Cleft Palate
Club Foot and Hand
Craniofacial
Cystic Fibrosis
Dentistry
Eye
Feeding (OT)
Genetics
Hearing
Hearing Aid
Hemophilia
Inborn Errors of Metabolism
Infant and Toddler Evaluation
Multiple Disabilities
Neurology
Neurosurgery
Orthopedic
Pediatric Surgery
Plastic
Psycho-education
Scoliosis
Seizure
Spina Bifida
Spinal Defromity
Therapeutic Positioning
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

EDS 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 an individual Medicaid provider number with ADRS/CRS identified as payee. Sparks Rehab Center shall submit claims for clinic services to Medicaid under the physician's clinic provider number or (if no physician is present) under the clinic provider number.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a clinic is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for clinic-related claims.

NOTE:

All nine digits are required when filing a claim.

Clinics are assigned a provider type of 24 (Clinics). Valid specialties for clinics include the following:

- Children's Rehab Services (SC)
- EPSDT (E3)
- Hemophilia (SH)
- Orthodontia (V6)
- Radiology Clinics (SR)
- Sparks Rehab Center (SD)
- United Cerebral Palsy (SF)

NOTE:

Physicians affiliated with children's specialty clinics are assigned their own Alabama Medicaid provider number, which links them to the clinic. The provider type for the physician is 24 (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 provider number, and are not assigned individual provider numbers.

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
- 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 clinic aides, 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:

- Amputee
- Arthritis
- Cerebral palsy
- Cleft palate
- Clubfoot
- Craniofacial
- Cystic fibrosis
- Eye
- Genetics
- Hearing
- Hemophilia
- Multi-handicapped
- Neurology
- Neurosurgical
- Orthopedic
- Pediatric surgery
- Plastic
- Scoliosis
- Seizure
- Spina bifida
- Spinal deformity
- 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, and infant/toddler functional evaluation.

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 amputee 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, social worker, and prosthetist 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 Section D.1.3 of the Managed Care appendix 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.

100.5 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.

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 HCFA-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). Medicaid does not cover diagnosis codes preceded by an "E," "M," or "Y." Do not use decimal points in the diagnosis code field.

100.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a 'Z'.

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 following procedure codes have been approved for billing by children's specialty clinics.

Clinic Services

Procedure Code	*Who Can Bill*	*Description*
Z5145	CRS, UCP	Regular Clinic, which includes Craniofacial Clinic, Eye Clinic, Neurosurgery Clinic, Orthopedic Clinic, Pediatric Surgery, and Plastic Clinic
Z5146	CRS, Sparks, UCP	Specialty Clinic, which includes Amputee Clinic, Arthritis Clinic, Clubfoot and Hand Clinic, Craniofacial Clinic, Pediatric Surgery Clinic, Scoliosis Clinic, Urology Clinic, Cerebral Palsy Clinic, Cleft Palate Clinic, Multi-handicapped Clinic, Spina Bifida Clinic, Spinal Deformity Clinic
Z5147	CRS, Sparks, UCP	Interdisciplinary Team Clinic (new patient) – limited to only once per physician per recipient lifetime
Z5148	CRS, Sparks, UCP	Interdisciplinary Team Clinic (established patient) – repeat clinic visits Interdisciplinary Team Clinics include Augmentative Communication Technology Evaluation, Cystic Fibrosis Clinic, Feeding Clinic, Genetics Clinic, Hemophilia Clinic, Infant/Toddler Functional Evaluation, Neurology Clinic, and Seizure Clinic
Z5149	CRS, UCP	Hearing Clinic, Hearing Aid Orientation and Maintenance Evaluation Clinic
D9430	Sparks	Dentistry Clinic

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
Z3276	CRS	Factor VIII
Z3277	CRS	Anti-Inhibitor Coagulant
Z3282	CRS	Factor IX
08080	CRS	Comprehensive Orthodontic Treatment of the Adolescent Dentition (requires prior authorization)
08680	CRS	Orthodontic Retention (removal of appliances, construction, and placement of retainer(s)) (requires prior authorization)
09310	CRS	Consultation

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:

- Form XIX-TPD-1-76
- 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
HCFA-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

EDS 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.

Provider Number, Type, and Specialty

Medicaid issues county health departments a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursement for health department-related claims.

NOTE:

All nine digits are required when filing a claim.

County health departments are assigned a provider type of 30 (County Health). Valid specialties for county health departments that employ physicians include the following:

- Family Planning (F1)
- Environmental Lead Assessment (L4)
- EPSDT (E3)
- Immunizations (V8)
- Primary Care Clinic (PC)
- Prenatal Clinic (MI)
- Preventive Education (P9)

County health departments that are enrolled to provide hospice services are assigned a provider type of 47 (Hospice). The valid specialty is Hospice (H6).

County health departments that are enrolled to provide home health services are assigned a provider type of 14 (Home Health). The valid specialty is Home Health (H3).

NOTE:

Physicians affiliated with county health departments are assigned their own Alabama Medicaid provider number, which links them to the health department. The provider type for the physician is 30 (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 provider number, and are not assigned individual provider numbers.

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 Family Planning

County health departments providing family planning services should refer to Appendix C, Family Planning, for specific benefits and limitations.

The following family planning services are covered in county health departments:

Procedure Code	*Covered Service*
11975	Implant insertion
11976	Implant removal
11977	Implant removal with reinsertion
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)
57170	Diaphragm fitting with instruction
58300	IUD insertion
58301	IUD removal
99401	HIV pre-test counseling service
99402	HIV post-test counseling service
Z3208	Depo-Provera injection
Z5181	Initial visit
Z5182	Annual visit
Z5183	Periodic visit

Procedure Code	Covered Service
Z5184	Home visit
Z5189	Oral contraceptive pills
Z5190	Extended contraceptive counseling visit
Z5245	Collection of PAP smear and specimen
Z5270	Norplant capsules
Z5272	Implant physical with counseling visit
Z5319	Hormonal IUD (Progestasert)
Z5320	Mechanical IUD (Paraguard)

Refer to Appendix C, Family Planning, for family planning diagnosis codes.

101.2.3 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.

County health departments providing prenatal services should contact the Medicaid Managed Care Customer Service Unit at (334) 353-5773 for information on billing the following procedure codes:

Procedure	Description
Z5185	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.
Z5195	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.

101.2.4 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
Z5267	Prenatal Parenting Education – Limited to pregnant female recipients. Limited to diagnosis code V2200.
99412	Adolescent Pregnancy Prevention Education – Limited to recipients ages 10-20. Limited to diagnosis code V2509.

101.2.5 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.

County Health Departments may bill procedure code Z5379, Environmental Lead Assessment.

101.2.6 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.

101.2.7 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.

101.2.8 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.

101.2.9 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 provider number 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.

101.2.10 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 Appendix D Managed Care, for more information on obtaining a referral through the Patient 1st Program.

101.4 Cost Sharing (Copayment)

The copayment amount is $1.00 per visit including crossovers. The copayment does not apply to services provided for pregnant women, nursing home residents, recipients less than 18 years of age, emergencies, and family planning.

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

➢ 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.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When an attachment is required, a hard copy HCFA-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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

101.5.3 Procedure Codes and Modifiers

Medicaid uses the HCFA 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

The locally assigned codes issued by Medicaid are five-position, alphanumeric codes beginning with a ‘Z’.

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.

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:

- Form XIX-TPD-1-76
- 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
HCFA-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
Managed Care	Appendix D
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

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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 provide 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a ICF-MR facility is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for ICF-related claims.

NOTE:

All eight characters are required when filing a claim.

ICF-MR facilities are assigned a provider type of 12 (Intermediate Care Facility). The valid specialty for ICF-MR facilities is Intermediate Care Facility (W4).

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, not to exceed 14 consecutive days at any time.

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/Mental Retardation (DMH/MR).

DMH/MR 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
- Has a financial interest in any 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/MR 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 monitors the admission and discharge system and maintains a record for each active patient in the ICF-MR.

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

To obtain medical need for admission or continued care in an ICF-MR, the ICF-MR facility must submit an application packet within 60 days from the date Medicaid coverage is sought.

The application packet contains the following:

- A fully completed written application form 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-92 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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-92 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
HCFA-1500 Claim Filing Instructions	Section 5.2
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Managed Care	Appendix D
Outpatient Hospital/ASC Procedure List	Appendix I
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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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, the Division of Special Education Services (DSES), 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:

(a) 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.

(b) 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.

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.

103.1 Enrollment

The LEA itself does not qualify as a Medicaid provider. However, if the LEA and the provider (professional staff) are willing to work out an agreement under which the provider reassigns payment to the LEA, and the LEA accepts the provider's responsibility, then the LEA may receive payment for services provided by the professional staff. The professional staff who meet Medicaid provider qualifications must be separately qualified and enrolled as a Medicaid provider and must have a separate provider number.

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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid to provide service in a local education setting is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for LEA-related claims.

NOTE:

All nine digits are required when filing a claim.

Service providers are assigned a provider type of 21 (Therapies) or 20 (Audiology/Hearing Services). Valid specialties for providers include the following:

- Audiology (64)
- Speech therapy (T2)
- Occupational therapy (T6)
- Physical therapy (T1)
- School-based therapy (SB)
- EPSDT/QMB (EQ)

Enrollment Policy for Service Providers

Qualified service providers (speech pathologists, physical therapists, occupational therapists, or audiologists) must be enrolled in the Alabama Medicaid Program before billing for services provided to any eligible Medicaid recipient.

NOTE:

Providers must furnish the renewal card showing the licensure number and expiration date to EDS each year to verify continued licensure.

Provider Qualifications

Service providers participating with LEAs must meet the qualifications listed in the following table:

Provider	***Qualifications***
Occupational Therapist	• Be registered by the American Occupational Therapy Association • Be licensed as an occupational therapist in the State of Alabama
Physical Therapist	• Be a graduate of a program of physical therapy approved by both the Council on Medical Education and the American Medical Association **and** the American Physical Therapy Association or its equivalent • Be licensed as a physical therapist in the State of Alabama
Speech Pathologist	• Be licensed as a speech pathologist by the State of Alabama
Audiologist	• Be licensed as an audiologist by the State of Alabama

103.2 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 discusses guidelines and requirements for the following LEA topics:

- Record Keeping Requirements
- Progress Notes
- Recipient Signature Requirement
- Parental Consent Requirements
- Sample Parental Consent Form
- Guidelines For Obtaining Parental Consent and Billing Information
- Sample Form Letter

103.2.1 Record Keeping Requirements

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:

- The EPSDT Screening Referral Form
- The Physician's written prescription/referral for occupational therapy, physical therapy, speech pathology, and/or audiology services (If the EPSDT screening is signed by a physician and the reason for the referral is for therapy, then the signed EPSDT screening referral form constitutes the written prescription; however, if the EPSDT screening referral form is not signed by the physician, then a physician's written and signed prescription is required.)
- A copy of the original and all updates of the Individualized Education Program (IEP) pertaining to therapy/pathology/audiology services
- A copy of the Student Enrollment/Parental Consent Form
- Description of specific therapy/pathology/audiology services and activities provided with the date, the actual time services and activities were rendered, and the name of the therapist/pathologist/audiologist providing services and activities

- Dated updates/progress notes describing the student's progress, or lack thereof, signed or initialed by the therapist/pathologist/audiologist providing services and activities
- Attendance record
- Discharge notes/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.

103.2.2 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.

103.2.3 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

103.2.4 Parental Consent Requirements

If a student has Medicaid or other medical insurance coverage, the LEA must obtain written permission to submit claims in order to access the benefits of the insurance coverage. The "Parental Consent for Filing Insurance Claims, Assignment of Insurance Benefits, and Release of Information Form" (referred to as "Consent Form") has been developed for this purpose.

In order to submit any type of insurance claim, including Medicaid, permission must be obtained in the form of a signed parental consent form for **each student** in the family. In all cases, the consent form must be signed by an individual who is able to authorize the LEA to access the child's health benefits and to release information about the child. In most cases, this individual will be the child's parent or guardian. If the child's parents are separated or are divorced and a court has awarded joint custody, both parents may need to sign the consent form. If the child is a foster child with a surrogate parent, the Department of Human Resources' representative is considered the legal parent or guardian and must sign the parental consent form.

Additionally, if the child is covered under private individual or group health insurance, the consent form must be signed by the insured or someone authorized to sign on behalf of the insured for each insurance policy. The individual may or may not be the same individual who is authorized to sign on behalf of the child. It is the responsibility of the LEA to determine who must sign each child's consent form and to obtain the needed signatures.

If a student does not have third party insurance coverage and his/her parent or guardian is unwilling or unable to obtain Medicaid coverage or if the parent denies permission to access coverage, the services cannot be billed to Medicaid. Denials and statements of no medical insurance or entitlement coverage should be documented by the LEA in the child's records.

NOTE:

A lack of Medicaid/third party coverage or denial of permission to access coverage in no way releases the LEA from its responsibility to provide services to the child.

103.2.5 Parental Consent Form for Filing Insurance Claims, Assignment of Insurance Benefits, and Release of Information

I agree to permit the school system to submit claims for my child to my insurance carrier or other benefits program (such as Medicaid) through the Medicaid/Third Party Billing Program.

I understand that I do not have to make use of my insurance, and by allowing the school system to submit claims to my insurance carrier there is the possibility that I might face a financial loss, which could include:

- A decrease in available lifetime coverage or any other benefit under an insurance policy
- An increase in premiums
- The discontinuation of a policy

I understand that the school system uses the State Department of Education as its agent to submit medical benefits claims for payment of health-related special education services. I authorize my insurance carrier or other benefits program to communicate directly with the State Department of Education for the school system. I request that payment of authorized services be made on my behalf to the State Department of Education as agent for the school system.

I authorize the release of any information, including medical records, necessary to process the claims for benefits. I authorize the school system or its agent to release information, including medical information, about my child that is necessary to process a claim to the insurance carrier or other benefit program as applicable. A photocopy of this authorization shall be considered as valid as the original.

I am aware that the school system is responsible for providing services necessary for my child's education at no cost to me. I understand that my permission is not necessary in order for my child to receive services and that I may revoke this permission at any time.

As parent or guardian of _____
(print full name of student)

(1) my permission **is granted** voluntarily.

_____ _____
(Signature of Responsible Party) Date

_____ _____
(Signature of Insured if different from Responsible Party) Date

(2) my permission is **not granted**.

_____ _____
(Signature of Responsible Party) Date

103.2.6 Guidelines For Obtaining Parental Consent and Billing Information

It is recommended that the LEA carefully consider the course of action it will take in counseling the parents or guardians of children receiving special education services when discussing the issue of access to Medicaid or private insurance coverage. Please keep in mind that potential liability of creating a financial loss for the parents has existed, exists now, and will continue to exist for all LEAs who access private insurance coverage. No statement the Division of Special Education Services (DSES) could design can absolve the LEAs of this potential liability. However, DSES suggests LEAs use the following approach to obtain parental consent and billing information:

LEA mails letter to parents.
Mail a letter to the parents or guardians of the student receiving medically related services, informing them of the Medicaid/Third Party Billing Program. (See Section 103.2.6, Sample Form Letter.)

LEA schedules an interview with student's parents or guardians.
The purpose of this interview is to (1) discuss the billing program with the parents, (2) obtain authorization to submit insurance claims for the services provided to the child, and (3) to obtain the information necessary to process claims for the child (Student Enrollment Form).

To avoid confusion, advise the student's parents/guardians to bring their insurance card(s) and/or other insurance documentation to the meeting. This interview could be conducted at the same time the student's IEP is completed.

LEA interviewer requests authorization to submit insurance claims.
Although the interviewer is expected to use his/her professional judgement concerning the timing and manner in which the information and consent are requested, the following sequence of steps is suggested:

- Explain the Medicaid/Third Party Billing Program. With reference to Medicaid, you should explain that there are no benefit limitations, deductibles, or co-insurance payments for Medicaid coverage and that the billing for these services will in no way affect their coverage.

  With reference to third party insurance, you may want to consider negotiating with the parents or guardians by offering to help limit expenses:

  - Pay the deductibles or coinsurance payments for the claims filed by the school system
  - Repay funds collected that reduce the lifetime cap when lifetime caps are threatened or funds are needed by other health providers
  - Place a cap on the amount of funds that the school system will access from the private insurance during a school year
- Ask whether the student has third party insurance coverage (Medicaid and/or private insurance).
- Advise the parents or guardians and any other individual whose insurance is involved of their rights with regard to the LEA billing claims against their third party insurers.
- Once the rights of the student, the parents, and the insured have been explained, ask the appropriate individual to sign the consent form.

LEA interviewer obtains information necessary to process claims.
The interviewer may personally complete or assist the parents or guardians in completing the Student Enrollment Form. If possible, examine the child's/family's insurance card(s) or other documentation to verify that coverage has not lapsed and to determine whether the child is covered by more than one third party source. The interviewer is advised to photocopy the insurance card(s).

LEA interviewer refers the child for an EPSDT screening. (Applies to Medicaid-eligible children only)

- Briefly explain EPSDT to the parents or guardians, emphasizing that the screening is simply a free well-child check-up.
- Question the parents to determine if the child is in Medicaid's Managed Care Program Patient 1st. If so, instruct the parents to contact their child's Primary Medical Provider (PMP) to arrange for a screening.
- For children not in a managed care program (for example, foster children, institutionalized children, dual-eligibles, or those in an HMO), allow the parents to choose an EPSDT screener. The interviewer may suggest a particular screener; however, the final choice lies with the parents.
- Call the selected screener for the parents to make an appointment for the screening.
- A sample LEA Referral for EPSDT Screening form has been included in Section 103.2.7, LEA Referral for EPSDT Screening. Although it is not mandatory that LEAs use this form, you may wish to complete the form and send it with the child to the screening. The form may be edited as necessary.
- The child takes the form to the screening and to the physician. The physician refers the child to the school system for treatment.
- Obtain the diagnosis code requested on the Student Enrollment Form from the physician's orders for treatment. If the diagnosis code is not included with the physician's orders, call the physician to obtain the code.

103.2.7 Sample Form Letter

Below is a sample letter to parents or guardians. The letter may be edited as necessary.

NOTE:

Use LEA letterhead when sending this communication to parents.

To: Parents or Guardians of Students Receiving Special Education Services
From:
Date:
Subject: New Initiative—Medicaid/Third Party Insurance Billing

As you know, the school system is responsible for providing your child with special education and related services at no cost to you. Since the amount of public funds expected in the future is uncertain, we are seeking funds for benefits payable through Medicaid and insurance companies in an effort to maintain the highest possible quality of special education services for all disabled students and to ease the burden on public funding. We know that many health-related services provided within the education setting by our professional staff as part of your child's Individual Education Program (IEP) may be paid for by Medicaid and insurance companies. Health-related services may include speech therapy, physical therapy, occupational therapy, and audiological services.

In order for us to submit claims to Medicaid and/or your insurance company, we must ask you if you will grant the school system permission to access your Medicaid and/or private insurance coverage. Carefully consider whether you are willing to grant the school system such consent. In making your decision, consider the following:

(1) Parents and Guardians are encouraged to review their insurance coverage and policy limitation

(2) Granting consent could affect:

- lifetime maximum benefits
- future insurability
- discontinuation of coverage
- premium costs
- annual or service coverage benefits

(3) Granting such consent could is strictly optional on your part.

(4) If you do give your consent, it can be revoked at any time.

(5) If you do not grant consent, your child will receive all special education and related services to which he/she is entitled.

(6) All special education and related services your child receives will be provided at no cost to you.

We are informing you of this new initiative so that you can be aware of it and can expect to be asked whether you will consent to allow the school system to access private insurance and/or Medicaid coverage you might have to assist in meeting the costs of your child's special education program.

If you have any questions about this new initiative, please contact _____*(name)*_____ at ____*(number)*_____ between the hours of _____ and _____, Monday through Friday.

103.3 Prior Authorization and Referral Requirements

LEA 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 Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

EPSDT Requirements

NOTE:

Physical, occupational, and speech therapy services are available as a result of an EPSDT screening referral **only**.

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. The patient's medical records must contain a completed Referral for Services Form that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped.

There are two approved referral for service forms: Form 167 and Form 345. The form number appears on the bottom left corner of the form. See Appendix A, EPSDT, for additional information.

LEA Referral for EPSDT Screening

Date _____

Dear _____:

A new program has been instituted in the local school system to seek reimbursement from Medicaid for health-related special education services provided to eligible students in the schools. To take part in this program, Medicaid-eligible children who receive health-related special education services must receive the following: (1) an EPSDT screening; (2) a physician's orders for treatment; and (3) a referral by the physician *to the school system* for therapy services.

In my professional opinion, _____ (Name of Student) has a _____ disability that calls for therapy services by a licensed _____. As the EPSDT screening is conducted and as physician's orders and referral are issued, please pay special attention to the following conditions:

_____

_____

_____

After these conditions are detected in the EPSDT screening, please refer the student (with this letter) to the physician of his or her choice to receive a prescription for treatment and to be referred to the school system for the actual therapy services. If you have any questions regarding this process, please feel free to contact me at _____.

Thank you so much for helping us out in this process.

_____

Student's Name _____ Date of Birth_____

Parent/Guardian_____

School _____

ICD-9 Diagnosis _____ Diagnosis Code_____

Physician's Signature_____ Date_____

Attach a copy of the Medicaid EPSDT Screening Referral Form and the Physician's orders to this form and return it to Medicaid Billing, Electronic Claims Submission.

103.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by service providers working with LEAs.

103.5 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 HCFA-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.

Performing and Billing Providers

In block 33 of the HCFA-1500 claim form, enter the billing provider number ‘529101730’ and the billing provider’s name ‘Ala State Dept of Edu-DSES’.

In block 24K of the HCFA-1500 claim form, enter the performing provider number (the individual therapist’s number). The individual’s provider number uses the following numbering scheme:

- The first digit of the provider number for an LEA is always zero.
- The second and third digits indicate the kind of provider:

  52 = Speech Pathologist
  64 = Audiologist
  65 = Physical Therapist
  68 = Occupational Therapist

- The fourth, fifth, and sixth digits indicate the LEA system’s number.
- The seventh, eighth, and ninth digits are assigned sequentially to indicate an individual provider within the LEA system.

Reminder Checklist

Parental Consent Form

- Must be signed
- Must be dated
- Responsible party signature and responsible party name must match
- Signature of insured must be completed

EPSDT Referral Form

- Must be a completed form
- Diagnosis(es) box must be completed
- Must be signed by referring physician
- Screening provider number box must be completed
- Consultant's report box must be completed by therapist
- Must be signed by consultant (therapist)
- Services must be provided during the valid months specified on the screening referral

Please note the block approximately one third of the way down the EPSDT Referral form the states, "This referral is valid for _____ months from date of screening. (Maximum of 12 months)".

Patient 1st Referral

- Must be documented in the student's record

Physician's Orders

- Must have prescription written by the physician if the EPSDT referral is not signed by the physician

Progress Notes/Documentation

- Must have progress notes for each date of service
- Notes must be signed or initialed
- Notes must be dated
- Notes must have a beginning and ending time recorded for services that are time-specific

103.5.1 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.

103.5.2 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). Medicaid does not cover diagnosis codes preceded by an "E," "M," or "Y." Do not use decimal points in the diagnosis code field.

The diagnosis code must come from the physician. For Medicaid recipients, the EPSDT screening referral form will have the diagnosis code written out. You may call the physician's office to obtain the ICD-9-CM diagnosis code required by Medicaid and/or private insurance companies. You may also refer to the following listing for some of the most common acceptable diagnosis codes for special education's population.

This listing is not designed to take the place of a doctor's diagnosis. A physician should always diagnose the child's condition.

315 **Specific delays in development** - Excludes those due to a neurological disorder (320.0-389.9)

315.00	Reading disorder, unspecified
315.01	Alexia
315.02	Developmental dyslexia
315.09	Other – Specific spelling disorder
315.1	Specific arithmetical disorder Dyscalculia
315.2	Other specific learning difficulties *[Excludes Specific arithmetical disorder (315.1) and Specific reading disorder (315.00-315.09)]*
315.31	Developmental speech or language disorder Developmental aphasia Word Deafness *[Excludes Acquired aphasia (784.3) and Elective mutism (309.83, 313.0, 313.23)]*
315.39	Other Developmental articulation disorder Dyslalia *[Excludes lisping and lalling (307.9) and Stammering and stuttering (307.0)]*
315.4	Coordination disorder Clumsiness syndrome Dyspraxia syndrome Specific motor development disorder

317 **Mild mental retardation**

317	High-grade defect Mild mental subnormality IQ 50-70

318 **Other specific mental retardation**

318.0	Moderate mental retardation Moderate mental subnormality IQ 35-49
318.1	Severe mental retardation Severe mental subnormality IQ 20-34
318.2	Profound mental retardation Profound mental subnormality IQ under 20

389 **Hearing loss**

389.00	Conductive hearing loss, unspecified
389.01	Conductive hearing loss, external ear
389.02	Conductive hearing loss, tympanic membrane
389.03	Conductive hearing loss, middle ear
389.04	Conductive hearing loss, inner ear
389.08	Conductive hearing loss of combined types
389.10	Sensorineural hearing loss, unspecified
389.11	Sensory hearing loss
389.12	Neural hearing loss
389.14	Central hearing loss
389.18	Sensorineural hearing loss of combined types
389.7	Deaf mutism, not elsewhere classifiable Deaf, non-speaking

Other Codes

299.00	Autistic behavior
307.00	Stuttering and stammering
388.12	Noise-induced hearing loss
388.30	Tinnitus
388.40	Abnormal auditory perception
388.43	Impairment of auditory discrimination
714.0	Rheumatoid arthritis and other inflammatory polyarthropathies [Excludes rheumatic fever (390) Rheumatoid arthritis of spine NOS (720.0)]
714.30	Polyarticular juvenile rheumatoid arthritis, chronic or unspecified
784.41	Aphonia Loss of Voice

749.0 Cleft palate

749.00	Cleft palate, unspecified
749.01	Unilateral, complete
749.02	Unilateral, incomplete Cleft uvula
749.03	Bilateral, complete
749.04	Bilateral, incomplete

749.1 Cleft lip

749.10	Cleft lip, unspecified Notched lip, congenital
749.11	Unilateral, complete
749.12	Unilateral, incomplete
749.13	Bilateral, complete
749.14	Bilateral, incomplete

749.2 Cleft palate with cleft lip

749.20	Cleft palate with cleft lip, unspecified
749.21	Unilateral, complete
749.22	Unilateral, incomplete
749.23	Bilateral, complete
749.24	Bilateral, incomplete
749.25	Other combinations

103.5.3 Procedure Codes and Modifiers

Local education agencies 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 services in this section may be covered by Medicaid when provided by an authorized provider according to an Individualized Education Plan (IEP) and when **all** of the following conditions have been met:

1. The student is eligible for Medicaid.
2. The student is screened by an EPSDT Medicaid screening provider with the condition documented relating to the services. The EPSDT referral form is only good for services for the valid time period on the form. It is not automatically valid for one year. (Not applicable for audiology services)
3. The student is referred for treatment of the condition discovered as a result of the screening. (Not applicable for audiology services)
4. The treatment is ordered/prescribed by a physician.
5. The pathologist, therapist, or audiologist providing the treatment is enrolled as a Medicaid provider.
6. The Parent's consent is obtained.
7. If the student is assigned to a Primary Medical Provider (PMP) through the Patient 1st Program, the student must have a referral from the PMP.

The following paragraphs provide a detailed list of covered services, grouped by specialty.

Speech Pathology

Use the following procedure codes for services provided by a qualified speech pathologist for individuals with speech disorders for which a patient is referred by a physician.

Procedure Code	***Description***
92506	Medical evaluation of speech, language, and/or hearing problems
92507	Speech, language or hearing therapy, with continuing medical supervision; individual
92508	Speech, language or hearing therapy, with continuing medical supervision; group
92597	Evaluation for use and/or fitting of voice prosthetic or augmentative/alternative communication device

Physical Therapy

Use the following procedure codes for services prescribed by a physician and provided by a qualified physical therapist.

Procedure Code	***Physical Therapy***
95831	Muscle testing, manual (separate procedure) extremity (excluding hand) or trunk, with report
95832	Hand, with or without comparison to other side
95833	Total evaluation of body, excluding hands
95834	Total evaluation of body, including hands
95851	ROM measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
97001	Physical therapy evaluation
97002	Physical therapy reevaluation
97010	Application of a modality to one or more areas; hot or cold packs
97012	traction, mechanical
97014	electrical stimulation, unattended
97016	vasopnuematic device
97018	paraffin bath
97022	whirlpool
97024	diathermy
97026	infrared
97028	ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97034	contrast baths, each 15 minutes
97035	ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, ROM and flexibility
97112	neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception
97113	aquatic therapy with therapeutic exercises
97116	gait training (includes stair climbing)
97124	Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion). **(This procedure requires prior authorization.)**
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97504	Orthotics fitting and training, upper and/or lower extremities, each 15 minutes
97520	Prosthetic training, upper and/or lower extremities, each 15 minutes
97530	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
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. **(This procedure requires prior authorization.)**
97542	Wheelchair management/propulsion training, each 15 minutes
97703	Checkout for orthotic/prosthetic use, established patient, each 15 minutes
97750	Physical performance test or measurement, (for example, musculoskeletal functional capacity) with written report, each 15 minutes

Occupational Therapy

Use the following procedure codes for services prescribed by a physician and provided by a qualified occupational therapist.

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***
97003	Occupational therapy evaluation
97004	Occupational therapy re-evalutation
97010	Application of a modality to one or more areas; hot or cold packs
97018	Paraffin bath
97022	Whirlpool
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97034	Contrast baths, each 15 minutes
97035	Ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense posture, and proprioception
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
97504	Orthotics fitting and training and / or upper lower extremities each visit 15 minutes.
97520	Prosthetic training (upper and lower extremities), each 15 minutes
97530	Therapeutic activities, direct (one on one) patient contact by the provider, (use of dynamic activities to improve functional performance), each 15 minutes
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. **(This procedure requires prior authorization.)**
97542	Wheelchair management / propulsion training, each 15 minutes
97703	Checkout for orthotic / prosthetic use, established patient, each 15 minutes
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes

Audiology

Use the following procedure codes for services prescribed by a physician and provided by a qualified audiologist.

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

103.5.4 Place of Service Codes

The following place of service code applies when filing claims for LEA services:

POS Code	***Description***
11	Office

103.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Form XIX-TPD-1-76
- Claims With Third Party Denials

Refer to Section 5.7, Required Attachments, for more information on attachments.

103.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-1500 Claim Filing Instructions	Section 5.2
EPSDT	Appendix A
Electronic Media Claims (EMC) Guidelines	Appendix B
Managed Care	Appendix D
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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a psychiatric hospital is issued an eight-character Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for psychiatric hospital-related claims.

NOTE:

All eight characters are required when filing a claim.

Psychiatric hospitals are assigned a provider type of 05 (Hospital). The valid specialty for psychiatric hospitals is Inpatient Psychiatric Hospital Over 65 (W2).

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.

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.

- 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.

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, xray, 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.

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.

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-92.

104.5 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.

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-92 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). Medicaid does not cover diagnosis codes preceded by an "E," "M," or "Y." Do not use decimal points in the diagnosis code field.

104.5.3 Revenue Codes

Refer to the Alabama UB-92 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-92 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-92 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, DPH, DMH

Rehabilitative services are specialized medical services delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness or 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

EDS 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a rehabilitative services provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit claims and receive reimbursements for rehabilitation-related claims.

NOTE:

All nine digits are required when filing a claim.

Rehabilitative services providers are assigned a provider type of 89 (State Rehabilitative Services). The valid specialties for State Rehabilitative Services are:

- Rehabilitative Services - DMH (M2)
- Rehabilitative Services – DHR, DPH, DYS (M8)
- Psychiatry (Psychiatrist only) (26)

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) or (2) and both (3) and (4) below.

1. A provider must be certified or licensed by DMH/MR, DHR, DPH, or DYS and must have demonstrated the capacity to provide the following services either directly or through contract with a certified or licensed provider:

   - Outpatient services that include the following components:
     - A variety of service types such as individual, family, group, medication administration, medication monitoring, and physician services that are available without regard to the age or the severity of the disorder of the client
     - Screening assistance to the courts as evidenced by a written agreement between the provider and the probate court specifying screening procedures for petitions referred by the court
     - Evaluation for admission to state psychiatric facilities as evidenced by written agreements between the provider and the appropriate state hospital specifying procedures for evaluating and coordinating admissions and discharges to state hospitals
     - Emergency rehabilitative services available to the general public that are well publicized within the provider's service area and include 24-hour a day telephone and face-to-face response capability
   - Consultation and education services designed to inform the general public about the nature of rehabilitative services problems and the location of services, to provide consultation to public agencies and private practitioners regarding the treatment of individuals as well as general program consultation, and to provide in-service training to other community resources as requested
   - Residential services including coordination with the Non-Institutional Care and Services (N-ICS) offices of the appropriate state hospital relative to discharge planning and service provision for persons discharged from state hospitals
   - Inpatient services through referral to community hospitals and through the attending physician for community hospitalizations
   - Case management services as defined in Chapter 40 of the *Alabama Medicaid Agency Administrative Code*
   - Mental illness intensive day treatment services
   - Mental illness rehabilitative day services
   - Substance abuse services including intensive outpatient services and residential services

   2. The Department of Human Resources (DHR), the Department of Public Health (DPH), and the Department of Youth Services (DYS) 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

2. 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.
3. 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 Professional Staff

Rehabilitative Services Professional Staff qualifications are as follows:

- 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 marriage and family therapist licensed under Alabama law
- A certified social worker licensed under Alabama law
- A registered nurse 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/MR 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 Substance Abuse Professional Staff

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 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 Child & Adolescent Services/ Adult Protective Services Professional Staff

Child and Adolescent Services/Adult Protective Services Professional Staff qualifications are as follows:

- 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 marriage and family therapist licensed under Alabama law
- A social worker licensed under Alabama law
- A registered nurse 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, assigned by a licensed physician or psychologist, of mental illness or substance abuse as listed in the most current International Classification of Diseases - Clinical Modification (ICD-CM). Alabama 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 V629, unspecified psychosocial circumstance.

Providers of rehabilitative services must meet the following eligibility requirements:

- Fully comply with applicable federal and state laws and regulations
- Submit evidence to Medicaid of full compliance with 560-47-X- .03; and have such compliance approved in advance
- Execute the Medicaid non-institutional provider agreement with appropriate attachments

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 and Resolution
- Individual Counseling/Mental Illness and Individual Counseling/Substance Abuse
- Family Counseling
- Group Counseling
- Medication Administration
- Medication Monitoring (non-physician)
- 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)
- 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 or licensing authority or as authorized by state law.

Intake Evaluation (Z5227)

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/Adult Protective 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 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/MR 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 - Child and Adolescent Services/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 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 Service Social Worker I, Public Health Social Worker I, or Youth Services Counselor II 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 Worker I, Public Health Social Worker I, Youth Services Counselor II, or above

Billing Unit:	Episode
Maximum Units:	One per year
Billing Restrictions:	May not be billed in combination with Treatment Plan Review (Z5242)

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 an outpatient 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 registered nurse with master's degree in psychiatric nursing, or a physician licensed under Alabama law.

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 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 (Z5228)

Definition

Face-to-face contact between a client and a licensed physician occurring in an individual, group, or family setting for the purpose of medical/psychiatric development of a medication regimen and the provision of therapeutic services.

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, and Child and Adolescent Services/Adult Protective Services

Physician medical assessment and treatment may be performed by 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.

Billing Unit:	15 minutes
Maximum Units:	6 per day, 52 per year
Billing Restrictions:	May not be billed in combination with partial Hospitalization (Z5240) and all other types of day treatment (Z5241, Z5432, Z5433, Z5435), and Adult Substance Abuse Intensive Outpatient Services (Z5436) Child and Adolescent Substance Abuse Intensive Outpatient Services (Z5437), or Assertive Community Treatment (Z5450).

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 type covers any service rendered by a physician except Treatment Plan Review (Z5242) and Mental Health Consultation (Z5243). For example, if a physician provides individual therapy, the service would be billed as Physician Medical Assessment (Z5228) and Treatment Plan Review (Z5242). The only variable is the amount of time spent with the client. An in-depth psychiatric evaluation may take up to the six units, but more routine medication review sessions will customarily take 15 minutes, or one unit.

Diagnostic Testing (Z5229)

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 staff member and interpretation of the test results.

Eligible Staff - Mental Illness, Substance Abuse, and Child and Adolescent Services/Adult Protective Services

Diagnostic testing 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 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:	30 minutes
Maximum Units:	10 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 and Resolution (Z5230)

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 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
- 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 - Child and Adolescent Services/Adult Protective Services

Services may be provided by an individual employed by a public provider department who meets the state merit system qualifications for Service Social Worker I, Public Health Social Worker I, or Youth Services Counselor II 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 Worker I, Public Health Social Worker I, Youth Services Counselor II, or above.

Billing Unit:	30 minutes
Maximum Units:	6 per day, 2190 per calendar year
Billing Restrictions:	May not be billed in combination with In-Home Intervention (Z5244).

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. Medicaid covers this service for mental illness diagnoses only. The code V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Individual Counseling - Mental Illness (Z5231) or Substance Abuse (Z5452)

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 and Child and Adolescent Services/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 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

The program must be staffed and have a program coordinator as required in the current Community Substance Abuse Services Standards manual or subsequent revisions.

Billing Unit:	30 minutes
Maximum Unit:	3 per day, 104 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (Z5240), Intensive Day Treatment (Z5241), Child & Adolescent Day Treatment (Z5433, Z5435), and In-Home Intervention (Z5244).

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 code V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Family Counseling (Z5232)

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 and Child and Adolescent Services/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 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 (Methadone clients only)

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 (Z5240), Intensive Day Treatment (Z5241), Child and Adolescent Day Treatment (Z5433, Z5435), and In-Home Intervention (Z5244).

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 is covered under substance abuse for methadone clients only. The code V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Group Counseling (Z5233)

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 and Child and Adolescent Services/Adult Protective Services

Group counseling, 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 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 (Methadone clients only)

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 (Z5240), Intensive Day Treatment (Z5241), Rehabilitative Day Program (Z5431), Child & Adolescent Day Treatment (Z5433, Z5435).

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 is covered under substance abuse for methadone clients only. The code V629 is covered only for children and adolescents, or adults receiving DHR Protective Services.

Medication Administration (Z5234)

Definition

Administration of oral or injectable medications as directed by a physician.

Eligible Staff – Mental Illness, Substance Abuse, and Child and Adolescent Services/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
- A licensed practical nurse under the direction of a physician
- A physician licensed in Alabama

Billing Unit	Episode
Maximum Units	1 per day, 365 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (Z5240), all forms of Day Treatment (Z5241, Z5431, Z5433, Z5435) and Assertive Community Treatment (Z5450)

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.

Medication Monitoring (Non-Physician) (Z5235)

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 and Child and Adolescent Services/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 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 Practical Nurse

Billing Unit	15 minutes
Maximum Units	2 per day, 52 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization (Z5240), all forms of Day Treatment (Z5241, Z5431, Z5433, Z5435), In-Home Intervention (Z5244), and Assertive Community Treatment (Z5450)

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 V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Partial Hospitalization Program (Z5240)

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, and/or reduction of inpatient length of stay.

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
- Medical evaluation and medication management
- 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 Physician Medical Assessment and Treatment (Z5228), Individual (Z5231), Family (Z5232), or Group Counseling (Z5233), Medication Administration (Z5234), Medication Monitoring (Z5235), Intensive Day Treatment (Z5241), and Rehabilitative Day Program (Z5431). 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.

Adult Intensive Day Treatment (Z5241)

Definition

An identifiable and distinct program that providers 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
- Medical evaluation and management
- 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:	Day (A minimum of 4 hours service per day)
Maximum Units:	1 per day, 260 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (Z5228), Individual (Z5231), Family (Z5232), or Group Counseling (Z5233), Medication Administration (Z5234), Medication Monitoring (Z5235), Partial Hospitalization Program (Z5240), and Rehabilitative Day Program (Z5431). 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.

Rehabilitative Day Program (Z5431)

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:	1 hour
Maximum Units:	4 per day, 1040 per year
Billing Restrictions:	May not be billed in combination with Partial Hospitalization Program (Z5240) or Intensive Day Treatment (Z5241).

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 (Z5433 – 3 hour minimum; Z5435 – 4 hour minimum)

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, Substance Abuse, and Child and Adolescent Services/Adult Protective Services

The program must be staffed and have a program coordinator as required in the current *Community Rehabilitative Services Center Contract Service Delivery Manual* and any subsequent revisions.

Billing Unit:	Z5433 – Minimum of three hours
	Z5435 – Minimum of four hours
Maximum Units:	1 per day, 260 per year
Billing Restrictions:	May not be billed in combination with Physician Medical Assessment and Treatment (Z5228), Individual (Z5231), Family (Z5232), or Group Counseling (Z5233), Medication Administration (Z5234), Medication Monitoring (Z5235). 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 (Z5242)

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 and Child and Adolescent Services/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 licensed psychologist
- 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
- A physician licensed under Alabama law

Billing Unit:	15 minutes
Maximum Units:	1 event with up to 2 per quarter, 8 per year
Billing Restrictions:	May not be billed in combination with Intake Evaluation (Z5227)

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 code V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Mental Health Consultation (Z5243)

Definition

Assistance by a rehabilitative services or child and adolescent services/adult protective services professional or a registered nurse to other service agency providers or independent practitioners in 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 physician licensed under Alabama law to practice medicine or osteopathy
- 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
- 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 - Child and Adolescent Services/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 Service Social Worker I, Public Health Social Worker I, or Youth Services Counselor II 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 Worker I, Public Health Social Worker I, Youth Services Counselor II, or above.

Billing Unit:	15 minutes
Maximum Units:	312 per year
Billing Restrictions:	None

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 code V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Adult Substance Abuse Intensive Outpatient Services (Z5436)

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* or subsequent revisions.

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 (Z5228)

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 (Z5437)

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* or subsequent revisions.

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 (Z5228).

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.

In-Home Intervention (Z5244)

Definition

Time limited home based services provided by a treatment team (two person team, minimally composed of one rehabilitative services professional and one person with a bachelor's degree) to defuse an immediate crisis situation, stabilize the living arrangement, and prevent out of home placement of the client.

Key service functions include the following:

- Individual or family counseling
- Crisis management
- Parent/guardian/significant other training
- Linkage to other community resources
- Medication monitoring

Eligible Staff – Mental Illness and Child and Adolescent Services/Adult Protective Services

In-home intervention for mental illness and child and adolescent services/adult protective services clients may be provided by a two-person team minimally composed of the following:

- A rehabilitative services or child and adolescent services/adult protective services professional staff member
- A registered nurse or a person with a bachelor's degree

Billing Unit:	15 minutes
Maximum Units:	24 per day, 2016 per year
Billing Restrictions:	May not be billed in combination with Crisis Intervention and Resolution (Z5230), Individual (Z5231), Family (Z5232), or Medication Monitoring (Z5235) 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 client's home, infrequently may be provided in other locations such as the clinic, jails, schools, etc. Such exceptions will not render the service ineligible for billing.

Additional Information

Medicaid covers this service for mental illness diagnoses only. The code V629 is covered only for children and adolescents, or adults receiving DHR protective services.

Pre-hospitalization Screening (Z5438)

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 and Child and Adolescent Services/Adult Protective Services

Pre-hospitalization screening 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 registered nurse
- 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 (Z5236 – Individual; Z5237 – 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, and stress management
- 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, and Child and Adolescent Services/Adult Protective Services

Basic living skills for mental illness, substance abuse, and child and adolescent services/adult protective services clients may be provided by an individual supervised by a staff member who meets at least one of the following qualifications:

- Meets the professional qualifications for Child and Adolescent Services/Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Service Social Worker I, Public Health Social Worker I, or Youth Services Counselor II 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 Worker I, Public Health Social Worker I, Youth Services Counselor II, or above
- Is a registered nurse

Billing Unit:	30 minutes
Maximum Units:	832 units per year
	10 per day for services provided to an individual
	4 per day for services provided to a group
Billing Restrictions:	May not be billed in combination with In-Home Intervention (Z5244)

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 (Z5238 – Individual; Z5239 – 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, and Child and Adolescent Services/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 professional qualifications for Child and Adolescent Services/Adult Protective Services Professional
- Is employed by a public provider department and meets the state merit system qualifications for Service Social Worker I, Public Health Social Worker I, or Youth Services Counselor II 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 Worker I, Public Health Social Worker I, Youth Services Counselor II, or above
- Is a registered nurse

Billing Unit:	30 minutes
Maximum Units:	208 units per year
	4 per day for services provided to an individual client's family
	4 per day for services provided to a group of clients' families
Billing Restrictions:	May not be billed in combination with In-Home Intervention (Z5244) and Family Therapy (Z5232)

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) (Z5450)

Definition

Treatment services provided primarily in a non-treatment setting by a member of an ACT team composed of a part-time psychiatrist, a master's level therapist, and/or registered nurse, 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 constantly 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 and resolution
- Mental health consultation
- Case management
- Family support
- Basic living skills

The only services that may be billed in addition to Assertive Community Treatment are Partial Hospitalization (Z5240), Intensive Day Treatment (Z5241), and Rehabilitative Day Program (Z5431). Billing in combination with Rehabilitative Day Program should occur only on a transitional basis 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) team that is identifiable by job title, job description, and job function. The team must have a part-time psychiatrist, a full-time masters clinician and/or registered nurse. 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 where the part-time psychiatrist is not counted as one staff member.

Billing Unit:	1 day (bill for each day of the month that a client is on the team's active caseload)
Maximum Units:	365 days per year
Billing Restrictions:	May not be billed in combination with Intake (Z5227), Physician Medical Assessment and Treatment (Z5228), Medication Administration (Z5234), Medication Monitoring (Z5235), Basic Living Skills (Z5236 or Z5237), Family Support (Z5238 or Z5239), Individual (Z5231), Family (Z5232), Group Counseling (Z5233), Crisis Intervention and Resolution (Z5230), or Mental Health Consultation (Z5243).

Location

The only excluded settings are hospitals and nursing homes. 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.

Methadone Treatment (Z5451)

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:	1 day (bill for each day of the month that a client is receiving Methadone treatment)
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.

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.

A written treatment plan (service plan, individualized family service plan, plan of care, etc.) must be completed by the fifth client visit or within ten working days after admission into a day treatment program, substance abuse intensive outpatient program, or residential program. The treatment plan must 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, licensed social worker, licensed professional counselor, marriage and family therapist, registered nurse with a master's degree in psychiatric nursing licensed under Alabama law, or physician licensed under Alabama law

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.

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
- 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

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. Treatment plan review, mental health consultation, pre-hospitalization screening, crisis intervention, family support, ACT and any other non-face-to-face services that can be provided by telephone do not require client signatures.

When clinical records are audited, Medicaid will apply the list of required documentation to justify payment.

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.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Section D.1.3 of the Managed Care appendix to determine whether your services require a referral from the Primary Medical Provider (PMP).

105.4 Cost Sharing (Copayment)

Copayment does not apply to rehabilitative services.

105.5 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.

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 HCFA-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 must be listed to the highest number of digits possible (3, 4, or 5 digits). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field. The code V629 is covered only for children and adolescents or adults receiving DHR protective services.

105.5.3 Procedure Codes and Modifiers

Services of the Rehabilitative Services Program are limited to the procedures listed below:

Code	***Description***
Z5227	Intake Evaluation (limit one per calendar year)
Z5228	Physician/Medical Assessment and Treatment (limited to 6 units per day, 52 units per year per recipient) (15 minutes = 1 unit)
Z5229	Diagnostic Testing (limited to 10 units per year per recipient) (30 minutes = 1 unit)
Z5230	Crisis Intervention and Resolution (limited to 6 units per day) (30 minutes = 1 unit)
Z5231	Individual Counseling/Mental Illness (limited to 3 units per day, 104 units per year per recipient) (30 minutes = 1 unit)
Z5232	Family Counseling (limited to 3 units per day, 104 units per year per recipient) (30 minutes = 1 unit)
Z5233	Group Counseling (limited to 3 units per day, 104 units per year per recipient) (30 minutes = 1 unit)
Z5234	Medication Administration (limited to 1 unit per day, 365 episodes per year per recipient) (Episode = 1 unit)
Z5235	Medication Monitoring (limited to 2 units per day, 52 units per year per recipient) (15 minutes = 1 unit)
Z5236	Basic Living Skills, Individual (limited to 832 units per recipient per year) (10 units per day when provided to an individual) (30 minutes = 1 unit)
Z5237	Basic Living Skills, Group (limited to 832 units per recipient per year) (4 units per day per client when provided to a group) (30 minutes = 1 unit)
Z5238	Family Support, Individual (limited to 208 units per recipient per year) (4 units per day per client when provided to client's family) (30 minutes = 1 unit)
Z5239	Family Support, Group (limited to 208 units per recipient per year) (4 units per day per client when provided to group of client's families) (30 minutes = 1 unit)
Z5240	Partial Hospitalization Program (limited to 1 unit per day, 130 units per year per recipient) (4 hours = 1 unit)
Z5241	Intensive Day Treatment (limited to 1 unit per day, 260 units per year per recipient) (4 hours = 1 unit)
Z5242	Treatment Plan Review (limited to 2 units per quarter, 8 units per year per recipient) (15 minutes = 1 unit)
Z5243	Mental Health Consultation (limited to 312 units per year per recipient) (15 minutes = 1 unit)
Z5244	In-Home Intervention (limited to 24 units per day, 2016 units per year per recipient) (15 minutes = 1 unit)
Z5380	Medicare exempt partial hospitalization claims physician
Z5401	Medicare deductible and coinsurance
Z5431	Rehabilitative Day Program (limited to 4 units per day, 1040 units per year per recipient) (1 hour = 1 unit)
Z5432	Adult Supportive Day Treatment (limited to 1 unit per day, 260 units per year per recipient) (4 hours = 1 unit) **No longer covered effective 01/01/01. See Z5431.**
Z5433	Child & Adolescent Day Treatment - With Education (limited to 1 unit per day, 260 units per year per recipient) (3 hours = 1 unit)
Z5435	Child & Adolescent Day Treatment - Without Education (limited to 1 unit per day, 260 units per year per recipient) (4 hours = 1 unit)
Z5436	Adult Substance Abuse Intensive Outpatient Services (limited to 6 units per day, 1040 units per year per recipient) (1 hour = 1 unit)
Z5437	Child & Adolescent Substance Abuse Intensive Outpatient Services (limited to 6 units per day, 1,040 units per year per recipient) (1 hour = 1 unit)

Code	Description
Z5438	Pre-hospitalization Screening (limited to 4 units per day, 16 units per year per recipient) (30 minutes = 1 unit)
Z5450	Assertive Community Treatment (limited to 1 unit per day, 365 units per year per recipient) (1 day = 1 unit)
Z5451	Methadone Treatment (limited to 1 unit per day, 365 units per year per recipient) (1 day = 1 unit)
Z5452	Individual Counseling/Substance Abuse (limited to 3 units per day, 104 units per year per recipient) (30 minutes = 1 unit)

105.5.4 Contra Edits

The following tables are provided as a quick reference to help you understand which procedure codes cannot be billed in combination with other codes for the same date of service.

Mental Illness Services

Procedure Code	Covered Service	Will Deny If Same Day of Service
Z5227	Intake Evaluation	Z5242
Z5228	Physician Medical Assessment and Treatment	Z5431,Z5432, Z5433, Z5435, Z5436, Z5437, Z5240, Z5241, Z5450
Z5229	Diagnostic Testing	N/A
Z5230	Crisis Intervention and Resolution	Z5244
Z5231	Individual Counseling	Z5240, Z5241, Z5433, Z5435, Z5244, Z5431
Z5232	Family Counseling	Z5240, Z5241, Z5433, Z5435, Z5244, Z5431
Z5233	Group Counseling	Z5240, Z5241, Z5433, Z5435, Z5431
Z5234	Medication Administration	Z5240, Z5241, Z5433, Z5435, Z5431, Z5450
Z5235	Medication Monitoring	Z5240, Z5241, Z5433, Z5435, Z5244, Z5431, Z5450
Z5236	Basic Living Skills, Individual	Z5244
Z5237	Basic Living Skills, Group	Z5244
Z5238	Family Support, Individual	Z5244, Z5232
Z5239	Family Support, Group	Z5244, Z5232
Z5240	Partial Hospitalization Program	Z5228, Z5231, Z5232, Z5233, Z5234, Z5235, Z5241, Z5433, Z5435, Z5431
Z5241	Intensive Day Treatment	Z5228, Z5231, Z5232, Z5233, Z5234, Z5235, Z5240, Z5431, Z5433, Z5435, Z5431
Z5242	Treatment Plan Review	Z5227
Z5243	Mental Health Consultation	N/A
Z5244	In-Home Intervention	Z5230, Z5231, Z5232, Z5235
Z5431	Rehabilitative Day Program	Z5240, Z5241
Z5432	Adult Supportive Day Treatment (Deleted effective 01/01/01)	Z5228, Z5231, Z5233, Z5234, Z5235, Z5240, Z5241, Z5433, Z5435
Z5433, Z5435	Child & Adolescent Day Treatment	Z5228, Z5231, Z5232, Z5234, Z5235, Z5240, Z5241, Z5432, Z5452
Z5438	Pre-hospitalization Screening	N/A
Z5450	Assertive Community Treatment	Z5227, Z5228, Z5230, Z5231, Z5232, Z5233, Z5234, Z5235, Z5236, Z5237, Z5238, Z5239, Z5242, Z5243
Z5451	Methadone Treatment	N/A

Substance Abuse Services

Procedure Code	*Covered Service*	*Will Deny If Same Day of Service*
Z5227	Intake Evaluation	Z5242
Z5228	Physician Medical Assessment and Treatment	Z5240, Z5241, Z5433, Z5435, Z5431
Z5229	Diagnostic Testing	N/A
Z5232	Family Counseling (Methadone clients only)	Z5240, Z5241, Z5433, Z5435, Z5436, Z5437, Z5244, Z5431
Z5233	Group Counseling (Methadone clients only)	Z5240, Z5241, Z5433, Z5435, Z5436, Z5437, Z5244, Z5431
Z5234	Medication Administration (Methadone only)	Z5240, Z5241, Z5433, Z5435, Z5431
Z5236	Basic Living Skills, Individual	Z5244
Z5237	Basic Living Skills, Group	Z5244
Z5238	Family Support, Individual	Z5244, Z5232
Z5239	Family Support, Group	Z5244, Z5232
Z5436	Adult Intensive Outpatient Services	Z5228
Z5437	Child & Adolescent Intensive Outpatient Services	Z5228
Z5438	Pre-hospitalization Screening	N/A
Z5452	Individual Counseling	Z5240, Z5241, Z5431, Z5433, Z5435, Z5244

105.5.5 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

105.5.6 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.

105.5.7 Billing Instructions for Medicare-related Day Treatment Hospitalization

Instructions for Claims with Dates of Service July 31, 2000 and Prior

1. Bill Medicare on a UB-92.
2. If Medicare pays on all services, send a Medical Medicaid/Medicare-related claim form to Medicaid using the clinic provider number (33000000x) and procedure code **Z5401**. Indicate coinsurance and deductible amounts due on the claim. (Medicaid will pay 100% of coinsurance and deductible.)
   A. If Medicare pays only part of services, send a Medical Medicaid/Medicare-related claim form to Medicaid using the clinic provider number (33000000x) and procedure code **Z5401**. Indicate coinsurance and deductible amounts due on the claim for the services that Medicare covered. (Medicaid will pay 100% of coinsurance and deductible.)
   B. For remainder of charges send a HCFA-1500 claim form to Medicaid using the clinic provider number (33000000x) and procedure code **Z5380**. Enter the difference of Medicare paid and Medicaid allowed as the submitted charge.
3. If Medicare does not pay on any part of the services, bill the amount due for the services on a HCFA-1500 claim form using the clinic provider number (33000000x) and procedure codes listed in the provider manual. Be sure to indicate an “M” override indicator in the “Other Insurance Indicator” field when submitting electronically. For paper claims, enter “key M override indicator” in block 19 of the HCFA-1500 form.

Instructions for Claims with Dates of Service August 1, 2000 and Thereafter

1. Bill Medicare on a UB-92.
2. Services covered by Medicare should be automatically crossed over to Medicaid as a UB-92 outpatient crossover.
3. A. 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. Use the institutional provider number assigned to the clinic (MHCxxxxM) for these claims.
   B. For remainder of charges non-covered by Medicare, send a UB-92 claim form to Medicaid using the institutional provider number (MHCxxxxM) and the procedure code **Z5380**. Enter the difference of Medicare paid and Medicaid allowed as the submitted charge.
4. If Medicare does not pay on any part of the services, bill the amount due for the services on a HCFA-1500 claim form using the clinic provider number (33000000x) and procedure codes listed in the provider manual. Be sure to indicate an “M” override indicator in the “Other Insurance Indicator” field when submitting electronically. For paper claims, enter “key M override indicator” in block 19 of the HCFA-1500 form.

105.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-1500 Claim Filing Instructions	Section 5.2
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Outpatient Hospital/ASC Procedure 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	N/A	N/A
Target Group 8	Adult protective service individuals	Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation
Target Group 9	Medically At Risk	Medicaid-eligible individuals enrolled or assigned to a Primary Medical Provider (PMP)

The policy provisions for TCM providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 40.

106.1 Enrollment

EDS enrolls Targeted Case Management (TCM) 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 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a TCM provider is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for case management-related claims.

NOTE:

All nine digits are required when filing a claim.

TCM providers are assigned a provider type of 46 (Targeted Case Management). Valid specialties for TCM providers include the following:

- Mentally Ill Adults (TE)
- Mentally Retarded Adults (TF)
- Handicapped Children (TG)
- Foster Child (TH)
- Pregnant Women (TI)
- AIDS/HIV Positive Individuals (TJ)
- Adult Protective Services (TK)
- Medically At Risk (TL)

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), AIDS/HIV-Positive Individuals (Target Group 6), and Medically at Risk Individuals (Target Group 9) 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 Targeted Case Managers for Foster Children (Target Group 4) and Adult Protective Service individuals (Target Group 8) must be employed as a social worker who is licensed as a social worker by the State of Alabama or is exempt from licensure.

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 14.1.1 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 14.1.1 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 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 14.1.1 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 14.1.1 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 14.1.1 and must complete training in a case management curriculum approved by Medicaid.

Minimum Qualifications for Target Group 8 Providers

TCM providers for Adult Protective Services (Target Group 8) must meet the minimum educational qualifications listed in Section 14.1.1 and must complete training in a case management curriculum approved by Medicaid.

Targeted Case Management Service Providers for Adult Protective Service Individuals (Target Group 8) 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 9 Providers

TCM providers for Medically at Risk Individuals (Target Group 9) must meet the minimum qualifications listed in Section 14.1.1 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. The case manager calls or visits these persons or agencies on the recipient's behalf.

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
- Multihandicapped

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
- Manifested before the person reaches age 22
- 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 multihandicapped. 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 8 – Adult Protective Service Individuals

Target Group 8 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 9 – Medically at Risk Individuals

Target Group 9 consists of Medicaid-eligible individuals of any age enrolled or assigned to a Primary Medical Provider (PMP).

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.

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 8):

- 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 8 (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 8 (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. Services are limited to a maximum of 52 hours per recipient per calendar year.

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. Refer to Section 4, Obtaining Prior Authorization, for general guidelines.

TCM providers must obtain prior authorization from EDS to avoid duplicate payments for targeted case management services in the following target groups:

- Handicapped Children (Target Group 3)
- Foster Children (Target Group 4)

Claims for recipients enrolled in the Patient 1st Program **do not require a referral** from the recipient's assigned Primary Medical Provider (PMP).

Direct all inquiries and requests relating to prior authorization for a specific target group to EDS' 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 EDS 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.

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.

106.5 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.

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 HCFA-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

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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” 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 following procedure codes apply when filing claims for TCM services:

Target Group	*Code*	*Description*	*Diagnosis Code*	*PA Required?*
3	Z5213	TCM-Mentally Retarded Child	V6149	Yes
3	Z5214	TCM-Emotionally Disturbed Child	V6149	Yes
3	Z5215	TCM-Sensory Impaired Child	V6149	Yes
3	Z5216	TCM-Disabling Health Conditions	V6149	Yes
3	Z5217	TCM-Multihandicapped Child	V6149	Yes
4	Z5218	TCM-Foster Child	V6129	Yes
3	Z5296	TCM-Developmentally Delayed (under 3 yrs)	V6149	Yes
5	Z5186	TCM-Pregnant Women	630-6769, V27-V39	No
2	Z5187	TCM-Adult MR	317-319	No
1	Z5188	TCM-Adult Mentally Ill	As appropriate	No
6	Z5219	TCM-AIDS HIV Positive	As appropriate	No
8	Z5378	TCM-Adult Protective Service Individuals	V6149	No
9	Z5413	TCM-Medically at Risk	As appropriate	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
65	End Stage Renal Disease Treatment 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
HCFA-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Guidelines	Appendix B
Managed Care	Appendix D
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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107 Waivered Services

Medicaid covers home and community-based services (HCBS) through the Elderly and Disabled Waiver (E&D) and the Homebound Waiver to categorically needy individuals who would otherwise require institutionalization in a nursing facility.

Medicaid covers HCBS through the Mentally Retarded/Developmentally Disabled Waiver (MR/DD) to Medicaid-eligible individuals who would otherwise require the level of care available in an intermediate care facility for the mentally retarded/developmentally disabled (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 waiver services. HCBS are provided through a Medicaid waiver for an initial period of three years and for five-year periods thereafter upon renewal of waiver by the Health Care Financing Administration.

The E&D Waiver is a cooperative effort among the Alabama Medicaid Agency, Alabama Department of Public Health, and the Alabama Commission On Aging. The policy provisions for E&D Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 36.

The Homebound Waiver is a cooperative effort between the Alabama Medicaid Agency and the Department of Rehabilitation Services. The policy provisions for Homebound Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 57.

The MR/DD Waiver is a cooperative effort between the Alabama Medicaid Agency and the Alabama Department of Mental Health and Mental Retardation. The policy provisions for MR/DD Waiver providers can be found in the *Alabama Medicaid Agency Administrative Code*, Chapter 35.

107.1 Enrollment

EDS enrolls providers of waiver services 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.

Provider Number, Type, and Specialty

A provider who contracts with Medicaid as a provider of waiver services is issued a nine-digit Alabama Medicaid provider number that enables the provider to submit requests and receive reimbursements for waiver claims.

NOTE:

All nine digits are required when filing a claim.

Providers of waivered services are assigned a provider type of 78 (Waivered Services). Valid specialties for these providers include the following:

- Elderly and Disabled Waiver (ED)
- Homebound Waiver (EC)
- MR/DD Waiver (EE)

Enrollment Policy for Waivered Services Providers

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

- Must have a contractual agreement with Medicaid
- Must meet the provider qualifications as outlined in the approved Waiver Document for the appropriate HCBS waiver.

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
Homebound 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 Assistive Technology Evaluation for Assisted Technology Assistive Technology Repairs

Waiver	*Services Covered*
Home- and community-based services for MR/DD waiver	Residential Habilitation Training Residential Habilitation-Other Living Arrangement Day Habilitation Prevocational Services Supported Employment Occupational Therapy Services Speech and Language Therapy Physical Therapy Behavior Management Companion Services In-Home Respite Care Out-of-Home Respite Care Personal Care Environmental Accessibility Adaptations Medical Supplies Skilled Nursing Assistive Technology

107.2.1 Financial Eligibility

Financial eligibility for the E&D waiver is limited to the following individuals:

- Individuals receiving SSI and/or State Supplementation
- "Pickle" individuals
- Widows and widowers under age 60
- Widows and widowers aged 60-64 years
- Individuals who would be eligible for Medicaid in an institution because income from parents or a spouse is not deemed available to them (Institutional Deeming)

Financial eligibility for MR/DD and Homebound is limited to the following individuals:

- SSI (protected groups deemed to be recipients of SSI)
- AFDC
- Special home and community-based optional categorically needy groups whose income is not greater than 300 percent of the SSI federal benefit rate
- Individuals who would be eligible for Medicaid either by being in an institution or by meeting the institutional level of care and the income from a parent or spouse is not available to them
- Children of disabled adults who lose supplemental security income or have an increase in social security benefits
- QMB and SLMB recipients may become eligible under the 300% SSI eligibility criteria

Financial determinations are made by the Alabama Medicaid Agency, the Department of Human Resources, or the Social Security Administration, 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

Eligibility criteria for the E&D Waiver 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 Homebound 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.

Homebound waiver services are provided to, 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-Nehan Syndrome)

Eligibility criteria for HCBS for MR/DD recipients are the same as eligibility criteria for an ICF-MR facility. MR/DD 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.

Medicaid or its administering 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 cost of serving an individual on the waiver exceeds the cost of caring for that individual in a nursing facility; if the individual does not cooperate with a provider in the provision of services; and if an individual meets the goals and objectives of being on the waiver program.

NOTE:
Homebound waiver recipients must be aged 18 years 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 (Z5175 – E&D)

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. The state agencies contracting for Adult Day Health Services must determine that each facility providing Adult Day Health meets the prescribed standards.

Homemaker Services (Z5178 – E&D)

Homemaker services are general household activities that include meal preparation, food shopping, bill paying, routine cleaning, and personal services. They are 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.

Case Management Services (Z5173 – E&D; Z5302 – Homebound)

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 services, 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.

Personal Care Services (Z5174 – E&D)

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 supervised by a registered nurse, and meet the qualifications of a Personal Care Attendant as specified in the approved waiver document. This service cannot be provided by a family member.

Personal Care Services (Z5303 – Homebound)

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.

This person may be a relative or a friend of the relative 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.

Respite Care (Z5176 – Skilled E&D; Z5177 – Unskilled E&D)

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.

Companion Services (Z5396 – E&D)

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.

NOTE:

Companion services are only available to recipients who live alone, and may not exceed four hours daily.

Day Habilitation (Z5201 – MR/DD)

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.

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.

Residential Habilitation Training (Z5202 – MR/DD)

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/MR. Retraining will be conducted as needed, at least annually.

Respite Care (Z5204 – In-Home; Z5205 – Out-of-Home – MR/DD)

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 may be provided up to a maximum of 720 hours per waiver year.

Respite care is not available in an institution (for example, ICF-MR, SNF, or hospital).

This service cannot be provided by a family member.

Residential Habilitation - Other Living Arrangement (OLA) (Z5343 – MR/DD)

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/MR. 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.

Supported Employment (Z5345 – MR/DD)

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 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.

Prevocational Services (Z5346 – MR/DD)

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.

Physical Therapy (Z5347 – MR/DD)

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.

Occupational Therapy Services (Z5348 – MR/DD)

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.

Speech and Language Therapy (Z5349 – MR/DD)

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.

Personal Emergency Response System (PERS) (Z5308 & Z5309 – Homebound)

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. Prior authorization is required for Z5308.

Personal Care (Z5352 – MR/DD)

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.

Personal care is not available to residents of a group home or SCLH.

The personal care attendant will work under the supervision of a QMRP and will be observed every 60 days. The personal care attendant is also required to complete the training requirements prior to providing services.

Companion Services (Z5353 – MR/DD)

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.

Behavior Management (Z5354 – MR/DD)

Behavior management refers to efforts to modify maladaptive or problem behavior through programs directed toward enhancing the development of the individual in accordance with the developmental model and the principles of normalization.

Such programs emphasize developing desirable and adaptive behaviors, rather than merely eliminating or suppressing of undesirable ones.

Providers of behavior management are behavior specialists. They must have a four-year degree in a human services field, at least two years' experience in the field of developmental disabilities, and training in the area of behavior management techniques.

Each behavior specialist is required to participate in an in-service training program approved by the Department of Mental Health and Mental Retardation prior to providing services.

Retraining will be conducted as needed, at least annually.

Environmental Accessibility Adaptations (Z5355 – MR/DD, Z5305 – Homebound))

Environmental modifications are those physical adaptations to the home, required by the recipients' 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 recipient.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient.

Environmental Modifications exclude adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver recipient, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are also excluded from this Medicaid-reimbursed benefit. All services provided must comply with applicable state or local building codes. This service requires prior authorization.

Medical Supplies (Z5356 – MR/DD)

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. Medicaid reimbursement is limited to $1,800 per waiver year for this service.

Providers of this service must meet the same standards required for the providers under Alabama’s State Plan.

Assistive Technology (Z5357 – MR/DD, Z5322 – Homebound)

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 includes 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 of the recipient. All items shall meet applicable standards of manufacture, design and installation. This service requires prior authorization.

Skilled Nursing (Z5358 – MR/DD)

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.

Medical Supplies (Z5307 – Homebound)

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, cotton swabs, Q-Tips, etc. These medical supplies will only be provided when authorized by the recipient's physician. Providers of this service will be those who have a signed provider agreement with Medicaid. Medicaid reimbursement is limited to $2,300 per waiver year for this service.

Evaluation for Assistive Technology (Z5404 - Homebound)

This service will provide for an evaluation and determination of the client's need for assistive technology. The evaluation must be physician-prescribed, be provided by a physical therapist licensed to do business in the state of Alabama, and 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 prior authorization request, and a copy must be kept in the recipient's file. This service must be listed on the recipients plan of care before 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.

Assistive Technology Repairs (Z5405 - Homebound)

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.

107.2.5 Characteristics of Persons Requiring ICF-MR Level of Care Through the MR/DD 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 MR/DD 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 MR/DD Waiver

Determination regarding eligibility for care under the MR/DD 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 MR/DD waiver service recipient. The Individual Habilitation Plan (IHP) is subject to review by Medicaid and the Health Care Financing Administration.

The DMH/MR (or its contract service providers) use assessment procedures to screen recipients for eligibility for the waivered services as an alternative to institutionalization. Assessment procedures are based on eligibility criteria for ICF-MR developed jointly by DMH/MR and Medicaid.

Review for "medical assistance" eligibility may be performed by a qualified practitioner in the DMH/MR, 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 the Health Care Financing Administration.

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 the Health Care Financing Administration.

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.

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 administering 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 administering agency for the previous quarter and include 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 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 and MR/DD must be received by Medicaid on or before December 31. Cost reports for the Homebound Waiver must be received on or before June 1. Extension may be granted only upon written request. If a complete cost report is not filed by the due date or an extension is not granted, a penalty of $100 per day for each day past the due date will be imposed on the provider. The penalty will not be a reimbursable Medicaid cost. For detailed information on penalties see MR/DD Waiver Fiscal Procedures Manual.

Quarters for MR/DD and 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 Homebound are defined as follows:

Quarter	***Reporting Period***	***Due Date***
1st	January – March	Due before June 1
2nd	April – June	Due before September 1
3rd	July – September	Due before December 1
4th	October – December	Due before March 1

107.2.9 HCBS Payment Procedures

Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a procedure code. Respite care will have one code for skilled and another for unskilled; hence, six procedure codes.

The basis for the rates is usually based on audited past performance with consideration being given to the health care index and renegotiated contracts. The interim rates 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.

NOTE:

The administering agencies are governmental; therefore, the interim rates for services must be adjusted to cost and the claims for services provided during that year must be reprocessed to adjust payments to the actual cost incurred by each administering agency. The rates for each service for each administering agency may differ. For the E&D waiver, administering agencies have 120 days from the end of a waiver year to file their claims. The administering agencies for MR/DD and Homebound waivers have 180 days from the end of a waiver year to file. Since the actual cost incurred by each administering 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.

Actual cost and units of services provided during a waiver year must be accounted on HCFA Form 372. The following accounting definitions are used to capture reporting data and audited figures used in establishing new interim fees:

- A waiver year consists of the 12 months following the start of any waiver year.
- 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-cash payments, such as depreciation, occur when transactions are recorded by the state agency.

The services provided by administering agencies are reported and paid by dates of service. All services provided during the 12 months of the waiver year are attributed to that year.

The provider's costs are divided between benefit and administrative cost. The benefit portion is included in the rate for service. The administrative portion is divided into 12 equal amounts and is invoiced by the provider directly to Medicaid. Since administration is a relatively fixed expense, it is not a rate per claim, but a set monthly payment. As each waiver year 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.

Medicaid pays providers the actual cost to provide the service. Each covered service is identified on a claim by a procedure code.

All claims for services must be submitted within six months from the date of service. At the close of the waiver year, the providers will be audited and a final rate will be calculated based on actual allowable cost for the year divided by the number of services provided during the year. Any difference between the actual allowable cost and the revenues received based on the interim rate will be adjusted.

107.2.10 Records for Quality Assurance Audits

The administering agencies for the E&D, Homebound, and MR/DD 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.

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 Section D.1.3 of the Managed Care appendix 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 case manager completes an assessment document in conjunction with the applicant's physician. This document reflects detailed information regarding social background, living conditions, and medical problems of the applicant.

The case manager completes an assessment document in conjunction with the applicant’s physician. This document reflects detailed information regarding social background, living conditions, and medical problems of the applicant. 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 case manager then submits the assessment to Medicaid Long Term Care (LTC) Admission/Records Unit for approval.

Medicaid reviews the application and determines if the individual meets the criteria for nursing facility care. If the application is approved, the applicant and the case manager will be notified in writing. If the application is denied, the applicant and the case manager will be notified and the reconsideration process will be explained in writing.

An approved application is given a payment authorization date for the approved level of care. No charges for services rendered under the waiver program prior to this approved payment date will be paid.

The case manager must submit a current assessment document, a new care plan, and a medical need admission form to Medicaid at each re-determination of eligibility, which occurs at least every 12 months.

Fair Hearings

An individual whose application to the waiver program is denied may request a hearing through the appropriate administering agency (the Alabama Department of Public Health, the Alabama Commission On Aging, the Alabama Department of Rehabilitation Services, or the Alabama Department of Mental Health/Mental Retardation).

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 60 days following notice of action for which an individual is dissatisfied.

107.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by waivered services providers.

107.5 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.

Waivered 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 HCFA-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.

107.5.1 Time Limit for Filing Claims

The administering agencies for the E&D waiver have 120 days at the end of the waiver year to process claims. The administering agencies for the MR/DD and Homebound waivers have 180 days at the end of the waiver year to process claims. At the close of the waiver year, Medicaid audits the administering agency and calculates a final rate based on actual allowable cost for the year divided by the number of services provided during the year. Medicaid adjusts any difference between the actual allowable cost and the revenues received based on the interim rate. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

107.5.2 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). Medicaid does not cover diagnosis codes preceded by an “E,” “M,” or “Y.” Do not use decimal points in the diagnosis code field.

Diagnosis Codes (Homebound)

Homebound Waiver services are limited to the following diagnosis codes:

277.00-277.9	330.0-337.9	343.0-344.9	430-438.0
310.0-310.9	340	359.9	711.00-716.99

107.5.3 Procedure Codes

The following procedure codes apply when filing claims for Elderly and Disabled Waiver services:

Code	***Description***	***PA Required?***
Z5173	Case Management – Billed per hour	No
Z5174	Personal Care – Billed per hour	No
Z5175	Adult Day Health – Billed per day	No
Z5176	Respite Care – Skilled – Billed per hour	No
Z5177	Respite Care – Unskilled – Billed per hour	No
Z5178	Homemaker – Billed per hour	No
Z5396	Companion – Billed per hour	No

The following procedure codes apply when filing claims for Homebound Waiver services. These services are limited to recipients age 18 and over.

Code	***Description***	***PA Required?***
Z5302	Case Management – Billed per hour	No
Z5303	Personal Care Services – Billed per hour	No
Z5305	Environment Modifications – Billed per service which must be prior authorized (exempt from TPL)	Yes
Z5307	Medical Supplies – Limited to one per month – Billed per month (exempt from TPL	No
Z5308	Personal Emergency Response Systems/Initial Setup – Billed per service which must be prior authorized (exempt from TPL)	Yes
Z5309	Personal Emergency Response Systems/Monthly Service Fee – Limited to one per month	No
Z5322	Assistive Technology – Billed per service which must be prior authorized	Yes

The following procedure codes apply when filing claims for Mentally Retarded/Developmentally Disabled services:

Code	*Description*	*PA Required?*
Z5201	Habilitation Services/DMH Waiver (per day)	No
Z5202	Residential Services (per day)	No
Z5204	In-home Respite Care (per hour)	No
Z5205	Out-of-Home Respite (per hour)	No
Z5343	Residential Services - Other Living Arrangements (per hour)	No
Z5345	Supported Employment Services	No
Z5346	Prevocational Services	No
Z5347	Physical Therapy	No
Z5348	Occupational Therapy	No
Z5349	Speech/Language Therapy	No
Z5352	Personal Care Service	No
Z5353	Companion Services	No
Z5354	Behavioral Management	No
Z5355	Environmental Accessibility Adaptation	Yes
Z5356	Medical Supplies	No
Z5357	Assistive Technology	Yes
Z5358	Skilled Nursing Services	No

107.5.4 Place of Service Codes

The following place of service codes apply when filing claims for waivered services:

POS Code	*Description*
12	Home (Residential) – MR/DD, Homebound Waiver
99	Other Unlisted Facility – MR/DD, Elderly & Disabled Waiver

107.5.5 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.

107.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
HCFA-1500 Claim Filing Instructions	Section 5.2
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
Managed Care	Appendix D
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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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 improve 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 — An unclothed physical examination using quick, simple procedures to sort out apparently well children from those who have a disease,

condition, or abnormality, and 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 improve 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 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, EDS Provider Electronic Solutions software, or the Provider Assistance Center at EDS. 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. 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 chronic conditions outside the established periodicity schedule and can occur at any age. Use of a Snellen chart is acceptable.
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.
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 valid nine-digit Alabama Medicaid provider number. New providers should refer to Chapter 2, Becoming a Medicaid Provider, for instructions on receiving an application.

Current Medicaid providers who wish to become an EPSDT screening provider should contact the EDS Provider Enrollment Unit at the following address to obtain EPSDT screening provider enrollment forms, or you may download the information from Internet:

EDS Provider Enrollment
P.O. Box 244035
Montgomery, Alabama 36124-4035
1 (888) 223-3630
Internet: http://www.medicaid.state.al.us

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 are 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

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.

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.6, 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.

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.

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 Appendix D, Managed Care, of this manual or call the Provider Assistance Center at 1-800-688-7989.

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 (wellchild 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 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 rescreen list each month. The provider should 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.

Please refer to Section A.4, Care Coordination, for more information on screening provider responsibilities.

A.3.5 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, height, and weight • Head circumference through age two • Blood pressure and pulse at age three and above
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	Recommendations for Tuberculosis Testing • All children need routine health care evaluations that include assessment of their risk of exposure to tuberculosis. Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. The frequency of such skin testing should be according to the degree of risk of acquiring tuberculous infection as detailed in Table 1. • Routine tuberculin skin testing (TST) of children with no risk factors residing in low-prevalence communities is not indicated. • Children who have no risk factors but who reside in high-prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin (Mantoux) skin testing at 4 to 6 and 11 to 16 years of age. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials. • Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of health care workers are not at increased risk of acquiring tuberculous infection unless the workers' tuberculin skin test results convert to positive or the workers have diagnoses of tuberculous disease. • Children with human immunodeficiency virus (HIV) infection or disease should receive annual tuberculin skin testing (5 tuberculin units, Mantoux). • The skin test interpretation guidelines for indurations of 5, 10, and 15 mm in diameter (Table 2) remain appropriate for decisions regarding contact investigations, tuberculosis control measures, and preventive therapy. **NOTE:** Because Alabama has a medium to high prevalence of tuberculosis, the Alabama Department of Public Health recommends that all children without specific risk factors should receive a TST at ages 4-6 and another TST at 11-16 years. Table 1. Revised Tuberculin Skin Test Recommendations* Children for whom immediate skin testing is indicated • Contacts of persons with confirmed or suspected infectious tuberculosis (contact investigation); this includes children identified as contacts of family members or associates in jail or prison in the last 5 years • Children with radiographic or clinical findings suggesting tuberculosis • Children immigrating from endemic countries (e.g., Asia, Middle East, Africa, Latin America) • Children with travel histories to endemic countries and/or significant contact with indigenous persons from such countries Children who should be tested annually for tuberculosis • Children infected with HIV • Incarcerated adolescents Children who should be tested every 2-3 years+ • Children exposed to the following individuals: HIV infected, homeless, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers; this would include foster children with exposure to adults in the above high-risk groups

Component	*Description*
	Children who should be considered for tuberculin skin testing at ages 4-6 and 11-16 years • Children whose parents immigrated (with unknown tuberculin skin test 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 tuberculin skin test status) should be an indication for repeat tuberculin skin testing • 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; it is recognized that 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 clinicians identify areas that have appreciable tuberculosis rates *BCG immunization is not a contraindication to tuberculin skin testing. +Initial tuberculin skin testing initiated at the time of diagnosis or circumstance. Table 2. Definition of a Positive Mantoux Skin Test (5 Tuberculin Units of Purified Protein Derivative) in Children# **Reaction ≥ 5mm** • Children in close contact with known or suspected infectious cases of tuberculosis • 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 is suspected • Children suspected to have tuberculosis disease • Chest roentgenogram consistent with active or previously active tuberculosis • Clinical evidence of tuberculosis~ • Children receiving immunosuppressive therapy^ or with immunosuppressive conditions, including HIV infection **Reaction ≥10mm** Children at increased risk of dissemination • Young age (<4 y) • Other medical risk factors, including diabetes mellitus, chronic renal failure, or malnutrition Children with increased environmental exposure • Born, or whose parents were born, in high-prevalence regions of the world • Frequently exposed to adults who are HIV infected, homeless, users of illicit drugs, medically indigent city dwellers, residents of nursing homes, incarcerated or institutionalized persons, and migrant farm workers Travel and exposure to high-prevalence regions of the world **Reaction ≥15mm** Children ≥4 y of age without any risk factors • The recommendations should be considered regardless of previous BCG administration. • Evidence on physical examinations or laboratory assessment that would include tuberculosis in the working diagnosis (i.e., meningitis). • Including immunosuppressive doses of corticosteroids.

Component	*Description*
Developmental 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 screenings should be culturally sensitive and valid.**
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.

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 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. The child should be rescheduled for an appointment to complete the vision screening. The vision screening should be performed and billed on the same date of service as the initial or periodic screening.

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.

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. The child should be rescheduled for an appointment to complete the hearing screening. The hearing screening should be performed and billed on the same date of service as the initial or periodic screening.

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.

Dental Services

Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental care under this 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:

(a) EPSDT Referral – If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is 1 year of age 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 Alabama Medicaid Agency Referral Form (Form 362) must be completed by the dentist and the appropriate copy must be returned to the screening provider.

(b) Recipient Seeking Treatment – If a recipient who has not been screened through the EPSDT Program requires dental care, care may be provided without having an EPSDT 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.

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 above. 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.

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) 242-5997.

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.

The following is a list of tests and procedures of laboratory screenings:

Laboratory Test	***Description***
Metabolic screening	The Alabama Newborn Screening Program tests for five disorders: phenylketonuria (PKU), hypothyroidism, galactosemia, congenital adrenal hyperplasia (CAH), and abnormal hemoglobin. Providers who wish to access the results of the Newborn Screening Program should register with the Family Health Services at (334) 206-2971. Providers who are already registered with the Alabama Newborn Screening Program may call toll free: 1-800-566-1556 to obtain results. A provider should have the mother's social security number and date of birth for the newborn available before calling. It should be noted physicians should not bill for the laboratory tests performed by the Alabama Newborn Screening Program. However, procedure code 36415 with modifier 90 may be billed for the specimen collection when referred to an outside laboratory. A single PKU and T4 is adequate when performed at least *24 hours after birth* in a well infant or when performed at 6-7 days of age in a premature or ill infant. Children with no record of the PKU, hypothyroidism, and CAH tests having been performed previously, during one of the neonatal visits, should be tested between birth and six months of age. Children over six months of age who have never been tested need only be screened when ordered by a physician. Routine testing for galactosemia is not recommended, unless ordered by a physician. Confirmation of positive newborn screening test results is always necessary. Additionally, newborn screening programs should not preclude the pediatricians assessment of clinical symptoms at any age. All the disorders screened are genetic or hereditary. Parents of affected children identified through a screening should be routinely offered counseling concerning the occurrence and reoccurrence of the disorder in existing or prospective siblings. These services are available at genetic centers at the University of Alabama in Birmingham and the University of South Alabama in Mobile.
Sickle Cell Disease and Sickle Cell Trait Screening	State law requires sickle cell screening at birth on all at-risk children. An abnormal hemoglobin is performed as part of the Alabama Newborn Screening Program. To contact the Alabama Newborn Screening Program for laboratory results, see 'Metabolic Screening' above for more information. Please note for recipients less than 6 months of age, sickle cell testing will be reimbursed when performed by electrophoresis. If verifiable results are unobtainable for children from birth to six months of age, a repeat sickle cell test should be performed. Children over age one who have never been tested need only be screened when ordered by a physician. Counseling should be provided, when appropriate, for those with abnormalities. It is recommended that children identified as having sickle cell disease be referred to Comprehensive Sickle Cell Centers at the University of Alabama in Birmingham or the University of South Alabama in Mobile.
Iron Deficiency Anemia Screening	Hematocrit or hemoglobin values must be determined at a medical screening visit between 1-9 months, between 11-20 years of age, and as deemed medically necessary based on physical examination and nutritional assessment.
Urine screening	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.

NOTE:

The hgb and/or hct and the urine dipstick for sugar and protein are included in the screening reimbursement and should not be billed separately.

Laboratory Test	***Description***
Lead toxicity screening	All children at 12 and 24 months of age must have a blood lead test performed. A screening blood lead test also is required for any child 36 to 72 months of age that has not previously been screened for lead poisoning. Administering a risk-assessment questionnaire instead of a blood lead test does not meet Medicaid requirements. An initial lead toxicity assessment should be performed beginning at nine months of age and continue through 72 months of age. Since virtually all children are at risk for lead poisoning, universal screening is recommended. Children's blood lead levels increase most rapidly at 6-12 months and peaks at 18-24 months of age. The screening test of choice is blood lead measurement (replaces the Erthrocyte Protoporphyrin {EP} Test).

Laboratory Test	*Description*
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.

Assessment and Interpretation of Lead Toxicity Screening

All children between the ages of 6 months and 6 years risk high-dose lead exposure. Screening for lead poisoning requires:

- Determining the child's risk for high-dose lead exposure by asking a few questions
- Measuring blood lead levels in children who are the greatest risk for high-dose lead poisoning when they are 6 months of age and at every periodic screening
- Measuring blood lead levels in children who are at lower risk for high-dose lead exposure at 9-12 months of age and at 24 months of age;
- Conducting necessary follow-up blood lead testing of children

Providers should ask questions about a child's risk for high-dose lead exposure at every visit. Priority groups at high risk are children, ages 6 to 72 months who:

- Live in or are frequent visitors to deteriorated housing built before 1960
- Live in housing built before 1960 with recent, ongoing, or planned renovation or remodeling
- Are siblings, housemates, or playmates of children with known lead poisoning
- Have parents or other household members who participate in a lead-related occupation or hobby
- Live near lead smelters, battery recycling plants, or other industries likely to result in atmospheric lead release

All children aged 6 months to 6 years who present with symptoms of possible lead poisoning should be screened. A child who is determined to be at low risk for high-dose lead exposure by questionnaire will be screened initially between 9 and 12 months of age.

If the child's initial capillary test is <10 µg/dL, the child will be retested in a year. A child who is determined to be potentially at high risk for high-dose exposure will be screened initially at 6 months of age.

If the child's initial capillary test is <10 µg/dL, the child will be retested at every periodic screening.

Children with blood lead level $\geq$ 10µg/dl should have the test confirmed with a venous blood lead level.

Interpretation of blood results and follow-up activities based on blood lead concentration are described below:

Blood Lead Concentration	*Comments*
<10	Is not indicative of lead poisoning **Low risk:** Retest annually. **High risk:** Retest every screening. After 2 consecutive tests < 10 µg/dL, or 3 consecutive tests < 15 µg/dL, retest annually. ***Case management:*** Schedule retest and provide parental education.
10-14	Retest every 3 months with capillary sample. After 2 consecutive tests < 10 µg/dL or 3 consecutive tests < 15 µg/dL, retest annually. ***Case management:*** Schedule retest and provide parental education.
15-19	Confirm with venous sample within one month of notification of capillary results. Retest every 3 months with venous sample. ***Case management:*** Schedule retest and provide parental education. If venous sample is ≥ 15 µg/dL, make an **environmental referral** by completing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, and mailing it to the address at the bottom of the form within three days.
20-44	Confirm with venous sample within 5 days of notification of capillary results. Retest every 3 months with venous sample or more often as determined by MD. ***Case management:*** Refer for medical evaluation. Schedule retests and provide parental education and nutritional counseling. Make an **environmental referral** (ADPH-FHS-135) and mail it to the address at the bottom of the form within three days.
45-59	Confirm with venous sample within 48 hours of notification of capillary results. Retest after treatment as recommended by MD. ***Case management:*** Refer for medical treatment within 48 hours. Treatment will usually include chelation therapy. Fax completed environmental referral form Refer to Public Health Epidemiology Department at (334) 206-2983 for environmental investigations and management for environmental investigations and management immediately. Child should only return to a lead-safe environment after chelation therapy. Schedule retest and provide parental education and nutritional counseling.
60-69	Confirm with venous sample within 24 hours of notification of capillary results. Retest after treatment as recommended by MD. ***Case management:*** Refer for medical treatment within 24 hours. Treatment will usually include chelation therapy. Fax completed environmental referral form (ADPH-FHS-135) to (334) 206-2983 immediately. Child should only return to a lead-safe environment after chelation therapy. Schedule retest and provide parental education and nutritional counseling.
>70 µg/dL	Confirm with venous sample immediately upon notification of capillary results. Retest after treatment as recommended by MD. ***Case management:*** Refer for immediate medical treatment including inpatient chelation. Refer for immediate environmental investigation and management. Child should only return to a lead-safe environment after chelation therapy. Schedule retest and provide parental education and nutritional counseling.

NOTE:

Alabama state regulations require blood lead levels greater than 10 µg/dL to be reported to the State Health Epidemiology Department as a reportable disease. You may request notifiable Disease Reporting cards from the Department of Public Health at (334) 206-5347.

Normal and Abnormal Findings

Abnormal findings screening procedure codes (Z5116 and Z5155) 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.

Normal findings procedure codes (Z5115 and Z5154) 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. Normal findings procedure codes should also be billed when the only referrals are for *routine* vision, hearing or dental services.

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 chronic 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 isssuing 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, 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, Section 13.3.3.

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.

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.

Documentation requirements for interperiodic screenings are:

1. consent;
2. medical-surgical history update;
3. problem-focused physical examination;
4. and anticipating guidance/counseling related to the diagnosis made.

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, from birth to age two, 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, **1-800-543-3098**. Please refer to pages A-34 and A-35 for an Early Intervention Referral Form or visit Medicaid's website at: "www.medicaid.state.al.us".

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 are located in seven districts in the state. Please call the toll free number if you are interested in information about local EI resources.

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.

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
Nutrition
Safety
Dental care
School readiness
Onset of sexual awareness
Peer relationship (male and female)
Preputertal body changes
Substance abuse
Contraceptive information (if sexually active)

14-21 years
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

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 copayments.
Prior Authorization	Screenings are not subject to prior authorization.
Referral	Please refer to Section A.3, 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. Medicaid does not cover diagnosis codes beginning with an ‘E’, ‘M’, or ‘Y’.
Procedure Codes and Modifiers	The following procedure codes should be used when billing EPSDT screening services: Z5115 Initial EPSDT Screening – Normal Z5116 Initial EPSDT Screening – Abnormal Z5154 Periodic EPSDT Screening – Normal Z5155 Periodic EPSDT Screening – Abnormal Z5316 Vision Screening – Annual Z5317 Hearing Screening – Annual The following procedure codes should be billed with abnormal diagnosis codes. 99391 Interperiodic EPSDT Screening (under 1 year of age) 99392 Interperiodic EPSDT Screening (age 1-4 years) 99393 Interperiodic EPSDT Screening (age 5-11 years) 99394 Interperiodic EPSDT Screening (age 12-17 years)

	99395 Interperiodic EPSDT Screening (age 18-20 years) Modifiers are not required
Intensive Developmental Diagnostic Assessment	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) 96110 - Intensive developmental diagnostic assessment, normal findings 96111 - Intensive developmental diagnostic assessment, abnormal findings
Third Party Coverage	Medicaid is a secondary payer to all available third party resources except EPSDT/Preventive Services (immunizations), which are TPL exempt for health departments and physicians.
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.

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.3.6 Patient 1st, Primary Care Case Management (PCCM) Referral Services

The Alabama Medicaid Agency has implemented a **Primary Care Case Management (PCCM)** program, known as Patient 1st, in selected Alabama counties. In a PCCM program, a physician contractually agrees to deliver and coordinate health care for eligible patients who select, or are assigned to, him or her as their primary medical provider (PMP). The PMP assumes explicit responsibility to provide or authorize a range of specified covered non-emergency care. The beneficiary utilizes this physician as the first contact for care.

Under the PCCM program, certain Medicaid-eligible persons are required to participate if they reside in a designated county.

In initiating the PCCM program, the Alabama Medicaid Agency intends to improve access to care for Medicaid-eligible persons, enhance the physician/patient relationship by creating a “medical home”, and by reduce medical costs now associated with unnecessary or inappropriate use of medical services.

Participants are required to select and use a primary medical provider (PMP) for all non-emergency care. PMPs will be general practitioners, family practitioners, pediatricians, internists, and gynecologists who provide primary care services, certain lab and x-ray procedures, routine newborn care, and patient education. Other providers may be assigned to patients with special needs on a case-by-case basis.

PMPs are required to enroll as EPSDT screeners. However, the PMP has the option of providing the screenings or referring to other providers (e.g. Health Departments). The provider performing the screening, other than the PMP, must indicate the PMP referral when billing or the claim will deny.

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 a fee 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.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. An EPSDT child is eligible to 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.

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. Services rendered by speech and occupational therapists are covered **only** as the result of an EPSDT screening.

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.

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.

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 is 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 F, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form.

Screening providers must include their provider number, name, and address for those recipients who do not participate in managed care.

PMPs must include their provider number, 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 on the back of the referral form and the guidelines for completion of the HCFA 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 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 rescreened in order to receive expanded benefits for the second condition noted. If not rescreened, 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 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 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 provider number 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 Alabama Medicaid provider number 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 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 provider number 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-92**, you must complete the following fields:

- Block 2 – Enter the screening provider's provider number
- Block 24 – Enter "**A1**" to indicate EPSDT

If you file **electronically** on the UB-92 using EDS *Provider Electronic Solutions* software, you must enter "**A1**" in Condition Code field on the H3 tab and the screening provider's Medicaid number in the Referring Physician field on the H2 tab.

If you file claims on the **HCFA-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's Medicaid provider number
- Block 24H – Enter "**1**" to indicate EPSDT

If you file **electronically** on the HCFA-1500 using EDS *Provider Electronic Solutions* software, you must enter "**E**" in the EPSDT/Family Planning field on the Services tab and the screening provider's Medicaid number in the Referring ID # field on the H2 tab.

For Patient 1st and EPSDT Referred Services

If you file claims on the **UB-92**, you must complete:

- Block 2 – Enter the referring PMP's provider number
- Block 24 – Enter "**X3**" to indicate EPSDT and managed care

If you file electronically on the UB-92 using EDS *Provider Electronic Solutions* software, you must enter "**X3**" in Condition Code field on the H3 tab and the screening provider's Medicaid number in the Referring Physician field on the H2 tab.

If you file claims on the **HCFA-1500**, you must complete:

- Block 17 – Enter the name of referring PMP
- Block 17a – Enter the referring PMP's Medicaid provider number
- Block 24H – Enter "**4**" to indicate EPSDT and managed care

If you file **electronically** on the HCFA-1500 using EDS *Provider Electronic Solutions* software, you must enter "**B**" in the EPSDT/Family Planning field on the Services tab and the referring provider's Medicaid number in the Referring ID # field on the H2 tab.

A.5 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.5.1 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 on a sign-in log book. The consent for services should be filed in the patient's permanent medical record. If a sign-in log book 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.5.2 Medical Records

All screening providers must maintain complete records for three years plus the current year on all children 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
- * 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.6 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. All RNs must be prior approved by Medicaid to perform EPSDT screenings. To be approved to perform EPSDT screenings, one must take an 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.

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.6.1 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, 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 for prior approval designating the dates, times, and the local agency in which you will be offering EPSDT services. This schedule must be submitted at least one week in advance to the office of Medical Services/Patient 1st, Medical Services Division. Failure to report changes in schedule 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. This is 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 provider number will be assigned to each off-site location and will be distinct from any other provider number. A separate application and contract is required for each off-site location.

A.6.2 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.6.3 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 off-site provider numbers have been assigned by Medicaid.

A.7 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, 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, almost 300,000 of Alabama’s children are Medicaid enrolled.

A.7.1 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.

Providers may charge non-Medicaid VFC patients an administration fee not to exceed $14.26 per dose. No VFC-eligible patient should be denied immunizations because of an inability to pay the administration fee.

A.7.2 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 1-800-469-4599.

Participation in Medicaid is not required for VFC enrollment.

A.7.3 Vaccines for Children Billing Instructions

Providers must use an appropriate CPT-4 code on a HCFA-1500 claim form in order to receive reimbursement for the administration of each immunization given from VFC stock.

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 21:

CPT-4 Procedure Code	***Immunization***
90645	*Haemophilus influenzae type b* (Hibtiter)
90647	*Haemophilus influenzae type b* (Pedvax)
90648	*Haemophilus influenzae type b* (ActHib)
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90669	Pneumococcal Conjugate vaccine
90700	Diphtheria, Tetanus, Acellular Pertussis (DTaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR))
90713	Poliomeylitis (IPV)
90716	Varicella (Chicken pox) vaccine *(for selected recipients)*
90718	Tetanus and Diptheria (Td) (*for adult use*)
90721	Diphtheria, Tetanus, Acellular Pertussis and *Hemophilus influenzae b* (DTaP-HIB)
90732	Pneumococcal polysaccharide virus
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and *Hemophilus influenzae b* (Hep B-Hib)

A.7.4 Recommended Immunization Schedule

The chart on the next page provides the recommended immunization schedule.

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.

Recommended Childhood Immunization Schedule
United States, January – December 2001

Vaccines[1] are listed under the routinely recommended ages. Bars indicate range of acceptable ages for immunization. Any dose not given at the recommended age should be given as a "catch-up" immunization at any subsequent visit when indicated and feasible. Shaded bars indicate catch-up vaccinations to be given if previously recommended doses were missed or given earlier than the recommended minimum age.

Age ➢ / Vaccine ⮟	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	4-6 yrs	11-12 yrs	14-16 yrs
Hepatitis B [2]	Hep B #1										
		Hep B #2			Hep B #3					Hep B[2]	
Diphtheria, Tetanus, Pertussis[3]			DTP	DTP	DTP		DTaP[3]		DTaP	Td	
H. Influenzae type b[4]			Hib	Hib	Hib	~~IPV[5]~~Hib					
Inactivated Polio[5]			IPV	IPV	IPV[5]				IPV[5]		
Pneumococcal Conjugate[6]			PCV	PCV	PCV	PCV					
Measles, Mumps, Rubella[7]						MMR			MMR[7] or	~~Hep B[2]~~MMR[7]	
Varicella [8]						Var				Var[8]	
Hepatitis A [9]								Hep A [9] in selected areas			

The above is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Notes:

1. This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of 11/1/00, for children through 18 years of age. Additional vaccines may be licensed and recommended during the year. Licensed 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.

2. Infants born to HBsAg-negative mothers should receive the first dose of hepatitis B (Hep B) vaccine by age 2 months. The second dose should be at least one month after the first dose. The third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at 1-2 months of age and the third dose at 6 months of age.

Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).

All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

3. The fourth dose of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months of age, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP or DT. Subsequent routine Td boosters are recommended every 10 years.

4. Three *Haemophilus influenzae* type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4 or 6 months of age, unless FDA-approved for these ages.

5. To eliminate the risk of vaccine-associated paralytic polio (VAPP), an all-IPV schedule is now recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at 2 months, 4 months, 6-18 months, and 4-6 years of age. Oral Polio Vaccine (OPV), if available, may be used only for the following special circumstances:

- Mass vaccination campaigns to control outbreaks of paralytic polio.
- Unvaccinated children who will be traveling in less than 4 weeks to areas where polio is endemic or epidemic.
- Children of parents who do not accept the recommended number of vaccine injections. These children may receive OPV only for the third or fourth dose or both; in this situation, health-care providers should administer OPV only after discussing the risk for VAPP with parents or caregivers.
- During the transition to an all-IPV schedule, recommendations for the use of remaining OPV supplies in physicians' offices and clinics have been issued by the American Academy of Pediatrics (see Pediatrics, December 1999).

6. The heptavalent conjugate pneumococcal vaccine (PCV) is recommended for all children 2-23 months of age. It is also recommended for certain children 24-59 months of age. (See MMWR Oct. 6, 2000/49(RR-9);1-35).

7. The second dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

8. Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e., those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or older should receive 2 doses, given at least 4 weeks apart.

9. Hepatitis A (Hep A) is shaded to indicate its recommended use in selected states and/or regions, and for certain high risk groups; consult your local public health authority. (Also see MMWR Oct. 1, 1999/48(RR-12); 1-37).

A.8 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								
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---->						
Metabolic Screening 9																	
Sickle Cell Screening 9																	
Anemia Screening	X----------X																
Urine Screening [3]												X					
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	O
Hearing Screening [6]	S	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)**	All children without specific risk factors should receive a TST at age 4-6 years and another at 11-16 years of age. Please refer to Section A.3.5 Critical Components of Screenings.																

Key

X	Required at the visit for this age
X+	Perform blood lead 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
<---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.
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. **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 after six months 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.
8	Please refer to Section A.3.5, Critical Components of Screenings, for detailed information.
9	These laboratory tests **do not** need to be performed again if you have obtainable, verifiable results. Screen for PKU and other disorders prior to discharge or 24 hours after birth, according to state law. A single PKU is adequate when performed at least 24 hours after birth in a well infant or when performed at 6 to 7 days of age in a premature or ill infant. The newborn screening Program tests results satisfies this requirement. For more information, please refer to Newborn Screening Program.

Adolescent Screening Protocols

For adolescents 11-20 years of age the following are performed annually:

- History
- Height/Weight
- Blood Pressure/Pulse
- Developmental Assessment
- Physical Exam
- Urine Screening
- 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.

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.

Newborn Screening Program

The newborn screening program administered by the Department of Public Health, Bureau of Clinical Laboratories test for five abnormalities on newborns. The tests performed are: (1) phenyl ketonuria, (2) abnormal hemoglobin, (3) congenital adrenal hyperplasia, (4) galactosemia, and (5) hypothyroidism.

Providers may register (at no charge) by calling (334) 206-2971. After providers register, they may call the toll free number, 1 800-566-1556, to obtain test results. Providers should have the following information available to obtain test results: (1) mother’s name, (2) mother’s social security number, (3) child’s name, (4) child’s date of birth, and preferably (5) the test kit number.

The Alabama Youth Passport

The Alabama Youth Passport is a pocket-sized booklet containing health information, as well as space to record important information about a child's growth and development. Similar to a passport in appearance, the booklet is provided in a durable plastic slipcase to make it easy for parents to take with them to the doctor or clinic.

The purpose of the project is to increase the number of Alabama parents who maintain current information about check-ups, shots and childhood illnesses. Passports are distributed free of charge to parents by private physicians, hospitals, and health departments. To obtain the Alabama Youth Passports contact your physician, local Health Department or local hospital, or you may fax your request to: Outreach and Education, the fax number is: (334) 353-5203.

A.9 Early Intervention Child Find Referral Form

ALABAMA

Early Intervention Child Find Referral Form
1-800-543-3098 / VOICE / TDD

SOURCE

1. PERSON MAKING REFERRAL: _____
2. ADDRESS: _____
3. CITY: _____ ZIP: _____ PHONE: ( ) _____
4. PARENTS INTERESTED: (Y, N) 5. BECAME AWARE OF CHILD FIND ( ) _____
6. REASON REFERRED TO CHILD FIND: _____

CHILD

7. LAST NAME _____ FIRST NAME: _____ MI: _____
8. SOCIAL SECURITY #: _____ 9. SEX: ____ (M,F) 10: CHILD'S DOB _____ / ____ / _____ (MM DD YY)
11. MEDICAID: YES NO 12. EPSDT: YES NO 13. CHIP: YES NO 14. INSURANCE: YES NO
15. ETHNIC ORIGIN: _____ 16. HOME LANGUAGE: _____
17. PRIMARY CARE PHYSICIAN: _____ PHONE: ( ) _____

FAMILY

18. PARENT/GUARDIAN (P, G) 19. MILITARY (Y, N)
20. LAST NAME: _____ FIRST NAME: _____ MI: _____
21. PHYSICAL ADDRESS: _____
22. CITY: _____ ZIP: _____ CO: _____
23. HOME PHONE: ( ) _____ 24. ALTERNATE PHONE:: ( ) _____

DSP

SENDER: _____

Refer to Program/AG#: _____

Service Coordinator: _____

MISC

DATE MAILED / FAXED TO CHILD FIND: _____

ADRS / EI, 2129 E. South Blvd. Montgomery, AL 36111

FAX NUMBER: (334) 613-3494

REFERRALS NOT ACCEPTED UNLESS ALL BLANKS ARE COMPLETED

EI

(STATE OFFICE USE ONLY) **PROCESSED BY:** _____

REFERRALS RECEIVED: PHONE FAX MAIL EMAIL PHONE: ( ) _____

OFFICIAL REFERRAL DATE: _____ **(DATE CHILD IS ENTERED: BEGINS 45 DAYS)**

QUESTION #5 - BECAME AWARE OF CHILD FIND

1 - Parent
2 - Agency
3 - Primary Referral Source
(EX: Daycare Provider, Hospital/Physician)
4 - Media
5 - Other
6 - Child Care
7 - Hospital
8 - Primary Care Physician
9 - Healthy Child Care Alabama

QUESTION #15 - ETHNIC ORIGIN

1. White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

2. Black: (not Hispanic) - A person having origins in any of the black racial groups of Africa.

3. American Indian or Alaskan Native: A person having origins in any of the original peoples of North America, and who maintains cultural identification through affiliation or community recognition.

4. Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

5. Hispanic: A person having origins in any of the original peoples of Mexico, Puerto Rico, Cuba, Central or South America or other Spanish culture.

6. Information not available.

QUESTION #16 - CHILD'S HOME LANGUAGE

1. American Sign Language
2. Braille
3. Large Print
4. Spanish/Hispanic
5. Asian
6. English
7. Other

QUESTION #22 - COUNTY CODE

County Code / County	County Code / County	County Code / County
01 Autauga	24 Dallas	47 Marion
02 Baldwin	25 DeKalb	48 Marshall
03 Barbour	26 Elmore	49 Mobile
04 Bibb	27 Escambia	50 Monroe
05 Blount	28 Etowah	51 Montgomery
06 Bullock	29 Fayette	52 Morgan
07 Butler	30 Franklin	53 Perry
08 Calhoun	31 Geneva	54 Pickens
09 Chambers	32 Greene	55 Pike
10 Cherokee	33 Hale	56 Randolph
11 Chilton	34 Henry	57 Russell
12 Choctaw	35 Houston	58 Saint Clair
13 Clarke	36 Jackson	59 Shelby
14 Clay	37 Jefferson	60 Sumter
15 Cleburne	38 Lamar	61 Talladega
16 Coffee	39 Lauderdale	62 Tallapoosa
17 Colbert	40 Lawrence	63 Tuscaloosa
18 Conecuh	41 Lee	64 Walker
19 Coosa	42 Limestone	65 Washington
20 Covington	43 Lowndes	66 Wilcox
21 Crenshaw	44 Macon	67 Winston
22 Cullman	45 Madison	
23 Dale	46 Marengo	

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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 EDS. It contains the following sections:

- General Information
- Provider Electronic Solutions
- Vendor Software

Technical support is available through the EDS Electronic Claims Submission Help Desk. Providers in Alabama call 1-800-456-1242. (Out of state providers call (334) 834-3330.)

B.1 General Information

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 PCs to submit claims to a central location, called a Bulletin Board Service (BBS). The BBS then sends the claims to the system for processing.

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.

Electronic claim submission assists providers in receiving quick payment. Just as ECS can greatly reduce claims processing time, it can also help providers receive payment faster than with paper submission. As providers track submissions, make corrections, and resubmit claims online, they receive payment much quicker than paper filing.

Electronic claims submission provides an audit trail of claims that have failed preliminary edits. Providers can receive information about certain problems on submitted claims within a few hours instead of a few weeks. Providers can correct the problem or error and resubmit the claim before the next scheduled checkwriting date.

To submit claims electronically, providers use software designed specifically for this purpose. Providers may use software created by EDS, called Provider Electronic Solutions software, or software developed by outside vendors. The following two 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 BBS so that they may be processed by the system.

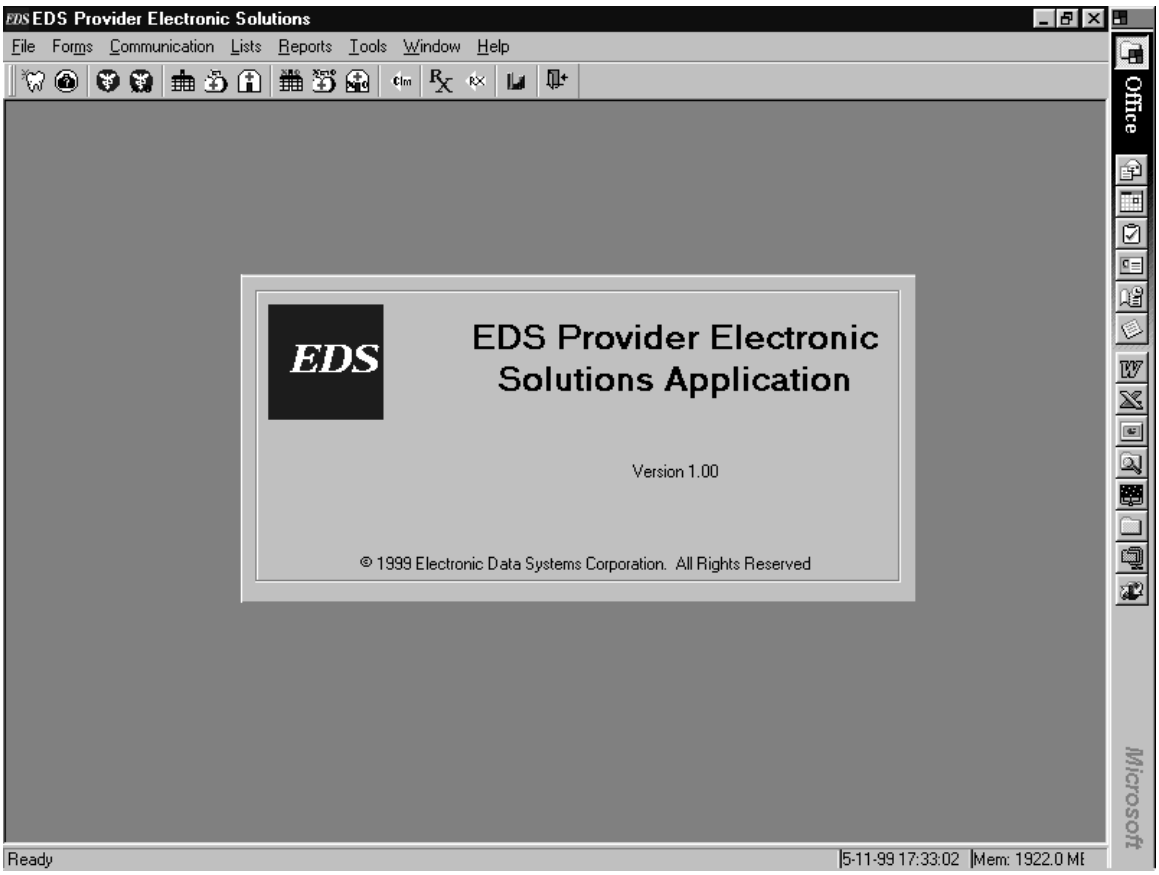
Provider Electronic Solutions software is available free of charge to any provider. EDS will mail the software to the provider at no cost, or the provider may download the software from the Bulletin Board (BBS), or the Internet. The Alabama Medicaid web address is **http://www.medicaid.state.al.us.**

With Provider Electronic Solutions, providers can verify eligibility and transmit claims from the same program. The software allows providers to submit eligibility requests and claims in batch or interactive mode. In batch mode providers transmit groups of information. Interactive mode permits providers to submit information one transaction at a time.

Providers use Provider Electronic Solutions software to submit the following claim types:

- Dental
- HCFA 1500
- HCFA 1500 Crossover (Medicare-related claims)
- UB92 - Inpatient, Outpatient, and Long Term Care
- UB92 Crossover - Inpatient, Outpatient, and Long Term Care (Medicare-related claims)
- Pharmacy

The software also allows providers to perform eligibility verification, claim reversal, pharmacy reversal, and long-term care (LTC) census transactions.


EDS Provider Electronic Solutions
File Forms Communication Lists Reports Tools Window Help
EDS
EDS Provider Electronic Solutions Application
Version 1.00
© 1999 Electronic Data Systems Corporation. All Rights Reserved
Office
Microsoft
Ready
5-11-99 17:33:02
Mem: 1922.0 MB

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 (PES) 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, if inquiring about 1998 eye care benefits, enter the current date with 1998 year.

B.2.2 Viewing Submission Information: Understanding your Data

Providers have access to the following information about their submissions.

- **Communication Log** - displays information about communication during submissions
- **Verification** - displays verification report that is downloaded from the BBS. This report tells the user how many claims EDS received and indicates any formatting errors that occurred.
- **Up-front Rejection Codes** - allow the user to view rejection codes immediately. Claims that are rejected will not be entered into the system. For an explanation of rejection codes, see Section J.3, Electronic Up-Front Rejections, in Appendix J of this manual.
- **View Response** - allows the user to view the response file that is downloaded from the BBS. This file indicates the status of the claims submitted within a batch.
- **View Electronic Remittance Advice (ERA)** - allows the user to view Electronic Explanation of Payments.

B.2.3 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 Solution software stores lists of data about the following topics:

- Provider
- Recipient
- Condition
- Diagnosis
- Occurrence
- Patient Status
- Place of Service
- Procedure/HCPCS
- Revenue
- Type of Bill
- Type of Service

Providers can generate reports about these lists, as well as detail and summary reports about the claims they have submitted.

B.2.4 Archive and Connection Tools: Protecting your Data

Providers use the Get Upgrades option to upgrade their software from any downloaded update through the BBS. 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 EDS sending new software.

B.2.5 Additional Information about Provider Electronic Solutions

Provider Electronic Solutions software does not interface with accounting systems or other databases. It requires claim data to be keyed twice, once when submitting the claim, and again when office staff enter it 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 EDS Electronic Claims Submission Help Desk at 1-800-456-1242 (Out of state providers call (334) 834-3330).

B.3 Vendor Software

Providers may prefer to submit claims using vendor software. Providers are recommended to contact EDS to determine if their vendor's software is approved for claims submission.

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 between 10 and 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 began October 1, 2000. The Health Care Financing Administration granted approval for an 1115 Research and Demonstration waiver that extends family planning coverage for women ages 19-44. 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:

1. Females, any age, after onset of menses. If age 14 or over, no parental or other consent is required.

2. 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 (Z5181)
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.

NOTE:

Questions about PT+3? Call the Outreach and Education Unit at (334) 353-5203.

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 (Z5182)

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 (Z5183)

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.

Home Visit (Z5184)

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 (Z5190)

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.

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 Z5190.

Implant Physical with Counseling Visit (Z5272)
The implant physical with counseling visit is a physical examination with contraceptive counseling using the PT+3 teaching method prior to insertion of Norplant capsules. The insertion procedure may be performed on the day of the physical exam with counseling. However, the physical examination with counseling **must be performed** within 30 days prior to the insertion procedure.
Pre-insertion counseling is a critical component of the contraceptive implant procedure. The health care provider should provide sufficient information that will allow the recipient to make an informed decision about the implants. Counseling should include:

- Contraceptive options
- Information about the Norplant method:
  - Possible side effects and adverse reactions including the warning signs of possible problems with the Norplant system (e.g., blood clots associated with smoking)
  - Risks, benefits, and effectiveness of Norplant
  - Insertion and removal procedures including how to arrange for removal
  - Drugs that impair the effectiveness of Norplant
- Necessary follow-up
- Need for STD prevention.

Insertion of Norplant should coordinate with contraceptive use, postpartum period, or during or within seven days of the menstrual cycle. Norplant should be inserted according to procedures and techniques as described in “Norplant System Prescribing Information” by Wyeth-Ayerst

The provider must advise the recipient that the capsules can be removed **at any time for any reason.** The health care provider inserting the capsules is responsible for either removing the capsules or the referral and acceptance by another health care provider for removal of the capsules.

NOTE:

Norplant removal is covered only for recipients who are eligible for benefits at the time.

A complete medical history and physical examination is to be done prior to insertion/reinsertion of Norplant capsules that includes:

- Recipient history
- Medical history and psychological suitability for this contraceptive method
- Screening for contraindications (e.g. thrombophlebitis, abnormal vaginal bleeding, suspected pregnancy, liver disease, suspected carcinoma of breast or other areas, and postpartum lactation from 0 to 6 weeks)
- Lab tests - Hgb or Hct, and urine
- Physical assessment as outlined in the initial visit requirements.

Norplant insertion (11975) may be covered in an inpatient setting ONLY during the immediate postpartum period. The physical exam/counseling is NOT covered as an inpatient service because the recipient normally receives continual examinations during pregnancy and delivery by the same physician. Follow-up in the office setting within one week of insertion is necessary to evaluate the insertion site.

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. Provide patient with materials prior to history taking
2. Determine degree of risk
3. Intervene with confrontation and counseling
4. Test for STDs and HIV as clinically indicated
5. Document using the form provided
6. Screen for risk at the initial and annual visit or as clinically indicated.

Requirements Detailed:
1. Provide patient with materials prior to history taking.
   A low-literacy handout – "Just for You to Think About" that incorporates Facts about HIV and HIV testing has been developed. It is to be used to introduce the subject of HIV risk assessment to the patient before the actual STD/HIV risk screening is done. This material is to be given to the patient during the registration process so that it can be read while waiting to be called for the appointment. See Attachments for a reproducible copy.
2. Determine degree of risk.
   Screen for STD/HIV risk using the screening tool provided. See Attachments for a reproducible copy.
3. 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. Use the low-literacy handout, "STDs – Don't Let'em Break Your Heart" as a counseling aid. (See Attachments.)
4. Test for STDs and HIV as indicated by screening results and clinical symptoms.
5. Document using the form provided.
6. 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:

Each procedure code is limited to two counseling services per patient per calendar year, and must be performed in conjunction with a family planning visit.

C.2.2 *Family Planning Protocols - Clinical*

➢ ***Table Legend***

X	Perform at this visit
CI	Do if clinically indicated
INIT	Initial
AN	Annual
PER	Periodic
IMP/PE	Implant physical exam
EXT/C	Extended family planning counseling
HOME	Home visit

Visits	*INIT*	*AN*	*PER*	*IMP/PE*	*EXT/C*	*HOME*
Consent For Services	*X*	*X*	*X*	*X*	*X*	*X*
History						
Family	X	X		X		X
Med/Surg/OB-GYN	X	X		X		X
Contraceptive	X	X		X		X
STD/HIV screening	X	X		X		X
Interim		X	X			
Blood Pressure	**X**	**X**	**X**	**X**		**X**
Weight	**X**	**X**	**X**	**X**		**X**
Physical Exam						
Skin/General appearance	X	X	CI	X		
Eyes/ENT	X	X	CI	X		
Head/Neck/Thyroid	X	X	CI	X		
Nodes	X	X	CI	X		
Heart/Lungs	X	X	CI	X		
Breast/SBE	X	X	CI	X		
Abdomen	X	X	CI	X		
Extremities/Back	X	X	CI	X		
External genitalia	X	X	CI	X		
Glands	X	X	CI	X		
Vagina	X	X	CI	X		
Cervix	X	X	CI	X		
Uterus size/shape	X	X	CI	X		
Adnexa	X	X	CI	X		
Recto-vaginal	X	X	CI	X		
Rectum	X	X	CI	X		
Laboratory						
HGB or HCT	CI	CI	CI	CI		
Urinalysis	CI	CI	CI	CI		
Pap smear	X	X		CI		
STD tests including HIV	CI	CI	CI	CI		
Pregnancy testing	CI	CI	CI	CI		

C.2.3 *Family Planning Protocols – Educational*

		INIT	AN	Per	IMP/P	EXT/C	Home
Counseling Using PT + 3 Teaching Method							
Priority One	*Patient expressed needs or problems*	X	X	X	X	X	X
	Contraceptives: **** Listing of the various options* ****How to use* **** Side effect management*	CI	CI	CI	CI	CI	CI
	Prevention of STDs including HIV	X	X	CI	CI	CI	CI
	Breast self-exam or testicular self-exam	X	X	X	X	X	X
Priority Two	*Explanation of any screening or lab testing done*	X	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	X
	Folic Acid	X	X				
Priority Three	*Need for Mammogram*	X	X				
Optional	Anatomy and physiology	CI	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 EDS. EDS will NOT pay any claims to ANY provider until a correctly completed original of the appropriate form is on file at EDS.

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," designation which is optional.

NOTE:

When the claim for the sterilization procedure is submitted to EDS, the claim will suspend in the system for 21 days waiting for the approved consent form to be entered. Once the claim is scanned into the system, it will check to see if the consent form has been entered. It will check the system each day, up to 21 days, for the approved consent form. After the 21st day, the claim will reject 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 day 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's, counselor's, and interpreter's signatures and dates must be affixed prior to the surgical procedure.
f. Description of the physician performing the procedure: It is acceptable to list a general description of the physician, such as "staff physician, on-call physician, OB/GYN physician" on the recipient's section of the consent form when it is not known in advance which specific physician will perform the procedure. When using a generic description and not a specific physician's name, the recipient is to be informed that the physician on call or on duty will perform the procedure at the time of the delivery. The name of the provider physician's group must also be entered on the blank # 5 when the generic physician description is used. Example: "Staff Physician – OB/GYN Clinic". The physician who is named in the first paragraph of the consent form does not have to be the physician who performs the surgery or signs the "Physician's Statement."

g. 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.

h. 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:
   1. Original - Patient
   2. Copy 2 - EDS
   3. 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*

All medically prescribed family planning drugs and supplies are covered.

C.4 Plan First

Effective October 1, 2000, the Alabama Medicaid Agency initiated a new 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. The program, called Plan First, operates under an 1115 Research and Demonstration waiver granted by the Health Care Financing Administration (HCFA).

Under Plan First, eligible women qualify for most family planning services and supplies, including birth control pills, the Depo-Provera and Lunelle shot, 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.

C.5 Eligible Individuals

Eligible individuals are females of childbearing age between 19 and 44 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 44 years of age who have SOBRA-eligible children (poverty level) are automatically eligible for family planning without a separate eligibility determination. These women are automatically eligible and are not required to complete an application.

Women who are non-citizens who are payees of SOBRA Medicaid children are sent a letter telling them how to apply for the Plan First Program.

Group 2
SOBRA poverty level pregnant women 19 through 44 years of age are automatically eligible for family planning services after 60 days postpartum without a separate eligibility determination. These women are automatically eligible and are not required to complete an application.

Group 3
Women 19 through 44 years of age who are not postpartum or who are not applying for a child may apply using a simplified shortened application. An eligibility determination is completed using poverty level eligibility rules and standards.

Recipient Eligibility Process
An individual wishing to apply for family planning services will be given the opportunity to apply without delay. A claimant or a person acting responsibly for the claimant may apply at the outreach site of her choice without regard to county of residence. The out-stationed workers in the Family Certification Division make eligibility determinations. Women between the ages of 19 and 44 who are not receiving Medicare may complete an application.

C.6 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 EDS, the provider must complete a Plan First agreement.

Plan First providers must agree to receive and distribute oral contraceptives provided through the Alabama Department of Public Health as described in the section entitled, Distribution of Oral Contraceptives to Plan First Providers.

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. Once a provider has enrolled as a Plan First provider, a specialty code of F7 will be added to the provider file. 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 is sorted alphabetically by the provider's last name (clinics are listed by the first word in the clinic name). 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 case managers 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 (http://www.medicaid.state.al.us) 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,** services for male family planners are not a part of the Plan First program.

Oral Contraceptives
Plan First recipients who chose to use oral contraceptives are to obtain them (OCPs) from their service provider. **Prescriptions for OCPs for Plan First patients will not be honored.** OCPs will be made available - at no cost to the provider - to all enrolled Plan First providers by the Alabama Department of Public Health. These oral contraceptives are for Plan First participants only.

Providers distributing oral contraceptives will be reimbursed a dispensing fee for each pack distributed up to 13 units. Pills are to be dispensed in the manner that prescriptions are normally written. If the usual practice is to give an initial prescription for 3 months, then dispense 3 packs. If an annual prescription is usual, dispense a year's supply or 12-13 packs. On occasion, a patient may receive a 13-month supply, and then may require a pill change or replacement due to loss. In these situations it is acceptable to provide more pills. Claims are to be submitted to the Alabama Medicaid Agency for the total number of packs provided to a patient.

OCP orders are to be placed on the Oral Contraceptives Order Form. (See Attachments.) Orders will be processed in increments of whole cases, as described on the order form. These forms may be photocopied. See attachments for a reproducible copy or a copy may be requested by contacting the ADPH Plan First Representative at (334) 206-2912.

Efforts will be made to offer a variety of oral contraceptives, however, if an oral contraceptive is determined to be medically necessary for a specific patient and is not routinely offered, consult the Medicaid Plan First Program Manager at (334) 353-5263.

Providers should maintain a minimum one-month supply, if possible, and reorder before pills are depleted. **Please order only what is needed.**

In the event of a manufacturer pill shortage, providers will be notified and alternate pills will be shipped upon request.

Order forms will be accepted by mail at the address below or by fax at (334) 206-2950 and will be processed within 5 working days of receipt of order form. Shipping will be via UPS.

Providers with questions may contact the Bureau of Family Health Services Plan First Representative at (334) 206-2912.

NOTE:

Providers should mail order forms to:

Alabama Department of Public Health
BFHS/Plan First, Suite 1350
Post Office Box 303017
Montgomery, Alabama 36130-3017

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 OCP dispensing - To obtain a fee for the dispensing of birth control pills, submit claims using the code **Z5440** and place the number of units (1 unit = 1 pack) in block 24 G on the HCFA-1500 to indicate the number of birth control pill packs dispensed. This claim is in addition to any service claims.

NOTE:

Procedure code Z5440 is TPL exempt.

Claims for family planning services - See sections C.8, Completing the Claim form and C. 8.1 and C.8.2 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 must submit a hard copy claim to EDS 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 Z5181 (initial), Z5182 (annual), or Z5183 (periodic). In addition to these codes, the diagnosis code V25.2 or V25.9 must be used.

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,
- Sample random review of Provider and Care Coordinator records for documentation standards,
  - Monitor Care Coordinator activity,
  - Review Summary Reports, (Care Coordinator and UAB)
- Request Plans of Correction for documentation not meeting standards (standards as outlined above), and
  - 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.
- Removals 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, an HCFA-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 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

C.10.2 *Diagnosis Codes*

Family Planning services **do not require** a referral from the Patient 1st PMP when one of the following diagnosis codes is used:

➢ 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.

V25	Encounter for contraceptive management
V250	General counseling and advice
V2501	Prescription of Oral Contraceptives
V2502	Initiation of other contraceptive measures – fitting of diaphragm, prescriptions of foams, creams, or other agents
V2509	Other – Family planning advice
V251	Insertion of intrauterine contraceptive device
V252	Sterilization
or	Admission for interruption of fallopian tubes or vas deferens
V615	Multiparity
V254	Surveillance of previously prescribed contraceptive methods, Checking, reinsertion, or removal of contraceptive device, Repeat prescription for contraceptive method, Routine examination in connection with contraceptive maintenance
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

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4 or 5 digits). Medicaid does not cover diagnosis codes preceded by an "E", "M" or "Y", do not use decimal points in the diagnosis code field.

C.10.3 *Procedure Codes and Modifiers*

Providers who collect laboratory specimens may bill the collection fee. The laboratory that processes the specimen bills for the test.

NOTE:

Family planning visits do not count against the recipients office visits when the above procedure codes 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
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.
88302	Surgical pathology, gross and microscopic examination
89300	Semen analysis; presence and/or motility of sperm *(not applicable for Plan First)*
88167	Cytopathology, slides, cervical or vaginal
88166	Cytopathology, slides, computer assisted rescreening
88165	Cytopathology, slides, cervical or vaginal
88164	Cytopathology, slides, cervical or vaginal
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
88145	Cytopathology, computer assisted rescreening using cell selection
88144	Cytopathology, computer-assisted rescreening 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
87797	Infectious agent detection by nucleic acid (DNA or RNA); not otherwise specified, 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
87482	Candida species, quantification
87481	Candida species, amplified probe technique
87480	Candida species, direct probe technique

Code	Procedure Description
87220	Tissue examination for fungi
87210	Smear, primary source, with interpretation, wet mount with simple stain, for bacteria, fungi, ova, and/or 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, 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
86703	HIV – 1&2
86702	Antibody HIV-2
86701	HIV – 1
86695	Herpes simples, type 1
86694	Herpes simplex, non-specific type test
86692	Hepatitis, delta agent
86689	HTLV or HIV antibody
86593	Syphilis
86592	Syphilis
85031	Blood count; hemogram, manual, complete CBC
85027	Blood count; RBC only
85025	Blood count; hemogram and platelet count, automated, and automated complete differential WBC count (CBC)
85024	Blood count; hemogram and platelet count, automated and automated partial differential WBC count (CBC)
85023	Blood count; hemogram and platelet count, automated, and manual differential WBC count (CBC)
85022	Blood count; hemogram, automated, and manual differential WBC count (CBC)
85021	Blood count; hemogram, automated (RBC, WBC, Hgb, Hct and indices only)
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
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
58301	IUD removal
58300	IUD insertion
57170	Diaphragm – fitting with instructions
55450	Vasectomy (*Not applicable for Plan first)*
55250	Vasectomy (*Not applicable for Plan first)*
11980	Subcutaneous Hormone Pellet implantation (implantation of estradiol and/or testosterone beneath the skin)
11977	Norplant – implant removal with reinsertion – limited to one procedure every 5 years.
11976	Norplant – implant removal
11975	Norplant – insertion – limited to no more than one insertion procedure per 365 days.

Code	Procedure Description
00940	Anesthesia for vaginal procedures; not otherwise specified
00860	Anesthesia for extraperitoneal procedures in lower abdomen
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00820	Anesthesia for procedures on lower posterior abdominal wall
00800	Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified
J1055	Depo-Provera – 150mg/ml – Limited to one injection *every 70 days*
J3490	Unclassified Drug (to be used for Lunelle)
Z5181	Initial visit
Z5182	Annual visit
Z5183	Periodic visit
Z5184	Home visit – Limited to one per 60 day post-partum period. *(Not applicable for Plan First)*
Z5189	Birth control pills (For Health Department billing only)
Z4998	Administration fee for injections
Z5190	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.)*
Z5440	Birth control pills (To be used for billing by Plan First Private Providers)
Z5270	Norplant capsules – limited to one Norplant system per 365 days
Z5272	Implant physical with counseling visit
Z5320	Mechanical (Paragard) IUD
Z5319	Hormonal (Progestasert) IUD
Q0091	Collection of Pap smear specimen
Q0111	Wet mounts
36415-90	Routine venipuncture for collection

C.11 Attachments

- Just for you to think about (Handout)
- STD/HIV Screening and Documentation Forms
- STDs – Don't' let 'em break your heart (Handout)
- Sterilization Consent Form
- Plan First Pill Order Form
- Plan First Pill Agreement

These handouts are available through Outreach and Education (334-353-5203)
How to do a Breast Self-Exam (Handout)
Folic Acid for Women for healthy babies (Handout)
Birth Control Method Sheets (Handout)

Facts About HIV and HIV Testing

What is the HIV test?
The HIV test is a blood test. A health care worker takes a blood sample from your arm and sends it to the lab. In about two weeks you get the results from the place that gave you the test.

What do the results mean?
If you are HIV positive, that means you have HIV antibodies in your blood. If there are no antibodies, the test is HIV negative – for now. It can take up to 6 months after you get the HIV virus for antibodies to show up in your blood. If you have had a recent chance of getting the HIV virus, then you need to get another test in 6 months. Talk this over with your health care worker.

Should you get the test?
If there is any chance you may have the HIV virus then you should get the test. Just because you look healthy does not mean you are healthy. You may have the HIV virus and not know it. You should get tested if:

- You use alcohol or drugs.
- You've had a STD (sexually transmitted disease).
- You've been forced to have sex.
- You've had sex without a condom, or your partner has had sex with someone besides you.
- You or your sex partner was given blood before 1985.

D You are thinking about having a baby.
If you are HIV positive, medical care can help you live healthier and longer. If you are thinking of getting pregnant, getting an HIV test is very important. Knowing if you have HIV will help you know the risks of passing the virus on to your baby. If you are pregnant -- knowing if you are HIV positive will help your doctor make the best decisions about the care of you and your baby. New drugs can cut the risks of passing the virus to the baby, but there is still some risk.

If you test negative
Talk to your health care worker about having another test in 6 months. Then:

- Use condoms EVERY TIME you have sex.
- DO NOT use needles that have been used by anyone else.
- Get all the information you can about how to keep from getting the HIV virus.

If you test positive

- Get medical care NOW!
- AVOID HAVING SEX OR USE A CONDOM EVERY TIME YOU HAVE SEX.

This will lessen the chance that you will pass the virus on and that you will get an STD. If you are HIV positive, it will be easier for you to give and get any kind of sex disease.
IF you test HIV positive: that does NOT mean you have AIDS. The HIV virus weakens the immune system. When that happens, your body cannot fight off infections or disease. Later, AIDS can result. There is much that can be done now to give hope to those with HIV.

If you are HIV positive
Sadness is normal. Finding out you are HIV positive can cause pain, confusion and sadness. You are not alone. There are many places where you can get help. Your health care worker can tell you about them. Not only can you get medical help, you can get help with your feelings too.

Can you give HIV to your family and friends?
No – not with casual contact. HIV is passed on through sharing needles and by having unprotected sex. Touching, hugging or eating with your friends or family will not spread the HIV virus.

Make a plan

Protect Yourself

While you are waiting, here are some things

Just for you to ...

Thanks for coming to see us for your exam!

Please answer the following questions and let the nurse know when you are finished.

Even though you don't want to even think about getting pregnant now –

You DO need to . . .

THINK ABOUT SEX

Think about sex as Your Decision.
No one should talk you into or force you to have sex.
If you want to know how to say "NO!"
_____ Check here

Think about talking to your family about your sexual feelings. Sometimes they can help.

The ONLY way to keep from getting a sex disease is to stop having sex!

A way to be safer while having sex is to use a condom (rubber) EVERY TIME!

THINK ABOUT BIRTH CONTROL

Circle it

Which one do you plan to use?

Saying "No"	Diaphragm
Sterilization	Condoms (Rubbers)
The Pill	Foam and Condoms
The Shot	IUD
Norplant	Natural Family Planning

and Emergency Contraception (the Morning After Pills)

THINK ABOUT FOLIC ACID

Folic Acid is one of the B vitamins. ALL women who ever want to have a baby need to take folic acid. This vitamin may help to keep a future baby from having a birth defect called spina bifida.

† Take a multivitamin every day **and**
- Eat foods that have folic acid in them.
- You can get information about folic acid foods from the nurse.

THINK ABOUT TAKING CARE OF YOURSELF

IF you smoke – TRY TO STOP.
Do you want information on how to stop smoking?
____ Check here

IF you think you have an alcohol or drug problem. Do you want help?
____ Check here

Ever tried to stop drinking or using drugs and couldn't?

Have family or friends ever been bothered by your drug or alcohol use?

If YES, you may need help.

Have you been hit, kicked, slapped or hurt by anyone close to you in the past year? If you have – please let us know.
Living with abuse is not really living at all.
Do you need help to live a safer life?
____ Check here

If you are 35 or over get a mammogram.

Want some information on mammograms?
_____ Check here

While you're thinking…

If you THINK you WANT to get pregnant — let us know — we are here to help you plan ahead!

What can we help you with today?
Please tell us what problem you would like to discuss with the nurse.
Write here:
_____
_____
_____

You need to know
Clinic Telephone Number
_____

Birth control supply appointment
_____

Next exam due
_____

Remember to think about
1. _____
2. _____
3. _____

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. **As far as you know,** 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:

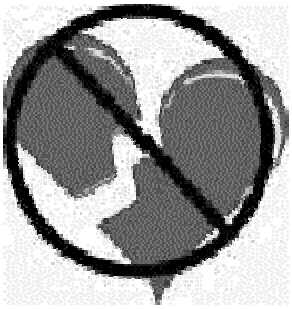
Additional Post- test counseling

Reason:

Points covered:

Signature/title of counselor _____ **Date** _____

Form 189 Alabama Medicaid Agency



STDs
Don't Let'em Break Your Heart!

STDs? What are you talking about?

STDs are sexually transmitted diseases (diseases passed mainly during vaginal, anal or oral sex.)

STD germs are passed:

- In semen (cum)
- In vaginal fluid
- In blood
- Through skin breaks

Some common STDs are:

- Syphilis
- Gonorrhea
- Herpes
- Chlamydia
- HIV, the virus that causes AIDS, and Hepatitis B are two other STDs. They are also passed by sharing needles to inject drugs, pierce body parts, make tattoos or for any other reason.

STDs? What do they look like?

Some STDs cause symptoms on or near sex organs. Some signs of STDs are:

- Blisters
- Warts
- Sores
- Itching
- Swelling
- Dripping
- Pain when going to the bathroom

Sores can also show up in the mouth.

Some people get a skin rash.

STDs can hurt you and the ones you love. If STDs are not treated early they can lead to:

- Not being able to have children
- Cancer
- Brain damage
- Birth defects

Some infected people have NO symptoms at all!

AIDS can't be cured.
Some people die from AIDS.

Women can pass AIDS and some STDS to their babies:

- Before birth
- During birth
- While breastfeeding

How can I stay free from STDs?

The safest way is to not have sex. It's the **only sure** way to prevent getting STDs through sex.

No sex doesn't mean no fun!
You can still show your feelings without having sex by:

- Touching and hugging
- Dry kissing --it's safe if you never touch a sore on the mouth or skin.)

Don't drink or use other drugs.

You might take chances with sex if you do.

If you do have sex, stay with one partner. .. ..

Sex is safest if both you and your partner:

- Do **not have** HIV or an STD
- Have **never** had sex with anyone else
- Have **never** shot drugs

All it takes is
ONE TIME
with an infected person to get an STD !

Always use a new latex condom

If you have vaginal, anal or oral sex.

- Read the package. Make sure the condom protects against STDs
- Keep condoms in a dry place, away from heat and sunlight.
- Put the condom on as soon as the penis is hard and before any vaginal, anal or oral contact.
- Hold the tip of the condom. Unroll it to the base of the penis.
- Use K-Y Brand Jelly (or another water-based lubricant) for vaginal and anal sex. But, don't use petroleum jelly, lotions or any oils.
- The male should pull out right away after coming. Hold on to the condom when pulling out.

Take care of your health. Have regular checkups.

If you think you might have an STD, go to:

- A health-care provider
- A health clinic

Simple tests can show if you have an STD.

Don't have sex until you have a checkup.

If you do have an STD:

- Follow what your health care provider says.
- Tell any sex partners to get checked
- Keep in mind that you can get the same STD more than once.

For more information call:

CDC National STD Hotline
1-800-227-8922

CDC National AIDS hotline
1-800-342-2437 (English)
1-800-344-7432 (Spanish)

The calls are free

Not having sex is the ONLY sure way to avoid passing STDs. Using a condom properly can help protect you.

Play it safe, prevent STDs now!

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 _____ 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 - EDS
Copy 3 - Patient's permanent record

Form 193 (Revised 4-23-01)

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 deliver: _____

(2) _____ Emergency abdominal surgery:
(Describe circumstances using an attachment)

(Signature) _____ (Date) _____

(Typed/Printed Name of Physician) _____

(Medicaid Provider Number) _____

Alabama Medicaid Agency

ORAL CONTRACEPTIVES ORDER FORM

please Print or Type

Date_____

Physician_____Office/Clinic_____

Provider Number_____Contact Person_____

Shipping Address_____

County_____Phone_____

Fax_____E-mail_____

Special Delivery Instructions (i.e., days/hours closed)_____

_____

*Type	Packs per Case	# of patients supplied per case @ 13 pks/yr	Number of Cases	Item No. (BFHS use only)
Triphasil 28 day	300	23		PF-1
Alesse 28 day (20 mcg)	300	23		PF-2
LoOvral 28 day	300	23		PF-3
Ortho Tri-Cyclen 28 day	144	11		PF-4
Ortho 7/7/7 28 day	288	22		PF-5
Ortho-Cyclen 28 day	144	11		PF-6
Micronor 28 day	120	9		PF-7

*Subject to change

Procedure for Ordering Contraceptives:
Indicate the type oral contraceptive(s) and number of cases needed in the space provided. Fax or mail the order form to the Alabama Department of Public Health, Bureau of Family Health Services. If you have any questions regarding your order, call the Plan First Program at 334-206-2957.

Mail Order Form to:
Alabama Department of Public Health
BFHS/Plan First
Post Office Box 303017, Suite 1350
Montgomery, Alabama 36130-3017
Fax Order Form to: (334) 206-2950

FHS-12/00

Distribution of Oral Contraceptives to Plan First Providers:

The Alabama Department of Public Health (ADPH), Bureau of Family Health Services will provide oral contraceptives to Plan First Providers at no cost - **for Plan First Patients only.**

Orders should be placed using the "Oral Contraceptives Order Form" provided. Orders will be processed in increments of whole cases, specifically described on the order form. The forms may be copied but additional forms will be provided upon request. Contact the ADPH Plan First Representative at 334-206-2912.

Provide the number of packs you would otherwise write a prescription with refills for, e.g., from 1-13 packs. IF pills are changed or are lost, it is acceptable to provide more pills. In any case, the total number of packs provided to a patient should be submitted on claims to the Alabama Medicaid Agency.

ADPH is striving to offer a variety of oral contraceptives through this program. If, however, a type oral contraceptive is medically necessary for a specific patient and is not routinely offered, consult the Medicaid Plan First Program Manager at 334-353-5263.

Providers should maintain a minimum one- month supply of pills, if possible, and reorder before pills are depleted. Please order only what is needed.

In the event of a Manufacturer pill shortage, providers will be notified and alternate pills shipped upon request.

Order forms will be accepted by general mail or fax at the address/number listed below. Orders will be processed within five working days of receipt of order form.

ADPH will utilize UPS shipping and tracking.

If questions, contact the ADPH Plan First representative at 334-206-2912.

Mail order forms to:

Alabama Department of Public Health

BFHS/Plan First
Post Office Box 303017, Suite 1350

Montgomery, Alabama 36130-3017

Fax order forms to: FAX: (334) 206-2950

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D Managed Care

This appendix provides information about the following Medicaid and Medicare managed care programs:

- Patient 1st
- Maternity Care
- Medicare Complete

D.1 Patient 1st

Effective January 1, 1997, the Alabama Medicaid Agency initiated a Primary Care Case Management (PCCM) program in Alabama known as Patient 1st. This medical program operates under a "freedom of choice" waiver granted by the Health Care Financing Administration (HCFA) under Section 1915 (b) of the Social Security Act. In a PCCM program, a physician contractually agrees to deliver and coordinate health care for patients who select or are assigned to the physician as their Primary Medical Provider (PMP).

Counties participating in the Patient 1st program were phased in over a two-year period beginning with Marengo county on January 1, 1997. With the addition of Mobile county on June 1, 2000, all counties now participate.

D.1.1 Recipient Eligibility

All Medicaid patients are required to present proper identification to providers of medical care services. To verify eligibility, providers should access Medicaid's Automated Eligibility Verification and Claim Submission (AEVCS) system or the Automated Voice Response System (AVRS) as explained in Chapter 3, Verifying Recipient Eligibility.

These systems indicate whether the recipient is enrolled in Patient 1st and provide the name and phone number of the Primary Medical Provider (PMP). Providers should be aware that Medicaid will not cover non-emergency services provided to Patient 1st participants unless they are approved by the patient's PMP. To obtain approval of care, the provider must contact the patient's PMP. It is the responsibility of the provider to verify eligibility before providing treatment or services under the Medicaid program. Emergency care services in the outpatient hospital setting are covered under the requirements of the Balanced Budget Act of 1997 using the prudent lay person definition. Physicians must certify that the visit meets this definition.

At present, the following individuals do not participate in the Patient 1st program:

- Foster children
- Recipients who have both Medicare and Medicaid
- SOBRA adults
- Those enrolled in private Managed Care plans
- Recipients who reside in a long term care facility
- Children certified through Department of Youth Services (DYS) county 69
- Recipients who are lock-ins
- Recipients whose Medicaid eligibility is retroactive only

D.1.2 Assignment of the PMP

Most Medicaid patients are required to participate in the Patient 1st Program and to select a Primary Medical Provider (PMP). Typically, PMPs are general and family practitioners, pediatricians, internists, OB/GYNs, federally qualified health centers and rural health clinics who provide a “medical home” through an ongoing patient-physician relationship.

Patients are assigned to a PMP based on newborn information, siblings, last PMP, historical patterns of care, location, and other variables. Each recipient receives a letter and welcome packet 30 to 45 days prior to their enrollment effective date. The letter indicates the PMP they have been assigned, the effective date of enrollment, and how to change PMPs if they choose. The welcome packet includes educational materials and a Patient 1st Provider List. Patients may select or change PMPs monthly by calling Medicaid at 1-800-362-1504.

Newborn Assignments

The Newborn Assignment Form (Form 354) is used to request assignment of the newborn's physician. The Managed Care Division collects these requests and sends them to EDS for assignment on a monthly basis. Forms are available by contacting Medicaid’s Managed Care Customer Service Unit at (334) 353-5773. Copies of these forms may be made as needed. Requests may also be faxed to the Customer Service Unit at (334) 353-5556.

D.1.3 Referrals

PMPs provide (or authorize others to provide) primary and preventive care and certain other services as outlined in the Patient 1st Provider Manual. PMPs coordinate patient referrals to specialists and offer 24-hour availability for care or referral.

PMPs continue to bill Medicaid on a fee-for-service basis for all direct care. In addition, PMPs receive a monthly fee ($3 per month per patient) for managing the patient’s care, up to a maximum of $3,000 per month.

Referred Services

All services, except those listed below, require a referral from the PMP in order for Medicaid to reimburse payments. **For services that require a referral, providers must indicate the referral information on the claim form**. You do not have to submit a copy of the referral with the claim, and these claims can be billed electronically. The referral must be documented in the patient’s medical records. Refer to Appendix E, Medicaid Forms, for sample Patient 1st referral forms.

Services That Do Not Require A Referral

Some services are not included in the Patient 1st program. For these services, patients can choose to receive care from any Medicaid-enrolled provider.

The following table lists services that **do not require a referral** from the PMP:

Service	***Claim Type***
Allergen/Immunotherapy	Medical
Ambulance	Medical
Anesthesia (ASA procedure codes only)	Medical
CRNA	Medical
Dental Care for Children (Dental Office Only)	Medical
EEG/EKG Related	Medical, Outpatient
EPSDT Intensive Evaluation	Medical
Factor 8	Any Claim Type
Family Planning	Medical, Inpatient, Outpatient
Glucose Test Strips/Lancets	Medical
HCBS Waiver	Medical
Health Education Prenatal Classes Adolescent Pregnancy Prevention	Medical
Hearing Aids	Medical
Hospice	Outpatient
Hospital – Inpatient	Inpatient
Hospital – Outpatient for: Chemotherapy Certified Emergency Lab Services X-Ray and Lab	Outpatient
Hospital – Psychiatric	Inpatient
Immunizations	Medical, Outpatient
Independent Labs	Medical
Independent Radiology	Medical
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Inpatient
Long Term Care (LTC)	Inpatient
Maternity Services	Medical, Inpatient, Outpatient
Mental Health Rehab Option	Medical
Nephrologists (End Stage Renal diagnosis only)	Medical
Non-emergency Transportation	Medical
Nuclear Medicine	Medical
Nurse Midwife, for office visits	Medical
OB/GYN	Medical, Outpatient
Ophthalmologist (Routine eye care only)	Medical
Optometry (Routine eye care only – glasses)	Medical
Oral Surgeons	Medical
Orthodontia	Medical
Pathology	Medical

Service	*Claim Type*
Pharmacy	Medical
Physicians, for certain services	Medical
Professional Component	Medical
Prenatal Clinics	Medical
Renal Dialysis	Outpatient
Targeted Case Management (does not include Targeted Case Management for medically at risk)	Medical

NOTE:

Dental hospitalization (inpatient or outpatient) requires a referral from the PMP.

D.1.4 Patient 1st Billing Instructions

This section provides billing instructions specific to Patient 1st and EPSDT-referred services. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

- Block 2 – Enter the referring PMP's nine-digit provider number
- Block 24 – Enter "**X2**" to indicate Patient 1st

If you file **electronically** on the UB-92 using EDS *Provider Electronic Solutions* software, you must enter "**X2**" in Condition Code field on the Header 3 tab and the referring provider's Medicaid number in the Referring Physician field on the Header 2 tab.

If you file hard copy claims on the **HCFA-1500**, you must complete the following fields:

- Block 17 – Enter the name of the referring Primary Medical Provider (PMP)
- Block 17a – Enter referring PMP's nine-digit provider number
- Block 24h – Enter "**3**" indicating Managed Care

If you file **electronically** on the HCFA-1500 using EDS *Provider Electronic Solutions* software, you must enter "**M**" in the EPSDT/Family Planning field on the Services tab and the referring provider's Medicaid number in the Referring ID # field on the Header 2 tab.

EPSDT and Patient 1st Referred Services

If you file hard copy claims on the **UB-92**, you must complete the following fields:

- Block 2 – Enter the referring PMP's provider number
- Block 24 – Enter "**X3**" to indicate EPSDT and managed care

If you file **electronically** on the UB-92 using EDS *Provider Electronic Solutions* software, you must enter "**X3**" in Condition Code field on the Header 3 tab and the referring provider's Medicaid number in the Referring Physician field on the Header 2 tab.

If you file hard copy claims on the **HCFA-1500**, you must complete the following fields:

- Enter the name of the referring Primary Medical Provider (PMP) in block 17.
- Enter referring PMP's nine-digit provider number in block 17a.
- Enter "**4**" indicating EPSDT and Managed Care in block 24h.

If you file **electronically** on the HCFA-1500 using EDS *Provider Electronic Solutions* software, you must enter "**B**" in the EPSDT/Family Planning field on the Services tab and the screening provider's Medicaid number in the Referring ID # field on the Header 2 tab.

If you have program or policy questions about Patient 1st, contact Medicaid's Managed Care Division at (334) 353-5773.

Certified Emergency Services

Hospitals and physicians who provide outpatient certified emergency services are not required to have a referral from the PMP. All related services for the emergency condition (provided on the same date of service), including those provided by a specialist, may be billed directly to EDS without a referral.

If you file hard copy claims on the **UB-92**, enter an "**E**" in block 78.

If you file electronically on the UB-92 using EDS *Provider Electronic Solutions* software, enter an "**E**" in the Emergency Indicator field on Header 2 tab.

If you file hard copy claims on the **HCFA-1500**, enter an "**E**" in block 24i.

If you file electronically on the HCFA-1500 using EDS *Provider Electronic Solutions* software, enter an "**E**" in the Co-Pay Indicator field on the Services tab.

NOTE:

If you file your claims electronically using a software vendor, you should obtain information directly from your vendor regarding where to place referral information.

D.2 Medicare HMOs

Effective January 1, 1998, certain Medicare and Medicaid recipients in Jefferson, Shelby, and Mobile counties became eligible to participate in Medicare Complete, a Medicare health maintenance program offered by United Healthcare of Alabama. Effective August 1, 2000, recipients in Jefferson County have a second choice for Medicare HMO coverage by VIVA Medicare Plus, a Medicare health maintenance program offered by VIVA Health.

These programs are open to those Medicaid recipients who have Medicare (Parts A & B) and full Medicaid (dual-eligible recipients) or who have Qualified Medicare Beneficiary (QMB) only coverage.

D.2.1 Enrollment

Enrollment in a Medicare HMO Plan is voluntary. Recipients who enroll in a Medicare HMO must select a primary care physician affiliated with the HMO who will provide or authorize services. Providers should be aware that non-emergency services provided to a Medicare HMO participant will not be covered unless approved by the patient's primary care physician.

Recipients may disenroll at any time by submitting a written request to the HMO. Recipients who disenroll by the last day of the month will have coverage through the HMO through the last day of that month.

D.2.2 Recipient Eligibility

Medicare HMO participants are required to present both a Medicaid card and a Medicare HMO identification card.

It is the responsibility of providers to verify eligibility before providing treatment or a service under the Medicaid program. To verify Medicaid eligibility, providers should access Medicaid's AEVCS or Automated Voice Response system as explained Chapter 3, Verifying Recipient Eligibility. These systems indicate whether the patient is enrolled in an HMO.

To contact the patient's primary care physician, refer to the number on the patient's HMO identification card.

A capitated payment is made to the HMO on behalf of recipients who elect to participate in the Medicare HMO program to cover the Medicare HMO copayment. Because of this payment, the Alabama Medicaid Agency does not pay any Medicare HMO-required copayments on behalf of enrolled recipients. Neither Medicaid recipients who participate in this program nor the Alabama Medicaid Agency will pay any copayments, coinsurance, or deductibles for services covered by the HMO.

D.2.3 Covered Services

Services covered by the Medicare HMO include those services covered by Medicare. Medicare HMOs may also provide certain additional benefits to eligible persons:

- Unlimited hospital days
- Annual physical exams
- Hearing exams
- Dental coverage – Shelby and Jefferson counties only
- Non-Emergency Transportation
- Some immunizations

Claims for services provided to Medicare HMO participants are to be filed directly with the HMO.

Medicaid-only covered services that are not a part of the Medicare HMO (for example, drugs) are covered on a fee-for-service basis by Medicaid. Providers must submit claims for these services directly to EDS. Providers may collect copayments for services covered only by Medicaid.

Patients with questions about enrolling in a Medicare HMO should call the HMOs directly.

If you have program or policy questions about Medicare Complete, contact Medicaid's Managed Care Division at (334) 353-5773.

D.3 Maternity Care

The Alabama Medicaid Maternity Care Program provides 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 pregnant woman has access to medical care, with the goal of lowering Alabama's high infant mortality rate and improving maternal and infant health overall.

The Alabama Medicaid Agency selects primary contractors for the Maternity Care Program through a competitive bid process. Contractors must meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to the *Maternity Care Operational Manual* published by the Alabama Medicaid Agency for further details.

D.3.1 Districts

Medicaid has established thirteen maternity care districts, and primary contractors must show that a care system operates in the entire district. Contractors are required to provide maternity care services to all women eligible for maternity care in the specified district.

Providers should advise recipients that if they knowingly and 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. The districts are as follows:

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. Claire, 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

NOTE:

Maternity care services provided to recipients who reside in Mobile county will be reimbursed on a fee-for-service basis.

D.3.2 Eligibility

The following recipients are required to participate in the Maternity Care Program:

- SOBRA recipients
- Those certified through the Medicaid for Low Income Families (MLIF) Program (formerly AFDC)
- Refugees
- SSI eligible women 19 and over

The following recipients **are not** required to participate:

- Dual recipients (Medicare/Medicaid)
- Indians who are members of a federally recognized tribe
- Children under the age of 19 who meet any of the following criteria:
  - Persons eligible for SSI under Title XIX
  - Persons in foster care or other out of home placement such as Department of Youth Services (DYS)
  - Persons receiving foster care or adoption assistance
  - Persons receiving services through a family-centered, community-based, coordinated system of care receiving grant funds (Special Needs)
- Recipients residing in Mobile county
- Recipients enrolled in a private HMO
- Those persons described in Section 1902(e)(3) of the Act

Medicaid recipients who are not required to participate may participate on a voluntary basis. If the recipient elects to participate in the program, Medicaid pays for services through the Maternity Care Program.

Providers can obtain Maternity Care enrollment information through Medicaid's automated eligibility systems, AEVCS and AVRS, as described in Chapter 3, Verifying Recipient Eligibility.

D.3.3 Covered Services

The primary contractor is responsible for all pregnancy-related care that occurs during the period before birth, at the time of delivery, and postpartum. Medicaid pays a global fee to the primary contractor for each recipient.

Claims for services covered under Maternity Care should be filed directly to the primary contractor for payment. In addition, hospitals are required to submit inpatient delivery claims directly to EDS for processing as encounter data (no payment, used for reporting purposes only).

The following services are covered under the Maternity Care Program.

- Antepartum care
- Delivery
- Hospitalization
- Outpatient care (except emergencies)
- Postpartum care
- Care coordination services
- Assistant surgeon fees
- Associated services
- Anesthesia services
- Home visits
- Ultrasounds

D.3.4 Separately Billable Services

Certain maternity care services are not considered part of the global fee. The following services may be billed directly to Medicaid on a fee-for-service basis:

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. Injections administered by the physician or outpatient facility can be billed on a fee-for-service basis (for example, Rhogam or Iron).
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.
Dental	Dental services are covered for recipients under 21. For SOBRA-eligible recipients, services must be pregnancy-related.
Physician	Physician fees for family planning procedures (for example, sterilization), genetic counseling, circumcision, routine newborn care, standby, and infant resuscitation may be billed on a fee-for-service basis. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number.
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.
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 expanded global fee. Access to emergency services will not be restricted by the Maternity Care Program.
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	Mental health visits for the purpose of outpatient mental health services may be billed on a fee-for-service basis.
Miscarriages at less than 21 weeks	All services may be billed fee-for-service.

Separately Billable Service	***Description***
Referral to Specialists	Services provided by non-OB specialty physicians (such as cardiologists, endocrinologists) for problems complicated or exacerbated by pregnancy can be billed fee-for-service by the provider of service. A general/family practitioner is not considered a specialty provider.
Exemptions	Claims for women who are granted an exemption may be billed fee-for-service.
Outlier Policy	The outlier policy is in effect when a Maternity Care Program recipient has an extended stay (or stays) and delivers at a Level III facility (USA, UAB, Huntsville Hospital, or the Medical Center in Columbus, Georgia). Extended stay is defined in excess of seven days but does not have to be consecutive. Days eight or greater (up to the 16 day limit) will be reimbursed directly to the hospital provider.
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.

D.4 Completing the Claim Form

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

D.4.1 Time Limit for Filing Claims

Medicaid requires all claims for managed care 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.

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*
*Case Management Request for Interagency Transfer (Form CM-1)	Long Term Care Customer Service	(334) 242-5657
Certification and Documentation of Abortion	Medical Services Customer Service	(334) 242-5524
Check Refund Form	EDS Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	Office of Associate Medical Director	(334) 242-5997
Alabama Medicaid Agency Referral Form	Medical Services Outreach and Education	(334) 353-5203
Home and Community Based Services (HCBS) Applications	Long Term Care Customer Service	(334) 242-5657
*Hospice Application	Long Term Care Customer Service	(334) 242-5657
Hysterectomy Consent Form	Medical Services Outreach and Education	(334) 353-5203
*Intermediate Care Facility for the Mentally Retarded (ICF/MR) Application	Long Term Care Customer Service	(334) 242-5657
*Medicaid Accident/Assignment Form XIX-TPD-1-76	EDS Provider Assistance Center	(800) 688-7989
Medicaid Adjustment Request Form	EDS Provider Assistance Center	(800) 688-7989
*Mentally Retarded/Developmentally Disabled (MR/DD) Application	Long Term Care Customer Service	(334) 242-5657
Nursing Home Statistical Report	EDS Provider Assistance Center	(800) 688-7989
Patient Status Notification (Form 199)	Long Term Care Customer Service	(334) 242-5657
Prior Authorization Form	EDS Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Medical Services Outreach and Education	(334) 353-5203

*A sample of these forms is not included. Call the number provided above for these forms.

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 Provider Number*		
Signature of Physician	*Date Physician Signed*		
Date of Surgery			

INSTRUCTIONS: The physician must send this form with the medical records and claim to:

EDS
P.O. Box 244034
Montgomery, AL 36124-4034

PHY-96-2 (Revised 10/01/99) Alabama Medicaid Agency
Formerly MSA-PP-81-1 Revised 10/11/96

E.2 Check Refund Form

Check Refund Form (REF-02)

Mail To: EDS
Refunds
P.O. Box 244038
Montgomery, AL 36124-4038

Provider Name _____ Provider 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)			

SAMPLE

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 _____

10/99

E.3 Alabama Prior Review and Authorization Dental Request

Section I – Must be completed by a Medicaid provider.

Requesting Provider License No. _____

Phone ( )_____

Name_____

Address _____

City/State/Zip_____

Provider Medicaid Number _____

(9-digit provider number is required.)

Section II

Medicaid Recipient Identification Number _____

(13-digit RID number is required.)

Name as shown on Medicaid card_____

Address _____

City/State/Zip _____

Date of EPSDT Screening (CCYYMMDD)_____

Section III

DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	REQUIRED PROCEDURE CODE	UNITS	PRICE/DOLLARS

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

with an X.

2. Periodontics – Evaluate the periodontal condition._____

_____

_____

_____

A. Indicate pocket depth for root planing (04341)_____

B. Indicate quadrant of diagram for gingival curettage (04220) _____

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

_____

_____

_____

4. Brief Dental/Medical History:_____

_____

_____

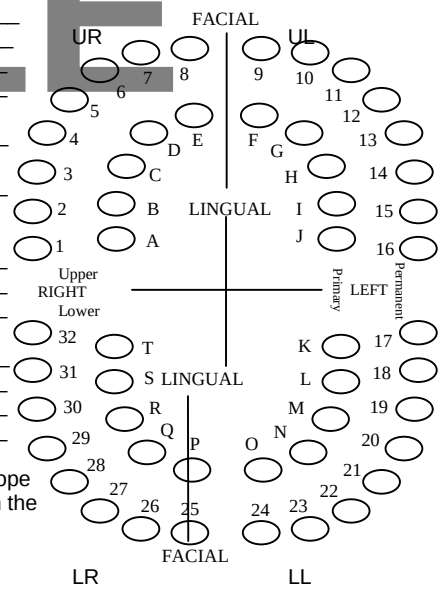
_____

Section IV

Does the Recipient have missing teeth?

Yes_____ No_____

If YES please indicate missing teeth



SAMPLE

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: EDS, P.O. Box 244036, Montgomery, Alabama 36124-4036

Form 343 10/99

Alabama Medicaid Agency

E.4 Hysterectomy Consent Form

ALABAMA MEDICAID AGENCY

HYSTERECTOMY CONSENT FORM

PART I. **P H Y S I C I A N**
Certification by Physician Regarding Hysterectomy

SAMPLE

I hereby certify that I have advised_____
Typed or Printed Name of Patient

Medicaid Number _____to undergo a hysterectomy because of the diagnosis

of_____, _____. Further, I have
diagnosis code

explained orally and in writing to this patient and/or her representative (_____)
Name of Representative, if any

that she will be permanently incapable of reproducing as a result of this operation. This explanation was

given before the operation was performed on _____.
Date of Surgery

_____ _____
Typed or Printed Name of Physician *Medicaid Provider Number*

_____ _____
Signature of Physician *Date of Signature*

PART II. **P A T I E N T**
Acknowledgment by Patient (and/or Representative) of Receipt of Above Information Regarding Hysterectomy

I,_____and/or_____
Name of Patient *Name of Representative, if any*

hereby acknowledge that 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 give to me before the operation.

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Representative, if any *Date*

INSTRUCTIONS: Before payment can be made for any services (physicians, hospitals, etc.) a copy of this consent form must be on file at EDS. Therefore, send this completed from to:

EDS
P.O. Box 244034
Montgomery, AL 36124-4034

PHY-81243 *(Revised 10/1/99)* *Alabama Medicaid Agency*

E.5 Medicaid Accident/Assignment – Form XIX-TPD-1-76

ALABAMA MEDICAL ASSISTANCE PLAN—TITLE XIX
FORM XIX-TPD-1-76
MEDICAL AUTHORIZATION ASSIGNMENT

SAMPLE

I. Patient's Name:_____Medicaid #:_____

II. Provider's Name:_____

III. TO BE COMPLETED IF INSURANCE INVOLVED:

A. Name of Insurance Company:_____

B. Address of Insurance Company:_____

C. Policy #: _____ Policyholder:_____

D. Name & Address of Employer if Group Insurance:_____

IV. TO BE COMPLETED IF SERVICES RENDERED AS A RESULT OF AN ACCIDENT:

A. Date of Accident:_____

B. Location_____
(LIST CITY & COUNTY FOR AUTO ACCIDENT; SITE (HOME, SCHOOL, ETC.) & ADDRESS FOR OTHER TYPE)

C. Describe Accident:_____

D. If auto accident, give name & address of driver(s):_____

_____

E. Was auto insurance carried? Yes_____ No_____ (If yes, complete Item III)

F. If school accident, was school insurance carried? Yes_____ No_____ (If yes, complete Item III)

G. Has an attorney been retained? Yes _____ No _____ Name of attorney:_____

V. COMPLETE THE FOLLOWING IF ANY MEMBER OF YOUR HOUSEHOLD IS EMPLOYED:

Employee:_____Relationship:_____

Employee:_____Address:_____

VI. TO BE COMPLETED IF THERE IS OTHER INSURANCE AND/OR IF AN ACCIDENT WAS INVOLVED:

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Alabama Medicaid Agency, and I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby assign to the Alabama Medicaid Agency all claims against third parties, including tort-feasors and insurance companies, who may be liable for any of my medical expenses, to the extent that such expenses are paid by Medicaid. I also assign all rights in any settlement made by me and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid, whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Alabama Medicaid Agency. I permit a copy of this Authorization and Assignment to be used in place of the original.

_____
SIGNATURE OF PATIENT (OR PARENT IF PATIENT IS UNDER 19) WITNESS (SIGNATURE BY MARK MUST BE WITNESSED)

_____ _____
SIGNATURE OF POLICYHOLDER WITNESS (SIGNATURE BY MARK MUST BE WITNESSED)

_____
DATE

MCD-16 (Rev. 10/98) EDS-3
380-206

E.6 Medicaid Adjustment Request Form

Medicaid Adjustment Request Form (ADJ-02)

Mail to: Adjustments
P.O. Box 244038
Montgomery, AL 36124-4038

SAMPLE

Section I: Provider Pay-To Information

Provider Number _____

Provider Name _____

Address _____

_____

☐ Overpayment: Please process to correct the overpayment

☐ Underpayment: Please process to correct the underpayment

☐ Information correction: Please process to reflect the correct information

Section II: Paid Claims Information

Please enter the following data from your remittance advice:

ICN Number: _____ Recipient Name: _____

Recipient ID Number: _____ EOP Date: _____

Date(s) of Service: _____

Billed Amount: _____ Paid Amount: _____

Section III: Description of the Problem

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

EDS Use Only

Date of Adjustment _____ Reviewer _____

Adjustment action:

_____ Pay

_____ Recoup

Revised 10-99

E.7 Nursing Home Statistical Report

NURSING FACILITY
ALABAMA MEDICAID PROGRAM - TITLE XIX

SAMPLE

EDS
P.O.BOX 244033
MONTGOMERY, AL 36124-4033

PROVIDER NO: _____

FACILITY NAME: _____

DATE _____

PLEASE RETURN THIS STATISTICAL REPORT TO EDS WITH YOUR REGULAR MONTHLY BILLING. THE SIGNATURE OF THE AUTHORIZED REPRESENTATIVE OF THE NURSING FACILITY MUST BE ENTERED IN THE SPACE PROVIDED.

NUMBER OF CERTIFIED BEDS _____

NUMBER OF MEDICAID RESIDENTS _____

NUMBER OF MEDICAID RESIDENTS WITHOUT SPONSORS _____

NUMBER OF PRIVATE PAY RESIDENTS IN FACILITY _____

NUMBER OF EMPTY BEDS IN FACILITY ON LAST DAY OF THE MONTH _____

NUMBER OF MEDICAID RESIDENTS DISCHARGED THIS MONTH _____

NUMBER OF MEDICAID RESIDENTS DECEASED THIS MONTH _____

NUMBER OF RESIDENT DAYS _____

NUMBER OF RESIDENTS MEDICARE ONLY _____

NUMBER OF ADMISSIONS WAITING LIST _____

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE, AND COMPLETE, AND THE FOLLOWING 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 OR STATE LAWS.

SIGNATURE OF NURSING FACILITY REPRESENTATIVE

_____ DATE _____

REVISED 10/99

E.8 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: _____ Provider Number: _____
(Name of Facility)

_____ Telephone Number: _____
(Address of Facility)

SAMPLE

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: _____

☐ New Admission ☐ Hospital ☐ Mental Institution

☐ Re-Admission From: ☐ Home

☐ Transferred Admission ☐ Other Home _____

For Medicaid Use Only
Over 60-days late _____
Medicare Denial _____

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
Blue: 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 7/01/94

E.9 Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

SAMPLE

(Required If Medicaid Provider) PMP ( )

Requesting Provider
License # or Provider # _____

Phone ( ) _____

Name _____

Recipient Medicaid Number_____

Name _____

Address _____

City/State/Zip _____

Rendering Provider Medicaid # _____

Phone ( )_____

Fax ( )_____

Name _____

Address _____

City/State/Zip _____

Certification ___ Yes __ No

Recertification/Continued Stay ___ Yes __ No

Date of EPSDT Screening CCYYMMDD _____

Date of Prescription CCYYMMDD _____

First Diagnosis _____ • ____ Ambulance Transport Code ____

Second Diagnosis _____ • ____ Ambulance Transport Reason Codes ____

PA Type_____ Patient Condition _____

(01) Durable Medical Equipment (06) Physical Therapy (11) Drugs (16) Oxygen
(02) Eyeglasses (07) Speech Therapy (12) Medical (17) Prosthetic Devices
(03) Home Health (08) Private Duty Nursing (13) Psychiatric* (18) Inpatient Stay *
(04) Transportation (09) Ultrasound (14) Customized Wheelchairs
(05) Occupational Therapy (10)Targeted Case Mgt (15) Surgical (19) Other

DATES OF SERVICE							
Line Item	START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	PRICE/ 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 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: EDS, P.O. Box 244036 Montgomery, Alabama 36124-4036

Form 342 1/00

Alabama Medicaid Agency

E.10 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

____ Black (not o f Hispanic origin)

_____ Hispanic

_____ Asian or Pacific Islander

_____ 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 this consent. I have also read him/her the consent form in _____ 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 - EDS
Copy 3 - Patient's permanent record

Form 193 (Revised 1-22-96)

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) _____

(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) _____

(Medicaid Provider Number) _____

Alabama Medicaid Agency

SAMPLE

E.11 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.

SAMPLE

Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

Form 138 (Formerly MED-FP9106)
Revised 2/99

E.12 Long Term Care Census Form

ALABAMA MEDICAID
LONG TERM CARE CENSUS FORM

Provider ID	
Provider Name	
Census Date Enter the month and year of this census	
Medicaid Enter the number of Medicaid approved (LTC2 forms on file) residents in the facility during the month the census was taken.	
Pending Enter the number of Medicaid pending (LTC2A forms on file) residents in the facility during the month the census was taken.	
Non-Medicaid Enter the number of non-Medicaid residents in the facility during the month the census was taken.	
Admitted Enter the total number of all residents admitted to the facility during the month the census was taken.	
Dead Enter the total number of all residents who died in the facility during the month the census was taken.	
Transferred Enter the total number of all residents who transferred from the facility (to another facility or hospice) during the month the census was taken.	
Discharged Enter the total number of all residents discharged from the facility during the month the census was taken.	

SAMPLE

This is to certify that the foregoing information is true, accurate, and complete, and the following 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 or state laws.

Signature of nursing facility representative

_____ Date: _____

Mail to the following address:

EDS
Post Office Box 244033
Montgomery, AL 36124-4033 revised 11/99

IF YOUR FACILITY IS STILL FILING PAPER CLAIMS, THIS CENSUS FORM MUST BE RECEIVED AND KEYED ON THE SAME DAY OR PRIOR TO THE DAY THE CLAIMS FOR THE CENSUS MONTH ARE KEYED. IF YOU FILE ELECTRONICALLY, PLEASE FILE YOUR CENSUS ELECTRONICALLY AT THE SAME TIME YOU TRANSMIT YOUR CLAIMS.

E.13 Etanercept/Enbrel Prior Authorization Request Form

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354

SAMPLE

Requester: _____
Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient Name: _____ Patient Medicaid #: _____

Diagnosis/Date Diagnosed: _____

Current Medications: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License #: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider #: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Medical Justification for Consideration for Approval Outside Criteria May Be Attached

History of Rheumatology Referral: yes or no

_____Initial Request

_____Renewal (effectiveness demonstrated) Dosage/Frequency Requested: _____

Prior Drug Usage:

DMARD (1): _____ Length of Therapy: _____

Reason for discontinuation: _____

DMARD (2): _____ Length of Therapy: _____

Reason for discontinuation: _____

STEROIDS: _____ Length of Therapy: _____

Reason for discontinuation: _____

NSAIDS: _____ Length of Therapy: _____

Reason for discontinuation: _____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED

_____ Approve request _____ Deny request _____ Deny/Request Additional Information

Authorization effective _____ through _____

Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 336
Revised 1/27/99 Alabama Medicaid Agency

E.14 Sildinafil Citrate/Viagra Prior Authorization Request Form

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

Requester: _____
Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License #: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____Fax #: _____

DRUG/CLINICAL INFORMATION

Strength requested: _____(mg) Quantity requested: _____

Duration of therapy requested: _____

Prior Rx drugs or devices prescribed for erectile dysfunction (impotence):

(1) Name of drug/device: _____ Dates of therapy: _____

Reason(s) discontinued: _____

(2) Name of drug/device: _____ Dates of therapy: _____

Reason(s) discontinued: _____

Please indicate the medically confirmed etiology, by history <u>and</u> physical exam, responsible for erectile dysfunction (impotence).

_____ Spinal cord injury _____ Prostatectomy (radical)

_____ Diabetic neuropathy _____ Drug abuse/drug dependency

_____ TURP associated neurological damage (irreversible) _____ Other:_____

Note: Therapy with alprostadil (Muse®) intraurethral pellets and /or alprostadil (Caverject®) injections is discouraged. Yohimbine and papaverine are not FDA approved for managing erectile dysfunction.

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED

_____ Approve request_ Deny request _____ Deny/Request Additional Information

Authorization effective _____ through _____

Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 337
Revised 8/99 Alabama Medicaid Agency

SAMPLE

E.15 Maximum Unit Override

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

SAMPLE

Requester: _____
Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License Number: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity/month: _____

Diagnosis: _____

Medical Justification: _____

_____

_____

_____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY

_____ Approve request _____ Deny request

_____ MEDICIAID ELIGIBILITY VERIFIED

_____ Deny/Request Additional Information

Authorization effective _____ through _____

Authorization #: _____

_____
Reviewer's Signature

_____
Response Date/Hour

Form 349
Revised 8/99

Alabama Medicaid Agency

E.16 Maximum Unit Institutional Override

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

Requester: _____
Name and Title (MD, RN, RPh)

SAMPLE

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License #: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider #: _____

NDC #: _____

Phone #: _____Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____Quantity/month: _____

Diagnosis: _____

_____

Medical Justification: _____

***Supporting documentation must be available in the patient record.

AQAF USE ONLY _____ MEDICAID ELIGIBILITY VERIFIED

_____ Approve _____ Deny _____ Deny/request additional information

Authorization effective: _____ through _____

Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 339
Revised 8/99 Alabama Medicaid Agency

E.17 NSAID/Antihistamine Prior Authorization Request Form

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

SAMPLE

Requester: _____
Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License Number: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Requested: _____ Number of refills:_____

**List previous drug usage for drug class requested: NSAID or Antihistamine (Circle One)

Generic (1): _____ Length of therapy: _____
Reason for discontinuation: _____
Generic (2): _____ Length of therapy: _____

Reason for discontinuation: _____

OTC (1) : _____ Length of therapy: _____

Reason for discontinuation: _____

OTC (2): _____ Length of therapy: _____

Reason for discontinuation: _____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED

_____ Approve request _____ Deny request _____ Deny/Request Additional Information

Authorization effective _____ through _____

Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 348
Revised 8/99

Alabama Medicaid Agency

E.18 Nutrition/Miscellaneous Prior Authorization Request Form

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

Requester: _____
Name and title (MD, RN, RPh)

SAMPLE

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License Number: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Formula / Drug Requested _____

Duration of administration / Number of refills _____

Method of Administration _____

Explanation of Medical Necessity _____

_____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED

_____ Approve request _____ Deny request _____ Deny/request Additional Information

Authorization effective _____ through _____

Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 350
Revised 8/99

Alabama Medicaid Agency

E.19 Synagis Prior Authorization Request Form

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

SAMPLE

Requester: _____
Name and title (MD,RN,RPh)

PATIENT INFORMATION

Patient Name: _____ **Patient Medicaid #:** _____

Patient DOB: _____ **Patient Weight:** _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ **License #:** _____

Address: _____ **Phone #:** _____

City/State/Zip: _____ **Fax #:** _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ **Provider Number:** _____

NDC #: _____ **Dose (ml) requested:** _____

Phone #: _____ **Fax #:** _____

DRUG/CLINICAL INFORMATION

_____ Infant with a gestational age 29-32 weeks and is six (6) months old or less

OR

_____ Infant with a gestational age 28 weeks or less and is twelve (12) months old or less

OR

_____ 24 months or less with a clinical diagnosis of BPD and ongoing medical treatment for BPD, defined as use of supplemental O2, steroids, bronchodilators, or diuretics within the past six(6) months

AND

_____ Currently an outpatient and has not been enrolled as an inpatient within 2-weeks of the date the medication is requested. Enter discharge date (if applicable) _____

*One of the first three criteria must be met in addition to the final criteria before approval can be granted.
*RSV prophylaxis approval will terminate at the end of RSV season, March 31, 2000. Additional information may be requested by reviewer.

Explanation of Medical Necessity: _____

_____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED
___ Approve request _____ Deny request _____ Deny/Request Additional Information
Authorization effective _____ through _____
Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 351
Revised 8/99 Alabama Medicaid Agency

E.20 H2 Antagonists Prior Authorization Request Form

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

Note: OTC and generic H2 Antagonists do not require prior authorization
Requester: _____
Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License Number: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Brand Drug Requested: _____ Strength/Quantity: _____
# of Refills Requested: _____ Daily Dose: _____

Prior antacid, PPI, H2 antagonist and/or prokinetic drug use (Complete if request secondary to clinical history of failed therapy)
(1) Name of drug: _____ Dates of therapy: _____
Reason for discontinuation: _____
(2) Name of drug: _____ Dates of therapy: _____
Reason for discontinuation: _____

Please check only one: ____ Acute therapy OR ____ Maintenance therapy

Please check the relevant patient diagnosis below: Type of testing performed and results:

				POS	or	NEG
_____	Peptic ulcer disease					
_____	Duodenal ulcer	_____	H.pylori	_____		_____
_____	Gastric ulcer	_____	Breath	_____		_____
_____	Unknown location	_____	Serologic	_____		_____
_____	Bleeding ulcer	_____	Biopsy	_____		_____
_____	GERD	_____	Endoscopy	_____		_____
_____	Barrett's Esophagitis	_____	UGI/Barium Swallow	_____		_____
_____	Zollinger-Ellison Syndrome	_____	PH monitoring	_____		_____
_____	Specify _____	_____	No testing done			

***Supporting documentation should be available in patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED
_____ Approve request _____ Deny request _____ Deny/Request Additional Information
Authorization effective _____ through _____
Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 352
Revised 8/99 Alabama Medicaid Agency

SAMPLE

E.21 Norplant Consent Form

NORPLANT CONSENT FORM

Consent for the Insertion of Norplant Capsule

I have asked for and received information about Norplant Capsules from _____. When I requested the information, I was told that the decision to have the Norplant Capsules inserted is completely up to me. I was told that I could decide not to have the capsules inserted and my decision would not affect my right to future care or treatment. I will not, because of my decision about Norplant, lose any help or benefits from programs receiving federal funds, such as ADC or Medicaid that I am now getting or for which I may become eligible.

SAMPLE

I understand that the Norplant method of birth control is not permanent and that if I do want to become pregnant, fertility will be restored upon removal of the capsules.

I was told about other temporary methods of birth control that are available and could be provided to me. I have rejected these alternatives and chosen the Norplant method.

I understand that six Norplant Capsules will be inserted under the skin in the upper arm using local anesthesia. The discomforts, risks and benefits associated with the procedure have been explained to me. All my questions have been answered to my satisfaction.

I understand that I can change my mind at any time and that my decision to have the capsules removed will not result in the withholding of any benefits or medical services provided by federally funded programs.

I, _____, hereby consent to the insertion of Norplant Capsules.

I also consent to the release of this form and other medical records about the insertion procedure to:

Representatives 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.

_____ DATE: _____
Signature Month/Day/Year

_____ DATE: _____
Signature of Person Obtaining Consent Month/Day/Year

White - Patient
Canary - Patient's medical record

Form 139 (Formerly MED-FP416C)
Revised 1/28/94

Alabama Medicaid Agency

E.22 Extended Family Planning Counseling

EXTENDED FAMILY PLANNING COUNSELING
(Provided Only at Time of Post Partum Visit)

Patient Name: _ Medicaid # ___

DOS: _____Chart or UMR# _____

NOTE: ONE OF THE TWO COUNSELING SECTIONS BELOW *MUST* BE COMPLETED

Family Planning Counseling Using PT + 3 Teaching Method (Initial Here): _____

OR

SAMPLE

Alternative Family Planning Counseling - Initial Each Blank Below As Completed (minimum of 10 min. face-to-face contact)* - the following topics (at a minimum) must be discussed and documented:

1. Age: _____ No. of pregnancies: _____
2. Determine patient's knowledge/perception of birth control:_____
3. Previous method of birth control (prior to pregnancy):_____

   Detail any problems with previous method:_____

   Did previous method fail?_____Why?_____
4. Review methods of birth control:Pills ___Depo-Provera _Spermicides ___Condoms _____

   Tubal ligation__Norplant_____IUD___Natural_(Explain methods that are unfamiliar to patient)
5. Chosen method of birth control/supplies issued/prescription:_____

   (Circle One Above)
6. Briefly describe instructions given regarding importance of correct, consistent, and careful use of contraception for maximum effectiveness:_____How to use chosen method____
7. Briefly describe instructions given regarding possible side effects/adverse reactions:_____

   _____# given to call for prob/emergency_____Contracep. literature (Fact sheets) given_
8. Is method compatible with patient's lifestyle? _____ Explain:_____
9. HIV/STD protection discussed:_
10. Patient's understanding of counseling/discussion:_____

NOTE: Follow-up and tracking is required to determine if chosen method was obtained in cases where a Norplant insertion or a tubal ligation was designated as the chosen method. Assist patient with consent forms and appointments, as needed.

11. Schedule appointment (explain frequency of revisit):_____

_____ _____

Counselor's Signature Date

*These are **EXTENDED COUNSELING SERVICES** provided in addition to the routine family planning service required during a post partum visit.

Form 328 Alabama Medicaid Agency
Revised 10/14/97

E.23 Family Planning Home Visit (2 pages)

A L A B A M A M E D I C A I D A G E N C Y

FAMILY PLANNING HOME VISIT

PATIENT NAME: _____ AGE: _____

MEDICAID NUMBER: _____

ADDRESS: _____

DATE OF SERVICE: _____ TYPE OF SERVICE: _____

SAMPLE

FAMILY PLANNING CONSENT

I, _____, voluntarily request and consent to receive family planning services from _____. I understand that a brief history, including family, personal, medical, and contraceptive information will be obtained prior to the provision of home visit services and selection of a birth control method. I understand that I should receive a follow-up visit within six weeks for regular family planning services at the provider's office/clinic.

_____
Patient Signature
Date

The patient has voluntarily given consent for family planning services. No coercion or mental pressure was applied in obtaining the patient's signature.

_____
Witness Signature Date

_____
Title

FAMILY HISTORY
(Code Member Having Disease)
(C: F--Father, M--Mother, S--Sibling, GP--Grandparent, O--Other)

Heart disease____ Diabetes ____ Blood problem/disease ____ Tuberculosis ____ Foster care ____
Stroke ____ Cancer ____ Nerve/mental problem ____ Birth defects ____ Other ____
Asthma ____ High BP ____ Alcohol/drug abuse ____ Mental Retardation ____

MEDICAL/SURGICAL/OB-GYN HISTORY
(Code: 0=Negative, +=Positive - Detail positive answers)

Diabetes_____Epilepsy_____Tobacco Use_____Mental_____Abortions_____
Hypertension_____Hepatitis_____Phlebitis_____GYN Surgery__Stillbirths_____
Heart Disease_____TB_____Asthma_____Gravida_Medications_____
Kidney Disease_____Thyroid_Allergies_____Para_____

Major Operations: Year/Type_____

Remarks:_____

Form 175 (Formerly MED-FP9003) **(Over)** **Alabama Medicaid Agency**
Revised 2/13/98

MENSTRUAL/CONTRACEPTIVE HISTORY:

Previous Contraceptive Method: _____

Problems with method: _____

Date of Delivery: _____

LMP: _____

Menses: _____

Contraindications: _____

BP: _____ WT: _____

NOTE: ONE OF THE TWO COUNSELING SECTIONS BELOW *MUST* BE COMPLETED

Family Planning Counseling Using PT + 3 Teaching Method (Initial Here): _____

OR

Alternative Family Planning Counseling (Initial Each Blank Below As Completed):

Reproductive anatomy/physiology _____

Contraceptive methods & effectiveness_____

Side effects/dangers_____

How to use chosen method_____

Contraceptive literature (Fact sheet) given_____

Phone number to call for problem/emergency_____

NEXT APPOINTMENT: _____ _____

Date Time

Supplies issued: _____ **Prescription:** _____

SUMMARY:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

SIGNATURE DATE

_____

TITLE

SAMPLE

E.24 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

SAMPLE

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 l 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 1 of 4

DEVELOPMENTAL ASSESSMENT

DATE	NORMAL	ABNORMAL (detail)	DATE	NORMAL	ABNORMAL (detail)

ANTICIPATORY GUIDANCE

(Should be done at each screening and documented with a date)

SAMPLE

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)

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					

SAMPLE

Date	PROGRESS NOTES	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									

SAMPLE

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.25 ALABAMA MEDICAID AGENCY REFERRAL FORM

Today's Date _____ Referral Date _____

RECIPIENT INFORMATION

Recipient Name	Recipient #:	Recipient DOB:

PRIMARY PHYSICIAN	SCREENING PROVIDER (IF DIFFERENT)
Name:	Name:
Address:	Address:
Telephone #:( )	Telephone #:( )
Fax #: ( )	Fax #:( )
Provider #:	Provider #:
Signature:	Signature:

SAMPLE

TYPE OF REFERRAL

❑ **Patient 1st**	❑ Lock-in
❑ EPSDT ***Screening Date*** _____	❑ Patient 1st/EPSDT **Screening Date** _____
❑ Targeted Case Management (TCM)	

LENGTH OF REFERRAL

Referral Valid for _____month (s) or _____visit (s) from referral date

REFERRAL VALID FOR

❑ Evaluation Only	❑ Treatment Only
❑ Evaluation and Treatment	❑ Hospital Care (Outpatient)
❑ Referral to other provider for identified condition	❑ Performance of Interperiodic Screening (if necessary)
Referral to other provider for additional conditions (diagnosed by consultant)	

Reason for Referral:

Co-morbid Diagnosis:

CONSULTANT INFORMATION

Consultant Name: Consultant Telephone # ( )

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to primary physician.

Please submit findings to Primary Physician by:

❑ Mail	❑ Fax # ( )
❑ E-mail	❑ In addition, please telephone

Form 362 **Alabama Medicaid Agency**

Rev. 4/01

F Medicaid Internal Control Numbers (ICN)

EDS assigns each claim an Internal Control Number (ICN) systematically when it is received electronically or by mail.

Processing or returning the claim constitutes EDS' final action on that claim. A resubmission of the same service is considered a new claim.

Each claim sent to EDS 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 EDS actually received the claim.

Example:	98	99	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***
05	Provider submitted AEVCS
07	Managed Care claims (systematically created) (PHP)
10	Electronic claim submission (ECS) and tape billing
22	Managed Care cap claims
33	Paper special batch
50	Online adjustment
51	Mass adjustment
98	Paper submission

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 1999, 2001, 2002, 2003, 2005, 2006, 2007, 2009, 2010, and 2011.

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 years 2000, 2004, 2008, and 2012.

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

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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 voucher 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. A recipient age 21 or older who 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

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:

- Transportation provided by relatives or individuals living in the same household with the Medicaid recipient, except in the case of evident hardship
- Transportation provided in the Medicaid recipient's vehicle or relative's vehicle, except in the case of evident hardship
- 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 1-800-204-3728. 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 sends you a voucher you can use like a check. Once the doctor or clinic staff signs the voucher, you can cash it and use the money to pay for your ride. If you want, you can give the signed voucher to the person who gave you the ride. Once it has been signed, the voucher can be cashed by anyone at a bank or other place that cashes checks.

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H Alabama Medicaid Injectable Drug List

Effective for dates of service October 1, 1999 and thereafter, Medicaid will begin using J, Q, X, and CPT codes to replace most of the non-standard Z codes. With the exception of Z3387 and Z4998, the Z codes formerly used by Medicaid will be phased out for dates of service as of September 30, 1999.

H.1 Policy

H.1.1 Injections

Medicaid covers injectable drugs when billed by a physician using the new list of approved J, Q, X, and CPT codes. There will be two basic payment methods, the first for general intramuscular injections, and the second for site-specific injections.

Intramuscular Injections

Payment for administration of intramuscular injections is included in payment of the office visit. Procedure code Z4998 may be billed for administration of injections when an office visit is not billed.

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 along with a separate J code for the drug; thus, site specific injections are submitted as two lines.

H.1.2 Office Visits and Injections

Medicaid covers administration of injections provided during an office visit as a component of the office visit charge. For example, if a physician sees a patient and diagnoses an infection, the physician may bill an injectable antibiotic in addition to the office visit but not the administration fee. Procedure code Z4998 for administration of injection **may not** be billed in conjunction with an office visit or a nursing home visit on the same date of service.

Chemotherapy Injections

Medicaid will pay separately for cancer chemotherapy injections, including intramuscular, intravenous, intra-arterial, and subcutaneous injections, in addition to the visit furnished on the same day. If an office visit is billed to Medicaid on the same day as chemotherapy, the diagnosis must not be related to the cancer (there must be a different diagnosis code from that of cancer). This means that the office visit must be a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service (chemotherapy).

Physicians will also be paid separately for chemotherapy injections when provided with an infusion during an office visit. (Again, there must be a different diagnosis code than that of cancer.) Separate payments will be made for each chemotherapeutic agent furnished on the day of chemotherapy. This also includes chemotherapy injections when provided with an infusion during an office visit.

Medicaid will not pay for chemotherapy administration in a hospital setting, and claims for these codes with modifier 26 will not be recognized.

Hydration Therapy and Chemotherapy

Medicaid will not pay for the infusion of saline, an antiemetic, or any other non-chemotherapy drug under codes 90780 and 90781 when these drugs are administered at the same time as a chemotherapy infusion (codes 96410, 96412, 96414). Medicaid will pay when these drugs are administered on the same day following a chemotherapy infusion (rather than at the same time as a chemotherapy infusion). Physicians should use modifier 59 to indicate when codes 90780 and 90781 are provided following a chemotherapy infusion.

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. 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. The number of units billed should be based on the number of 0.5 ml doses in the vial(s). Multiple vials of the same allergen are not covered for the same date of service.

When billing these codes, physicians must specify the number of doses provided. For example, if a multi-dose vial of antigens is prepared (i.e., a vial with 7 doses) and only one dose is injected, then seven doses of antigen and one injection service may be billed. For those remaining doses, only the injection codes may be billed.

Units of Service

Injectable drug prices are calculated based on a “per dose” basis, unless otherwise indicated by the narrative of the code. When administering a lesser or greater dosage than what the per unit rate assumes to be one dose, 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

Flu Vaccination

Flu vaccination (90657, 90658, 90659) is a covered service for Medicaid recipients regardless of age. The cost of administration of the vaccine may be billed using the procedure code Z4998 if an office visit is not billed.

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 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 the appropriate CPT codes. Refer to Section A.7, Vaccines for Children, in the EPSDT appendix in this manual, for covered CPT codes.

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 (procedure code Z4998) may be billed separately if an office visit is not billed.

Unclassified Drugs

A provider who administers an injectable drug not listed should use the following J codes:

- J3490 - Unclassified Drugs
- J9999 - Not otherwise classified, antineoplastic drugs.

The claim must be sent on paper with a description of the injectable drug attached. Please be sure to search the Injectable Drug List to see if the drug is possibly under a generic name. The claims containing the unclassified procedure code must be sent to: EDS, Attn: Medical Policy, PO Box 244035, Montgomery, AL 36124-4035. EDS will determine the price of the drug.

Pricing of Injectable Drugs

All injectable drug prices will continue to be updated semi-annually by EDS. The updates effective July 1 are reviewed and finalized in June; those effective for January 1 are reviewed and finalized in December. Medicaid reimbursement will be calculated by averaging the Average Wholesale Prices (AWP) from the *Red Book, Blue Book,* and *Medispan.*

H.2 Injectable Drug List by Name

The following table provides a listing of valid injectable drug codes sorted alphabetically by name. To view this list sorted numerically, refer to Section H.3, Injectable Drug List by Procedure Code.

The following drugs can be injected subcutaneously, intramuscularly, or intravenously.

Procedure Code	***Description***
J0120	Achyromycin, up to 250 mg (Tetracycline)
J0150	Adenosine, 6 mg
J0151	Adenosine, 90 mg
J0170	Adrenalin, Epinephrine up to 1 ml ampoule
J0210	Aldomet Ester HCl, up to 250 mg (Methyldopate HCl)
J0256	Alpha 1-proteinase inhibitor, 10 mg
J2996	Alteplase recombinant, per 10 mg
X1015	Amikacin Sulfate, Amikin 500 mg
J0280	Aminophyllin, up to 250 mg (Aminophylline, vial, 125)
J1320	Amitriptyline HCl, up to 20 mg (Elavil HCl)
J0300	Amobarbital, up to 125 mg (Amytal Sodium)
J0295	Ampicillin sodium, 1.5 g
J0290	Ampicillin, up to 500 mg (Polycillin)
J0350	Anistreplase 30 units
X1745	Ascorbic Acid, 500 mg (5ml)
J2060	Ativan Lorazepam 2 mg
J0460	Atropine sulfate up to 0.3 mg
J2910	Aurothioglucose, up to 50 mg (Solganal)
J0510	Benzquinamide HCl up to 50 mg (Emete-Con)
J0515	Benztropine (Congentin 1 mg/ml;2 ml)
J0702	Betamethasone, 3 mg
J0704	Betamethasone, 4 mg
J0520	Bethanechol chloride Myatonachol or Urecholin up to 5 mg
J0585	Botulinum toxin type A per 100 units
J0945	Brompheniramine Maleate (10 mg/ml)
X1655	Butorphanol Tartrate, stadol 2 mg (1ml)
J0630	Calcitonin Salmon up to 400 units (Calcimar)
J0635	Calcitrol 1 mcg ampoule Calcijex
J0610	Calcium Gluconate up to 10 ml
J0620	Calcium Lactate, per 10 ml (Calphosan)
X1445	Cefamandole Nafate, Mandol 500 mg (10 ml)
J0690	Cefazolin Sodium up to 500 mg
J0695	Cefonocid Sodium, 1 g (Monocid)
J0698	Cefotaxime Sodium per g
J0694	Cefoxitin Sodium, 1 g (Mefoxin)
J0713	Ceftazidime, 500 mg
J0715	Ceftizoxime Sodium, per 500 mg
X1573	Ceftriaxone Sodium Rocephin, 500 mg
J0696	Ceftriaxone Sodium, per 250 mg
X1574	Ceftriaxone Sodium, Rocephin, 1 g
J1890	Cephalothin Sodium up to 1 g
J0710	Cephapirin Sodium up to 1 g
J0720	Chloramphenicol Sodium Succinate up to 1 g
J1990	Chlordiazepoxide HCl up to 100 mg (Librium)
J2400	Chloroprocaine HCl, per 30 ml (Nesacaine)
J1205	Chlorothiazide, 500 mg
J0730	Chlorpheniramine Maleate, per 10 mg
J3230	Chlorpromazine HCl, up to 50 mg

Procedure Code	***Description***
J0725	Chorionic Gonadtropin (per 1,000 units-10 ml each)
J0743	Cilastatin Sodium; Imipenem, per 250 mg
X1090	Clindamycin Phosphate 300 mg ampoule
J0735	Clonidine Hydrochloride, 1 mg
J0745	Codeine Phosphate (ampoule 30 mg/ml)
J0760	Colchicine, per 1 mg
J0800	Corticotropin, up to 40 units (ACTH)
J0810	Cortisone up to 50 mg Cortisone Acetate
J0835	Cosyntropin, 0.25 mg
J0895	Deferoxamine Mesylate 500 mg per 5 cc
J1000	Depo-estradiol Cypionate, up to 5 mg
J2597	Desmopressin Acetate per 1 mcg
J1095	Dexamethasone acetate, per 8 mg
J1100	Dexamethosone Sodium Phosphate, up to 4mg/ml (Decadron Phosphate)
X1200	Dextrose 5 ml 10%
J3360	Diazepam, up to 5 mg (Valium)
J0500	Dicyclomine up to 20 mg (Bentyl)
J1160	Digoxin up to 0.5 mg
J1110	Dihydroergotamine, per 1 mg (DHE 45)
J1240	Dimenhydrinate, up to 50 mg (Dramamine)
J1200	Diphenhydramine HCl up to 50 mg (Benadryl HCl)
J1245	Dipyridamole, per 10 mg
J1250	Dobutamine, 250 mg
J1810	Droperidol and Fentanyl Citrate, up to 2 ml ampoule
J1790	Droperidol up to 5 mg
J1180	Dyphylline up to 500 mg (Lufyllin)
J0600	Edetate Calcium Disodium, up to 1000 mg (Calcium Disodium)
J1330	Ergonovine Maleate up to 0.2 mg (Ergotrate Maleate)
J1364	Erythromycin Lactobionate per 500 mg
J1362	Erythromycin, 250 mg
J1380	Estradiol Valerate up to 10 mg
J1390	Estradiol Valerate up to 20 mg
J0970	Estradiol Valerate up to 40 mg (Delestrogen)
J1410	Estrogen conjugated per 25 mg or 20,000 units
J1435	Estrone per 1 mg
J1438	Etanercept, 25 mg
J1436	Etidronate Disodium per 300 mg
J3010	Fentanyl Citrate up to 2 ml
J1440	Filgrastim (G-CSF) 300 mcg
J1441	Filgrastim (G-CSF), 480 mcg
J2680	Fluphenazine Decanoate, up to 25 mg
X1530	Fluphenazine Enanthate, prolixin Enanthate 25 mg (1 ml)
X1525	Fluphenazine HCL, Prolixin 2.5 mg (1 ml)
X1310	Folic Acid, 5 mg (1ml)
J1455	Foscarnet sodium per 1000 mg

Procedure Code	Description
J1940	Furosemide up to 20 mg
J1550	Gamma Globulin IM 10 cc
J1470	Gamma Globulin IM 2 cc
J1480	Gamma Globulin IM 3 cc
J1490	Gamma Globulin IM 4 cc
J1500	Gamma Globulin IM 5 cc
J1510	Gamma Globulin IM 6 cc
J1520	Gamma Globulin IM 7 cc
J1530	Gamma Globulin IM 8 cc
J1540	Gamma Globulin IM 9 cc
J1460	Gamma Globulin IM I cc (Immune Globulin)
J1560	Gamma Globulin, IM over 10 cc
J1570	Ganciclovir Sodium 500 mg
J1580	Garamycin Gentamicin up to 80 mg
J1610	Glucagon Hydrochloride per 1 mg
J1600	Gold Sodium Thiomaleate, up to 50 mg
J1620	Gonadorelin Hydrochloride per 100 mcg
J1626	Granisetron Hydrochoride 100 mcg (Kytril)
J1631	Haloperidol Decanoate per 50 mg (Haldol Decanoate)
J1630	Haloperidol up to 5 mg (Haldol)
J1642	Heparin Sodium per 10 units
J1644	Heparin Sodium per 1000 units
J3470	Hyaluronidase, up to 150 units (Wydase)
J0360	Hydralazine HCl up to 20 mg (Apresoline)
X1365	Hydrocortisone Acetate 50 mg (1ml)
J1700	Hydrocortisone Acetate, up to 25 mg
J1710	Hydrocortisone Sodium Phosphate up to 50 mg
J1720	Hydrocortisone Sodium Succinate up to 100 mg
J1170	Hydromorphone (HCl), up to 4 mg
J1739	Hydroxyprogesterone Caproate 125 mg/ml
J1741	Hydroxyprogesterone Caproate 250 mg/ml
J3410	Hydroxyzine HCl, up to 25 mg
J1980	Hyoscyamine Sulfate up to 0.25 mg (Levsin)
X1415	Hyoscyamine Sulfate, Levsin .05 mg (10 ml)
J1742	Ibutilide Fumarate 1 mg
J3270	Imipramine HCl, up to 25 mg (Tofranil)
J1561	Immune Globulin (IV) per 500 mg, (20 ml)
J1562	Immune Globulin intravenous, 5 g
J1820	Insulin up to 100 units
J1825	Interferon Beta-1A 33 mcg
J1830	Interferon Beta-IB per 0.25 mg
J1750	Iron Dextran, 50 mg injection
J1840	Kanamycin Sulfate up to 500 mg
J1850	Kanamycin Sulfate up to 75 mg (Kantrex Pediatric)
J1885	Ketorolac Tromethamine per 15 mg
J1910	Kutapressin up to 2 ml
J0640	Leucovorin Calcium per 50 mg
J1950	Leuprolide Acetate [for depot suspension] per 3.75 mg
J1955	Levocarnitine per 1 g
J1960	Levorphanol Tartrate up to 2 mg (Levo-Dromoran)
J2000	Lidocaine HCl 50 cc
J2010	Lincomycin HCl up to 300 mg (Lincocin)
J3475	Magnesium Sulfate per 500 mg
J2150	Mannitol 25% in 50 ml
J1050	Medroxyprogesterone acetate up to 100 mg
X1460	Medroxyprogesterone Acetate, (Depo-Provera) 200 mg
J1055	Medroxyprogesterone acetate, 150 mg

Procedure Code	Description
J2180	Meperidine and Promethazine HCl, up to 50 mg (Mepergan)
J2175	Meperidine Hydrochloride, per 100 mg
J3450	Mephentermine Sulfate, up to 30 mg (Wyamine)
J0380	Metaraminol per 10 mg (10 ml)
J1230	Methadone HCl up to 10 mg (Dolophine) HCl
J2970	Methicillin Sodium up to 1 g (Staphcillin)
J1970	Methotrimeprazine up to 20 mg (Levoprome)
J3390	Methoxamine, up to 20 mg (Vasoxyl)
J2210	Methyl Ergonovine Maleate, up to 0.2 mg (Methergine)
J1020	Methylprednisolone Acetate 20 mg (Depo-Medrol)
J1030	Methylprednisolone Acetate 40 mg (Depo-Medrol)
J1040	Methylprednisolone Acetate 80 mg (Depo-Medrol)
J2930	Methylprednisolone Sodium Succinate, up to 125 mg
J2920	Methylprednisolone Sodium Succinate, up to 40 mg
J2765	Metoclopramide HCl, up to 10 mg (2ml) Reglan
J2250	Midazolam HCL per 1 mg
J2260	Milrinone Lactate (primacor), per 5 ml
J2275	Morphine Sulfate preservative-free sterile solution per 10 mg
J2270	Morphine Sulfate up to 10 mg
J2271	Morphine Sulfate, 100 mg
J2300	Nalbuphine Hydrochloride, per 10 mg
J2310	Naloxone HCl per 1 mg
J2321	Nandrolone Decanoate up to 100 mg
J2322	Nandrolone Decanoate up to 200 mg
J2320	Nandrolone Decanoate up to 50 mg
J0340	Nandrolone Phenpropionate, up to 50 mg (Durabolin)
J2710	Neostgmine Methylsulfate, up to 0.5 mg
J2350	Niacinamide, niacin, up to 100 mg
J2405	Ondansetron HCl (Zofran) per 1 mg
J2360	Orphenadrine up to 60 mg (Norflex)
J2700	Oxacillin Sodium up to 250 mg
J2460	Oxytetracyline HCl up to 50 mg (Terramycin)
J2590	Oxytocin up to 10 units (Pitocin)
J2430	Pamidronate Disodium per 30 mg
J2440	Papaverine HCl up to 60 mg
J0550	Penicillin G Benzathine and Penicillin B Procaine up 2,400,000 Units
J0530	Penicillin G Benzathine and Penicillin G Procaine up 600,000 Units
J0540	Penicillin G Benzathine and Penicillin G Procaine up to 1,200,000 Units
J0570	Penicillin G Benzathine up to 1,200,000 units
J0580	Penicillin G Benzathine up to 2,400,000 units
J0560	Penicillin G Benzathine up to 600,000 units (Bicillin) 600,000 Units
J2540	Penicillin G Potassium, up to 600,000 units
J2510	Penicillin G Procaine, aqueous, up to 600,000 units
J2512	Pentagastrin per 2 ml
J2545	Pentamidine for aerosol inhaler for Pneumocystis Carini Pneumon, per 300 mg, administered through a DME
J3070	Pentazocine HCl up to 30 mg (Talwin Lactate)
J2515	Pentobarbital Sodium per 50 mg, Nebutal Sodium ampoule

Procedure Code	Description
J3310	Perphenazine, up to 5 mg (Trilafone)
J2560	Phenobarbital Sodium up to 120 mg (Phenobarbital)
J2760	Phentolamine Mesylate up to 5 mg (Regitine)
J2370	Phenylephrine HCl up to 1ml
J1165	Phenytoin Sodium, per 50 mg
J3480	Potassium Chloride per 2 meq
J2650	Prednisolone Acetate up to 1 ml
J2640	Prednisolone Sodium Phosphate to 20 mg (Hydeltrasol)
J1690	Prednisolone Tebutate, up to 20 mg
J2690	Procainamide HCl up to 1 g
J0780	Prochlorperazine, up to 10 mg (Compazine)
J2675	Progesterone per 50 mg
J2950	Promazine HCl up to 25 mg
J2550	Promethazine (HCl) up to 50 mg
J1930	Propiomazine up to 20 mg
J1800	Propranolol HCl, up to 1 mg (Inderal)
J2725	Protirelin per 250 mcg
X1550	Pyridoxine HCL Vit. B6 100 mg (1 ml)
J1565	Respiratory Syncytial virus Immune Globulin, (IV), 50 mg
J2790	RHO D Immune Globulin, Human, one dose package (Rhogam)
J2792	RHO D Immune Globulin, IV, Human, Solvent Detergent, 100 IU
J2820	Sargramostim (GM-CSF), 50 mg
J2860	Secobarbital Sodium up to 250 mg
J2912	Sodium Chloride, 0.9%, per 2 ml
X1630	Sodium Thiosalicylate 50 mg (1ml)
J3320	Spectinomycin Dihydrochloride, up to 2 g
J2995	Streptokinase per 250,000 IU
J3000	Streptomycin up to 1 g (Streptomycin Sulfate)
J0330	Succinylcholine chloride up to 20 mg
J3030	Sumatriptan Succinate 6 mg
J3105	Terbutaline Sulfate up to 1 mg
J1080	Testosterone Cypionate 1 cc, 200 mg
J1060	Testosterone Cypionate and Estradiol Cypionate up to 1 ml
J1070	Testosterone Cypionate up to 100 mg
J1090	Testosterone Cypionate, 1 cc, 50 mg
J0900	Testosterone Enanthate and Estradiol Valerate up to 1 cc
J3120	Testosterone Enanthate, up to 100 mg (Delatestryl)
J3130	Testosterone Enanthate, up to 200 mg (Delatestryl)
J3150	Testosterone Propionate, up to 100 mg
J3140	Testosterone Suspension, up to 50 mg
J1670	Tetanus Immune Globulin, Human, up to 250 units
J2810	Theophylline per 40 mg
X1705	Thiamine HCL 100 mg (1ml)
J3280	Thiethylperazine Maleate, up to 10 mg (Torecan)
J2330	Thiothixene, up to 4 mg (Navane IM)
J3260	Tobramycin Sulfate, up to 80 mg
J3265	Torsemide 10 mg/ml
X1717	Triamcinolone Acetonide 40 mg
J3301	Triamcinolone Acetonide, per 10 mg
J3302	Triamcinolone Diacetate, per 5 mg
J3303	Triamcinolone Hexacetonide, per 5 mg
J3400	Triflupromazine HCl, up to 20 mg (Vesprin)
J3250	Trimethobenzamide HCl, up to 200 mg

Procedure Code	Description
J3305	Trimetrexate Glucuronate per 25 mg
J3490	Unclassified drugs
J3365	Urokinase 250,000 IU vial (Abbokinase)
J3364	Urokinase 5000 IU vial
J3370	Vancomycin HCl, up to 500 mg (Vancocin)
J3420	Vitamin B-12 Cyanocobalamin, up to 1000 mcg
J3430	Vitamin K, Phytonadione, per 1 mg
J0697	Zinacef, 750 mg

Miscellaneous Drugs and Solutions by Name

Procedure Code	Description
J7070	D5W (IV), 1000 cc
J7042	Dextrose/Normal saline I5% (IV) (500 ml = 1 unit)
J7060	Dextrose/water 5% (IV) (500 ml = 1 unit)
J7194	Factor IX, complex per I.U.
J7191	Factor VIII (antihemophilic factor, porcine), per I.U.
J7192	Factor VIII (antihemophilic factor, recombinant) per I.U.
J7190	Factor VIII, (antihemophilic factor, human) per I.U.
J7040	Normal saline solution (IV) (500 ml = 1 unit)
J7030	Normal saline solution (IV) 1000 cc
J7050	Normal saline solution, 250 cc
J7120	Ringer's lactate infusion (IV) up to 1000 cc
J7051	Saline or water, sterile, (IV) up to 5 cc
J7130	Saline solution, Hypertonic 50 or 100 meq (IV) 20 cc vial
A9500	Supply of radiopharm diagnostic imaging agent, technetium, per dose
A9505	Supply of radiopharm diagnostic imaging agent, thallous chloride, per MCI

Chemotherapy Drugs by Name

The cost of the drug does not include administration.

Procedure Code	*Description*
J9015	Aldesleukin, per single use vial
J9020	Asparaginase, 10,000 units (Elspar)
J9031	BCG (Intravesical) per instillation
J9040	Bleomycin sulfate, 15 units (Blenoxane)
J9045	Carboplatin, 50 mg (paraplatin)
J9050	Carmustine, 100 mg (Bicnu)
J9062	Cisplatin, 50mg (Plantinol, Plantinol AQ)
J9060	Cisplatin, powder or solution, per 10 mg (Plantinol, Plantinol AQ)
J9065	Cladribine, per 1 mg (Leustatin)
J9092	Cyclophosphamide 2 g
J9070	Cyclophosphamide, 100 mg (Cytoxan, Neosar)
J9080	Cyclophosphamide, 200 mg (Cytoxan, Neosar)
J9090	Cyclophosphamide, 500 mg (Cytoxan, Neosar)
J9097	Cyclophosphamide, lyophilized 2 g (Cytoxan, Lyophilized)
J9096	Cyclophosphamide, lyophilized, 1 g (Cytoxan, Lyophilized)
J9093	Cyclophosphamide, lyophilized, 100 mg (Cytoxan, Lyophilized)
J9094	Cyclophosphamide, lyophilized, 200 mg (Cytoxan, Lyophilized)
J9095	Cyclophosphamide, lyophilized, 500 mg (Cytoxan, lyophilized)
J9091	Cyclophosphamide, 1 g
J9100	Cytarabine, 100 mg (Cytosar-U)
J9110	Cytarabine, 500 mg (Cytosar-U)
J9130	Dacarbazine, 100 mg (DTIC-Dome)
J9140	Dacarbazine, 200 mg (DTIC-Dome)
J9120	Dactinomycin, 0.5mg (Cosmegen)
J9150	Daunorubicin , 10 mg (Cerubidine)
J9165	Diethylstilbestrol diphosphate, 250 mg (Stilphostrol)
J9170	Docetaxel, 20 mg
J9000	Doxorubicin HCL, 10 mg (Adriamycin PFS, Adriamycin RDF, Rubex)
J9181	Etoposide, 10 mg (VePesid)
J9182	Etoposide, 100 mg (VePesid)
J9200	Floxuridine 500 mg (FUDR)
J9185	Fludarabine phosphate, 50 mg (Fludara)
J9190	Fluorouracil, 500 mg (Adrucil)
J9201	Gemcitabine HCL, 200mg
J9211	Idarubicin HCL, 5 mg (Idamycin)
J9208	Ifosfamide, per 1 g (Ifex)
J9212	Interferon Alfacon - 1, Recombinant, 1 mcg
J9213	Interferon, ALFA-2A, Recombinant, 3 Million Units
J9214	Interferon, ALFA-2B, Recombinant, 1 Million Units
J9215	Interferon, ALFA-N3, (Human Leukocyte Derived), 250,000 IU
J9216	Interferon, Gamma 1-B, 3 Million Units
J9206	Irinotecan, 20 mg
J9217	Leuprolide Acetate (For Depot Suspension), 7.5 mg
J9218	Leuprolide Acetate, per 1 mg
J9245	Melphalan HCL, 50 mg
J9209	Mesna, 200 mg (Mesnex)
J9250	Methotrexate Sodium, 5 mg

Procedure Code	*Description*
J9260	Methotrexate sodium, 50 mg (Folex, Folex PFS, Methotrexate LPF)
J9290	Mitomycin, 20 mg (Mutamycin)
J9291	Mitomycin, 40 mg (Mutamycin)
J9280	Mitomycin, 5 mg (Mutamycin, Mitomycin)
J9293	Mitoxantrone HCL, per 5 mg (Novantrone)
J9265	Paclitaxel, 30 mg (Taxol)
J9266	Pegaspargase, per single dose vial (Oncaspar)
J9268	Pentostatin per 10mg
J9270	Plicamycin, 2.5 mg (Mithracin)
J9320	Streptozocin, 1 g (Zanosar)
J9340	Thiotepa, 15 mg
J9350	Topotecan, 4 mg
J9355	Trastuzumab, 10 mg (Herceptin)
J9360	Vinblastine sulfate, 1 mg (Velban)
J9370	Vincristine sulfate, 1 mg (Oncovin, Vincasar PFS)
J9375	Vincristine sulfate, 2 mg (Oncovin, Vincasar PFS)
J9380	Vincristine sulfate, 5 mg (Oncovin, Vincasar PFS)
J9390	Vinorelbine Tartrate (Navelbine) per 10 mg
J9999	Not otherwise classified antineoplastic drugs

Injection Codes for EPO by Name

Procedure Code	*Description*
Q0136	Epogen Injection, per 1000 units
Q9920	Injection of EPO, per 1000 units, at patient HCT of 20 or less
Q9921	Injection of EPO, per 1000 units, at patient HCT of 21
Q9922	Injection of EPO, per 1000 units, at patient HCT of 22
Q9923	Injection of EPO, per 1000 units, at Patient HCT of 23
Q9924	Injection of EPO, per 1000 units, at patient HCT of 24
Q9925	Injection of EPO, per 1000 units, at patient HCT of 25
Q9926	Injection of EPO, per 1000 units, at patient HCT of 26
Q9927	Injection of EPO, per 1000 units, at patient HCT of 27
Q9928	Injection of EPO, per 1000 units, at patient HCT of 28
Q9929	Injection of EPO, per 1000 units, at patient HCT of 29
Q9930	Injection of EPO, per 1000 units, at patient HCT of 30
Q9931	Injection of EPO, per 1000 units, at patient HCT of 31
Q9932	Injection of EPO, per 1000 units, at patient HCT of 32
Q9933	Injection of EPO, per 1000 units, at patient HCT of 33
Q9934	Injection of EPO, per 1000 units, at patient HCT of 34
Q9935	Injection of EPO, per 1000 units, at patient HCT of 35
Q9936	Injection of EPO, per 1000 units, at patient HCT of 36
Q9937	Injection of EPO, per 1000 units, at patient HCT of 37
Q9938	Injection of EPO, per 1000 units, at patient HCT of 38
Q9939	Injection of EPO, per 1000 units, at patient HCT of 39
Q9940	Injection of EPO, per 1000 units, at patient HCT of 40

Special Purpose Codes by Name

Procedure Code	*Description*
Z3417	Palivzumab, Synagis, 50 mg, sdv
Z3387	Palivzumab, Synagis, 100 mg

CPT Codes by Name

Procedure Code	*Description*
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90725	Cholera vaccine for injectable use
90702	Diphtheria and tetanus toxoids (DT) adsorbed for pediatric use
90719	Diphtheria toxoid, for intramuscular use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) , for intramuscular use
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza b vaccine (DTaP-Hib), for intramuscular use
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4-dose schedule), for intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use
90744	Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests
95015	Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests
90788	Intramuscular injection of antibiotic (specify)
90780	IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
90781	IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours (list separately in addition to code for primary procedure)
90735	Japanese encephalitis virus vaccine, for subcutaneous use

Procedure Code	Description
90708	Measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90705	Measles virus vaccine, live, for subcutaneous or jet injection use
90707	Measles, mumps, and rubella (MMR) virus vaccine, live, for subcutaneous or jet injection use
90733	Meningococcal polysaccharide vaccine (and group(s)), for subcutaneous or jet injection use
90704	Mumps virus vaccine, live, for subcutaneous or jet injection use
95044	Patch or application test(s) (specify number of tests)
95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, specify number of tests
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests
90727	Plague vaccine, for intramuscular or jet injection use
90669	Pneumococcal conjugate vaccine, polyvalent, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use or immunosupressed patient.
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous use
95120	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; single injection
95125	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; two or more injections
95130	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; one stinging insect venom
95131	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; two stinging insect venoms
95132	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; three stinging insect venoms
95133	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; four stinging insect venoms
95134	Professional services for allergen immunotherapy in prescribing physician's office or institution, including provision of allergenic extract; five stinging insect venoms
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; two or more injections

Procedure Code	Description
95145	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom
95146	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms
95147	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms
95148	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms
95149	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms
95170	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); whole body extract of biting insect or other arthropod
95078	Provocative testing (e.g., Rinkel test)
90676	Rabies vaccine, for intradermal use
90675	Rabies vaccine, for intramuscular use
95180	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, horse serum)
90709	Rubella and mumps virus vaccine, live, for subcutaneous or jet injection use
90706	Rubella virus vaccine, live, for subcutaneous or jet injection use
95027	Skin end point titration
90718	Tetanus and diphtheria toxoids (Td) adsorbed for adult use, for intramuscular or jet injection
90703	Tetanus toxoid adsorbed, for intramuscular or jet injection use
90782	Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90784	Therapeutic or diagnostic injection (specify material injected); intravenous
90799	Unlisted therapeutic or diagnostic injection
90716	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use

H.3 Injectable Drug List by Procedure Code

The following table provides a listing of valid injectable drug codes sorted numerically by procedure code. To view this list sorted alphabetically, refer to Section H.2, Injectable Drug List by Name.

The following drugs can be injected subcutaneously, intramuscularly, or intravenously.

Procedure Code	***Description***
J0120	Achyromycin, up to 250 mg (Tetracycline)
J0150	Adenosine, 6 mg
J0151	Adenosine, 90 mg
J0170	Adrenalin, Epinephrine up to 1 ml ampoule
J0210	Aldomet Ester HCl, up to 250 mg (Methyldopate HCl)
J0256	Alpha 1-proteinase inhibitor, 10 mg
J0280	Aminophyllin, up to 250 mg (Aminophylline, vial, 125)
J0290	Ampicillin, up to 500 mg (Polycillin)
J0295	Ampicillin sodium, 1.5 g
J0300	Amobarbital, up to 125 mg (Amytal Sodium)
J0330	Succinylcholine chloride up to 20 mg
J0340	Nandrolone Phenpropionate, up to 50 mg (Durabolin)
J0350	Anistreplase 30 units
J0360	Hydralazine HCl up to 20 mg (Apresoline)
J0380	Metaraminol per 10 mg (10 ml)
J0460	Atropine sulfate up to 0.3 mg
J0500	Dicyclomine up to 20 mg (Bentyl)
J0510	Benzquinamide HCl up to 50 mg (Emete-Con)
J0515	Benztropine (Congentin 1 mg/ml;2 ml)
J0520	Bethanechol chloride Myatonachol or Urecholin up to 5 mg
J0530	Penicillin G Benzathine and Penicillin G Procaine up 600,000 Units
J0540	Penicillin G Benzathine and Penicillin G Procaine up to 1,200,000 Units
J0550	Penicillin G Benzathine and Penicillin B Procaine up 2,400,000 Units
J0560	Penicillin G Benzathine up to 600,000 units (Bicillin) 600,000 Units
J0570	Penicillin G Benzathine up to 1,200,000 units
J0580	Penicillin G Benzathine up to 2,400,000 units
J0585	Botulinum toxin type A per 100 units
J0600	Edetate Calcium Disodium, up to 1000 mg (Calcium Disodium)
J0610	Calcium Gluconate up to 10 ml
J0620	Calcium Lactate, per 10 ml (Calphosan)
J0630	Calcitonin Salmon up to 400 units (Calcimar)
J0635	Calcitrol 1 mcg ampoule Calcijex
J0640	Leucovorin Calcium per 50 mg
J0690	Cefazolin Sodium up to 500 mg
J0694	Cefoxitin Sodium, 1 g (Mefoxin)
J0695	Cefonocid Sodium, 1 g (Monocid)
J0696	Ceftriaxone Sodium, per 250 mg
J0697	Zinacef, 750 mg
J0698	Cefotaxime Sodium per g
J0702	Betamethasone, 3 mg
J0704	Betamethasone, 4 mg
J0710	Cephapirin Sodium up to 1 g
J0713	Ceftazidime, 500 mg
J0715	Ceftizoxime Sodium, per 500 mg

Procedure Code	***Description***
J0720	Chloramphenicol Sodium Succinate up to 1 g
J0725	Chorionic Gonadtropin (per 1,000 units-10 ml each)
J0730	Chlorpheniramine Maleate, per 10 mg
J0735	Clonidine Hydrochloride, 1 mg
J0743	Cilastatin Sodium; Imipenem, per 250 mg
J0745	Codeine Phosphate (ampoule 30 mg/ml)
J0760	Colchicine, per 1 mg
J0780	Prochlorperazine, up to 10 mg (Compazine)
J0800	Corticotropin, up to 40 units (ACTH)
J0810	Cortisone up to 50 mg Cortisone Acetate
J0835	Cosyntropin, 0.25 mg
J0895	Deferoxamine Mesylate 500 mg per 5 cc
J0900	Testosterone Enanthate and Estradiol Valerate up to 1 cc
J0945	Brompheniramine Maleate (10 mg/ml)
J0970	Estradiol Valerate up to 40 mg (Delestrogen)
J1000	Depo-estradiol Cypionate, up to 5 mg
J1020	Methylprednisolone Acetate 20 mg (Depo-Medrol)
J1030	Methylprednisolone Acetate 40 mg (Depo-Medrol)
J1040	Methylprednisolone Acetate 80 mg (Depo-Medrol)
J1050	Medroxyprogesterone acetate up to 100 mg
J1055	Medroxyprogesterone acetate, 150 mg
J1060	Testosterone Cypionate and Estradiol Cypionate up to 1 ml
J1070	Testosterone Cypionate up to 100 mg
J1080	Testosterone Cypionate 1 cc, 200 mg
J1090	Testosterone Cypionate, 1 cc, 50 mg
J1095	Dexamethasone acetate, per 8 mg
J1100	Dexamethosone Sodium Phosphate, up to 4mg/ml (Decadron Phosphate)
J1110	Dihydroergotamine, per 1 mg (DHE 45)
J1160	Digoxin up to 0.5 mg
J1165	Phenytoin Sodium, per 50 mg
J1170	Hydromorphone (HCl), up to 4 mg
J1180	Dyphylline up to 500 mg (Lufyllin)
J1200	Diphenhydramine HCl up to 50 mg (Benadryl HCl)
J1205	Chlorothiazide, 500 mg
J1230	Methadone HCl up to 10 mg (Dolophine) HCl
J1240	Dimenhydrinate, up to 50 mg (Dramamine)
J1245	Dipyridamole, per 10 mg
J1250	Dobutamine, 250 mg
J1320	Amitriptyline HCl, up to 20 mg (Elavil HCl)
J1330	Ergonovine Maleate up to 0.2 mg (Ergotrate Maleate)
J1362	Erythromycin, 250 mg
J1364	Erythromycin Lactobionate per 500 mg

Procedure Code	Description
J1380	Estradiol Valerate up to 10 mg (Delestrogen)
J1390	Estradiol Valerate up to 20 mg (Delestrogen)
J1410	Estrogen conjugated per 25 mg or 20,000 units
J1435	Estrone per 1 mg
J1436	Etidronate Disodium per 300 mg
J1438	Etanercept, 25 mg
J1440	Filgrastim (G-CSF) 300 mcg
J1441	Filgrastim (G-CSF), 480 mcg
J1455	Foscarnet sodium per 1000 mg
J1460	Gamma Globulin IM I cc (Immune Globulin)
J1470	Gamma Globulin IM 2 cc
J1480	Gamma Globulin IM 3 cc
J1490	Gamma Globulin IM 4 cc
J1500	Gamma Globulin IM 5 cc
J1510	Gamma Globulin IM 6 cc
J1520	Gamma Globulin IM 7 cc
J1530	Gamma Globulin IM 8 cc
J1540	Gamma Globulin IM 9 cc
J1550	Gamma Globulin IM 10 cc
J1560	Gamma Globulin, IM over 10 cc
J1561	Immune Globulin (IV) per 500 mg, (20 ml)
J1562	Immune Globulin intravenous, 5 g
J1565	Respiratory Syncytial virus Immune Globulin, (IV), 50 mg
J1570	Ganciclovir Sodium 500 mg
J1580	Garamycin Gentamicin up to 80 mg
J1600	Gold Sodium Thiomaleate, up to 50 mg
J1610	Glucagon Hydrochloride per 1 mg
J1620	Gonadorelin Hydrochloride per 100 mcg
J1626	Granisetron Hydrochoride 100 mcg (Kytril)
J1630	Haloperidol up to 5 mg (Haldol)
J1631	Haloperidol Decanoate per 50 mg (Haldol Decanoate)
J1642	Heparin Sodium per 10 units
J1644	Heparin Sodium per 1000 units
J1670	Tetanus Immune Globulin, Human, up to 250 units
J1690	Prednisolone Tebutate, up to 20 mg
J1700	Hydrocortisone Acetate, up to 25 mg
J1710	Hydrocortisone Sodium Phosphate up to 50 mg
J1720	Hydrocortisone Sodium Succinate up to 100 mg
J1739	Hydroxyprogesterone Caproate 125 mg/ml
J1741	Hydroxyprogesterone Caproate 250 mg/ml
J1742	Ibutilide Fumarate 1 mg
J1750	Iron Dextran, 50 mg injection
J1790	Droperidol up to 5 mg
J1800	Propranolol HCl, up to 1 mg (Inderal)
J1810	Droperidol and Fentanyl Citrate, up to 2 ml ampoule
J1820	Insulin up to 100 units
J1825	Interferon Beta-1A 33 mcg
J1830	Interferon Beta-IB per 0.25 mg
J1840	Kanamycin Sulfate up to 500 mg
J1850	Kanamycin Sulfate up to 75 mg (Kantrex Pediatric)
J1885	Ketorolac Tromethamine per 15 mg
J1890	Cephalothin Sodium up to 1 g
J1910	Kutapressin up to 2 ml
J1930	Propiomazine up to 20 mg
J1940	Furosemide up to 20 mg
J2810	Theophylline per 40 mg
J2820	Sargramostim (GM-CSF), 50 mg
J2860	Secobarbital Sodium up to 250 mg

Procedure Code	Description
J1950	Leuprolide Acetate [for depot suspension] per 3.75 mg
J1955	Levocarnitine per 1 g
J1960	Levorphanol Tartrate up to 2 mg (Levo-Dromoran)
J1970	Methotrimeprazine up to 20 mg (Levoprome)
J1980	Hyoscyamine Sulfate up to 0.25 mg (Levsin)
J1990	Chlordiazepoxide HCl up to 100 mg (Librium)
J2000	Lidocaine HCl 50 cc
J2010	Lincomycin HCl up to 300 mg (Lincocin)
J2060	Ativan Lorazepam 2 mg
J2150	Mannitol 25% in 50 ml
J2175	Meperidine Hydrochloride, per 100 mg
J2180	Meperidine and Promethazine HCl, up to 50 mg (Mepergan)
J2210	Methyl Ergonovine Maleate, up to 0.2 mg (Methergine)
J2250	Midazolam HCL per 1 mg
J2260	Milrinone Lactate (primacor), per 5 ml
J2270	Morphine Sulfate up to 10 mg
J2271	Morphine Sulfate, 100 mg
J2275	Morphine Sulfate preservative-free sterile solution per 10 mg
J2300	Nalbuphine Hydrochloride, per 10 mg
J2310	Naloxone HCl per 1 mg
J2320	Nandrolone Decanoate up to 50 mg
J2321	Nandrolone Decanoate up to 100 mg
J2322	Nandrolone Decanoate up to 200 mg
J2330	Thiothixene, up to 4 mg (Navane IM)
J2350	Niacinamide, niacin, up to 100 mg
J2360	Orphenadrine up to 60 mg (Norflex)
J2370	Phenylephrine HCl up to 1ml
J2400	Chloroprocaine HCl, per 30 ml (Nesacaine)
J2405	Ondansetron HCl (Zofran) per 1 mg
J2430	Pamidronate Disodium per 30 mg
J2440	Papaverine HCl up to 60 mg
J2460	Oxytetracyline HCl up to 50 mg (Terramycin)
J2510	Penicillin G Procaine, aqueous, up to 600,000 units
J2512	Pentagastrin per 2 ml
J2515	Pentobarbital Sodium per 50 mg, Nebutal Sodium ampoule
J2540	Penicillin G Potassium, up to 600,000 units
J2545	Pentamidine for aerosol inhaler for Pneumocystis Carini Pneumon, per 300 mg, administered through a DME
J2550	Promethazine (HCl) up to 50 mg
J2560	Phenobarbital Sodium up to 120 mg (Phenobarbital)
J2590	Oxytocin up to 10 units (Pitocin)
J2597	Desmopressin Acetate per 1 mcg
J2640	Prednisolone Sodium Phosphate to 20 mg (Hydeltrasol)
J2650	Prednisolone Acetate up to 1 ml
J2675	Progesterone per 50 mg
J2680	Fluphenazine Decanoate, up to 25 mg
J2690	Procainamide HCl up to 1 g
J2700	Oxacillin Sodium up to 250 mg
J2710	Neostgmine Methylsulfate, up to 0.5 mg
J2725	Protirelin per 250 mcg
J2760	Phentolamine Mesylate up to 5 mg (Regitine)
J2765	Metoclopramide HCl, up to 10 mg (2ml) Reglan
J2790	RHO D Immune Globulin, Human, one dose package (Rhogam)
J2792	RHO D Immune Globulin, IV, Human, Solvent Detergent, 100 IU

X1573	Ceftriaxone Sodium Rocephin, 500 mg
X1574	Ceftriaxone Sodium, Rocephin, 1 g
X1630	Sodium Thiosalicylate 50 mg (1ml)

Procedure Code	Description
J2910	Aurothioglucose, up to 50 mg (Solganal)
J2912	Sodium Chloride, 0.9%, per 2 ml
J2920	Methylprednisolone Sodium Succinate, up to 40 mg
J2930	Methylprednisolone Sodium Succinate, up to 125 mg
J2950	Promazine HCl up to 25 mg
J2970	Methicillin Sodium up to 1 g (Staphcillin)
J2995	Streptokinase per 250,000 IU
J2996	Alteplase recombinant, per 10 mg
J3000	Streptomycin up to 1 g (Streptomycin Sulfate)
J3010	Fentanyl Citrate up to 2 ml
J3030	Sumatriptan Succinate 6 mg
J3070	Pentazocine HCl up to 30 mg (Talwin Lactate)
J3105	Terbutaline Sulfate up to 1 mg
J3120	Testosterone Enanthate, up to 100 mg (Delatestryl)
J3130	Testosterone Enanthate, up to 200 mg (Delatestryl)
J3140	Testosterone Suspension, up to 50 mg
J3150	Testosterone Propionate, up to 100 mg
J3230	Chlorpromazine HCl, up to 50 mg
J3250	Trimethobenzamide HCl, up to 200 mg
J3260	Tobramycin Sulfate, up to 80 mg
J3265	Torsemide 10 mg/ml
J3270	Imipramine HCl, up to 25 mg (Tofranil)
J3280	Thiethylperazine Maleate, up to 10 mg (Torecan)
J3301	Triamcinolone Acetonide, per 10 mg
J3302	Triamcinolone Diacetate, per 5 mg
J3303	Triamcinolone Hexacetonide, per 5 mg
J3305	Trimetrexate Glucuronate per 25 mg
J3310	Perphenazine, up to 5 mg (Trilafone)
J3320	Spectinomycin Dihydrochloride, up to 2 g
J3360	Diazepam, up to 5 mg (Valium)
J3364	Urokinase 5000 IU vial
J3365	Urokinase 250,000 IU vial (Abbokinase)
J3370	Vancomycin HCl, up to 500 mg (Vancocin)
J3390	Methoxamine, up to 20 mg (Vasoxyl)
J3400	Triflupromazine HCl, up to 20 mg (Vesprin)
J3410	Hydroxyzine HCl, up to 25 mg
J3420	Vitamin B-12 Cyanocobalamin, up to 1000 mcg
J3430	Vitamin K, Phytonadione, per 1 mg
J3450	Mephentermine Sulfate, up to 30 mg (Wyamine)
J3470	Hyaluronidase, up to 150 units (Wydase)
J3475	Magnesium Sulfate per 500 mg
J3480	Potassium Chloride per 2 meq
J3490	Unclassified drugs
X1015	Amikacin Sulfate, Amikin 500 mg
X1090	Clindamycin Phosphate 300 mg ampoule
X1200	Dextrose 5 ml 10%
X1310	Folic Acid, 5 mg (1ml)
X1365	Hydrocortisone Acetate 50 mg (1ml)
X1415	Hyoscyamine Sulfate, Levsin .05 mg (10 ml)
X1445	Cefamandole Nafate, Mandol 500 mg (10 ml)
X1460	Medroxyprogesterone Acetate, (Depo-Provera) 200 mg
X1525	Fluphenazine HCL, Prolixin 2.5 mg (1 ml)
X1530	Fluphenazine Enanthate, prolixin Enanthate 25 mg (1 ml)
X1550	Pyridoxine HCL Vit. B6 100 mg (1 ml)

Procedure Code	Description
X1655	Butorphanol Tartrate, stadol 2 mg (1ml)
X1705	Thiamine HCL 100 mg (1ml)
X1717	Triamcinolone Acetonide 40 mg
X1745	Ascorbic Acid, 500 mg (5ml)

Miscellaneous Drugs and Solutions by Code

Procedure Code	Description
A9500	Supply of radiopharm diagnostic imaging agent, technetium, per dose
A9505	Supply of radiopharm diagnostic imaging agent, thallous chloride, per MCI
J7030	Normal saline solution (IV) 1000 cc
J7040	Normal saline solution (IV) (500 ml = 1 unit)
J7042	Dextrose/Normal saline I5% (IV) (500 ml = 1 unit)
J7050	Normal saline solution, 250 cc
J7051	Saline or water, sterile, (IV) up to 5 cc
J7060	Dextrose/water 5% (IV) (500 ml = 1 unit)
J7070	D5W (IV), 1000 cc
J7120	Ringer's lactate infusion (IV) up to 1000 cc
J7130	Saline solution, Hypertonic 50 or 100 meq (IV) 20 cc vial
J7190	Factor VIII, (antihemophilic factor, human) per I.U.
J7191	Factor VIII (antihemophilic factor, porcine), per I.U.
J7192	Factor VIII (antihemophilic factor, recombinant) per I.U.
J7194	Factor IX, complex per I.U.

Chemotherapy Drugs by Code

The cost of the drug does not include administration.

Procedure Code	*Description*
J9000	Doxorubicin HCL, 10 mg (Adriamycin PFS, Adriamycin RDF, Rubex)
J9015	Aldesleukin, per single use vial
J9020	Asparaginase, 10,000 units (Elspar)
J9031	BCG (Intravesical) per instillation
J9040	Bleomycin sulfate, 15 units (Blenoxane)
J9045	Carboplatin, 50 mg (paraplatin)
J9050	Carmustine, 100 mg (Bicnu)
J9060	Cisplatin, powder or solution, per 10 mg (Plantinol, Plantinol AQ)
J9062	Cisplatin, 50mg (Plantinol, Plantinol AQ)
J9065	Cladribine, per 1 mg (Leustatin)
J9070	Cyclophosphamide, 100 mg (Cytoxan, Neosar)
J9080	Cyclophosphamide, 200 mg (Cytoxan, Neosar)
J9090	Cyclophosphamide, 500 mg (Cytoxan, Neosar)
J9091	Cyclophosphamide, 1 g
J9092	Cyclophosphamide 2 g
J9093	Cyclophosphamide, lyophilized, 100 mg (Cytoxan, Lyophilized)
J9094	Cyclophosphamide, lyophilized, 200 mg (Cytoxan, Lyophilized)
J9095	Cyclophosphamide, lyophilized, 500 mg (Cytoxan, lyophilized)
J9096	Cyclophosphamide, lyophilized, 1 g (Cytoxan, Lyophilized)
J9097	Cyclophosphamide, lyophilized 2 g (Cytoxan, Lyophilized)
J9100	Cytarabine, 100 mg (Cytosar-U)
J9110	Cytarabine, 500 mg (Cytosar-U)
J9120	Dactinomycin, 0.5mg (Cosmegen)
J9130	Dacarbazine, 100 mg (DTIC-Dome)
J9140	Dacarbazine, 200 mg (DTIC-Dome)
J9150	Daunorubicin , 10 mg (Cerubidine)
J9165	Diethylstilbestrol diphosphate, 250 mg (Stilphostrol)
J9170	Docetaxel, 20 mg
J9181	Etoposide, 10 mg (VePesid)
J9182	Etoposide, 100 mg (VePesid)
J9185	Fludarabine phosphate, 50 mg (Fludara)
J9190	Fluorouracil, 500 mg (Adrucil)
J9200	Floxuridine 500 mg (FUDR)
J9201	Gemcitabine HCL, 200mg
J9206	Irinotecan, 20 mg
J9208	Ifosfamide, per 1 g (Ifex)
J9209	Mesna, 200 mg (Mesnex)
J9211	Idarubicin HCL, 5 mg (Idamycin)
J9212	Interferon Alfacon - 1, Recombinant, 1 mcg
J9213	Interferon, ALFA-2A, Recombinant, 3 Million Units
J9214	Interferon, ALFA-2B, Recombinant, 1 Million Units
J9215	Interferon, ALFA-N3, (Human Leukocyte Derived), 250,000 IU
J9216	Interferon, Gamma 1-B, 3 Million Units
J9217	Leuprolide Acetate (For Depot Suspension), 7.5 mg
J9218	Leuprolide Acetate, per 1 mg
J9245	Melphalan HCL, 50 mg
J9250	Methotrexate Sodium, 5 mg

Procedure Code	*Description*
J9260	Methotrexate sodium, 50 mg (Folex, Folex PFS, Methotrexate LPF)
J9265	Paclitaxel, 30 mg (Taxol)
J9266	Pegaspargase, per single dose vial (Oncaspar)
J9268	Pentostatin per 10mg
J9270	Plicamycin, 2.5 mg (Mithracin)
J9280	Mitomycin, 5 mg (Mutamycin, Mitomycin)
J9290	Mitomycin, 20 mg (Mutamycin)
J9291	Mitomycin, 40 mg (Mutamycin)
J9293	Mitoxantrone HCL, per 5 mg (Novantrone)
J9320	Streptozocin, 1 g (Zanosar)
J9340	Thiotepa, 15 mg
J9350	Topotecan, 4 mg
J9355	Trastuzumab, 10 mg (Herceptin)
J9360	Vinblastine sulfate, 1 mg (Velban)
J9370	Vincristine sulfate, 1 mg (Oncovin, Vincasar PFS)
J9375	Vincristine sulfate, 2 mg (Oncovin, Vincasar PFS)
J9380	Vincristine sulfate, 5 mg (Oncovin, Vincasar PFS)
J9390	Vinorelbine Tartrate (Navelbine) per 10 mg
J9999	Not otherwise classified antineoplastic drugs

Injection Codes for EPO by Code

Procedure Code	*Description*
Q0136	Epogen Injection, per 1000 units
Q9920	Injection of EPO, per 1000 units, at patient HCT of 20 or less
Q9921	Injection of EPO, per 1000 units, at patient HCT of 21
Q9922	Injection of EPO, per 1000 units, at patient HCT of 22
Q9923	Injection of EPO, per 1000 units, at Patient HCT of 23
Q9924	Injection of EPO, per 1000 units, at patient HCT of 24
Q9925	Injection of EPO, per 1000 units, at patient HCT of 25
Q9926	Injection of EPO, per 1000 units, at patient HCT of 26
Q9927	Injection of EPO, per 1000 units, at patient HCT of 27
Q9928	Injection of EPO, per 1000 units, at patient HCT of 28
Q9929	Injection of EPO, per 1000 units, at patient HCT of 29
Q9930	Injection of EPO, per 1000 units, at patient HCT of 30
Q9931	Injection of EPO, per 1000 units, at patient HCT of 31
Q9932	Injection of EPO, per 1000 units, at patient HCT of 32
Q9933	Injection of EPO, per 1000 units, at patient HCT of 33
Q9934	Injection of EPO, per 1000 units, at patient HCT of 34
Q9935	Injection of EPO, per 1000 units, at patient HCT of 35
Q9936	Injection of EPO, per 1000 units, at patient HCT of 36
Q9937	Injection of EPO, per 1000 units, at patient HCT of 37
Q9938	Injection of EPO, per 1000 units, at patient HCT of 38
Q9939	Injection of EPO, per 1000 units, at patient HCT of 39
Q9940	Injection of EPO, per 1000 units, at patient HCT of 40

Special Purpose Codes by Code

Procedure Code	*Description*
Z3387	Palivzumab, Synagis, 100 mg
Z3417	Palivzumab, Synagis, 50 mg, sdv

CPT Codes by Code

Procedure Code	*Description*
90585	Bacillus Calmette-Guerin vaccine (BCG) for tuberculosis, live, for percutaneous use
90586	Bacillus Calmette-Guerin vaccine (BCG) for bladder cancer, live, for intravesical use
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4-dose schedule), for intramuscular use
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3-dose schedule), for intramuscular use
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4-dose schedule), for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use
90658	Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use
90669	Pneumococcal conjugate vaccine, polyvalent, for intramuscular use
90675	Rabies vaccine, for intramuscular use
90676	Rabies vaccine, for intradermal use
90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) , for intramuscular use
90702	Diphtheria and tetanus toxoids (DT) adsorbed for pediatric use
90703	Tetanus toxoid adsorbed, for intramuscular or jet injection use
90704	Mumps virus vaccine, live, for subcutaneous or jet injection use
90705	Measles virus vaccine, live, for subcutaneous or jet injection use
90706	Rubella virus vaccine, live, for subcutaneous or jet injection use
90707	Measles, mumps, and rubella (MMR) virus vaccine, live, for subcutaneous or jet injection use
90708	Measles and rubella virus vaccine, live, for subcutaneous or jet injection use
90709	Rubella and mumps virus vaccine, live, for subcutaneous or jet injection use
90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous use
90716	Varicella virus vaccine, live, for subcutaneous use
90717	Yellow fever vaccine, live, for subcutaneous use
90718	Tetanus and diphtheria toxoids (Td) adsorbed for adult use, for intramuscular or jet injection
90719	Diphtheria toxoid, for intramuscular use

Procedure Code	***Description***
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza b vaccine (DTaB-Hib), for intramuscular use
90725	Cholera vaccine for injectable use
90727	Plague vaccine, for intramuscular or jet injection use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use or immunosupressed patient.
90733	Meningococcal polysaccharide vaccine (and group(s)), for subcutaneous or jet injection use
90735	Japanese encephalitis virus vaccine, for subcutaneous use
90744	Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use
90746	Hepatitis B vaccine, adult dosage, for intramuscular use
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use
90780	IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour
90781	IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours (list separately in addition to code for primary procedure)
90782	Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular
90784	Therapeutic or diagnostic injection (specify material injected); intravenous
90788	Intramuscular injection of antibiotic (specify)
90799	Unlisted therapeutic or diagnostic injection
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, specify number of tests
95146	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms
95147	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms
95148	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms
95149	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms
95170	Professional services for the supervision and provision of antigens for allergen immunotherapy (specify number of doses); whole body extract of biting insect or other arthropod
95180	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, horse serum)

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I Outpatient Hospital/ASC Procedure List

These CPT codes are currently covered for outpatient hospital billing. The list also includes outpatient procedures for hospitals and ambulatory surgical centers.

NOTE:

The following list is used for scheduling Medicaid recipients for outpatient procedures. 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.

If a procedure is not listed, use the AVRS line at EDS (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.

A “PA” 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 EDS, Attn: Prior Authorization; P O Box 244035; Montgomery, AL 36124.

A “EQ” in the EPSDT column indicates that the procedure requires an EPSDT referral or is for QMB recipients only.

A number in the Group column indicates which one of the following established group rates applies to the procedure payment:

Group Indicator	***Group Rate***
Group 1	$193.18
Group 2	258.57
Group 3	297.21
Group 4	365.56
Group 5	416.84
Group 6	593.80 (includes intraocular lens)
Group 7	578.82
Group 8	678.50 (includes intraocular lens)
Group 9	Various rates less than Group 1

A number in the Limit column indicates the maximum allowable units that may be billed.

NOTE:

Benefit limits may also apply in addition to the hard-coded maximum units.

AMMIS Outpatient Hospital Covered Procedure Codes as of 7/24/00

Code	PA	EPSDT	Grp	Limit
10060			01	1.00
10061			02	1.00
10081			02	
10120			01	
10121			01	
10140			02	1.00
10160			01	
10180			01	
11010			01	1.00
11011			01	1.00
11012			02	1.00
11041			01	1.00
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11043			02	1.00
11044			02	1.00
11055			01	1.00
11056			01	1.00
11057			01	1.00
11100			01	
11101			01	
11400			01	1.00
11401			01	1.00
11402			01	1.00
11403			01	1.00
11404			01	1.00
11406			02	1.00
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11423			01	1.00
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11426			01	1.00
11440			01	1.00
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11444			01	1.00
11446			01	1.00
11450			01	1.00
11451			01	1.00
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11470			02	1.00
11471			02	1.00
11600			01	1.00
11601			01	1.00
11602			01	1.00
11603			01	1.00
11604			01	1.00
11606			01	1.00
11620			01	1.00
11621			01	1.00
11622			01	1.00
11623			01	1.00
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11721			01	1.00
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11750			01	1.00
11752			01	1.00
11762		EQ	01	1.00
11770			03	1.00
11771			03	1.00
11772			03	1.00
11960			02	1.00
11970			02	1.00
11971			01	1.00
12001			09	1.00
12002			09	1.00
12004			09	1.00
12005			09	1.00
12006			09	1.00
12007			09	1.00
12011			01	1.00
12013			09	1.00
12014			09	1.00
12015			09	1.00
12016			09	1.00
12017			09	1.00
12018			09	1.00
12020			09	1.00
12021			09	1.00
12032			01	1.00
12034			01	1.00
12035			01	1.00
12036			02	1.00
12037			02	1.00
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12042			01	1.00
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12045			02	1.00
12046			02	1.00
12047			02	1.00
12051			01	1.00
12052			01	1.00
12053			01	1.00
12054			01	1.00
12055			01	1.00
12056			02	1.00
12057			02	1.00
13100			01	1.00
13101			03	1.00
13102			02	
13120			01	1.00
13121			03	1.00
13122			01	
13131			02	1.00
13132			03	1.00
13133			02	
13150			02	1.00
13151			02	1.00
13152			03	1.00
13153			02	
13160			03	1.00
14000			02	1.00
14001			03	1.00
14020			03	1.00
14021			03	1.00
14040			03	1.00
14041			03	1.00
14060			03	1.00
14061			03	1.00
14300			04	1.00
14350			03	1.00
15000			02	1.00
15001			02	1.00
15050			02	1.00
15100			02	1.00
15101			01	1.00
15120			03	1.00
15121			01	1.00
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15201			02	1.00
15220			02	1.00
15221			01	1.00
15240			03	1.00
15241			01	1.00
15260			02	1.00
15261			01	1.00
15350			02	1.00
15351			02	1.00
15400			02	1.00
15401			02	1.00
15570			03	1.00
15572			03	1.00
15574			03	1.00
15576			03	1.00
15600			03	1.00
15610			03	1.00
15620			03	1.00
15630			03	1.00
15650			05	1.00
15732			03	1.00
15734			03	1.00
15736			03	1.00
15738			03	1.00
15740			02	1.00
15750			02	1.00
15756			02	1.00
15757			01	1.00
15758			01	1.00
15760			02	1.00
15770			03	1.00
15780			01	1.00
15781			01	1.00
15782			01	1.00
15786			01	1.00
15787			01	1.00
15820	PA		02	1.00
15821	PA		02	1.00
15822	PA		02	1.00
15823	PA		02	1.00
15824	PA	EQ	03	1.00
15831			03	1.00
15832			02	1.00
15833			02	1.00
15834			02	1.00
15835			02	1.00
15836			02	1.00
15837			02	1.00
15838			02	1.00
15839			02	1.00
15840			04	1.00
15841			04	1.00
15842			04	1.00
15845			04	1.00
15850			01	1.00
15851			01	1.00
15852			01	1.00
15876	PA		02	1.00
15877	PA		02	1.00

Code	PA	EPSDT	Grp	Limit
15878	PA		02	1.00
15879	PA		02	1.00
15920			03	1.00
15922			04	1.00
15931			02	1.00
15933			03	1.00
15934			02	1.00
15935			03	1.00
15936			02	1.00
15937			03	1.00
15940			02	1.00
15941			03	1.00
15944			02	1.00
15945			03	1.00
15946			02	1.00
15950			02	1.00
15951			03	1.00
15952			02	1.00
15953			03	1.00
15956			02	1.00
15958			03	1.00
16010			01	1.00
16015			02	1.00
16020			09	1.00
16025			09	1.00
16030			09	1.00
17000			01	1.00
17003			01	1.00
17004			01	1.00
17106			01	1.00
17107			01	1.00
17108			01	1.00
17110	PA		01	1.00
17111	PA		01	1.00
17260			01	1.00
17261			01	1.00
17262			01	1.00
17263			01	1.00
17264			01	1.00
17266			02	1.00
17270			01	1.00
17271			01	1.00
17272			01	1.00
17273			01	1.00
17274			01	1.00
17276			02	1.00
17280			01	1.00
17281			01	1.00
17282			01	1.00
17283			01	1.00
17284			01	1.00
17286			02	1.00
19000			01	1.00
19020			02	1.00
19100			01	1.00
19101			02	1.00
19110			01	1.00
19112			01	1.00
19120			03	1.00
19125			03	1.00
19126			03	1.00
19140			03	1.00
19160			03	1.00
19162			07	1.00
19180			04	1.00
19182			04	1.00
19260			05	1.00
19290			01	1.00
19291			01	1.00

Code	PA	EPSDT	Grp	Limit
19318	PA		04	1.00
19328			01	1.00
19330			01	1.00
19340	PA		02	1.00
19342	PA		03	1.00
19350	PA		02	1.00
19355		EQ	03	1.00
19357	PA		03	1.00
19361	PA		04	1.00
19364	PA		05	1.00
19366	PA		05	1.00
19367	PA		04	1.00
19368	PA		04	1.00
19369	PA		04	1.00
19370			03	1.00
19371			03	1.00
19380	PA		04	1.00
20005			02	1.00
20100			02	1.00
20101			02	1.00
20102			02	1.00
20103			02	1.00
20150			02	1.00
20200			01	1.00
20205			02	1.00
20206			09	1.00
20220			01	1.00
20225			02	1.00
20240			02	1.00
20245			03	1.00
20250			03	1.00
20251			03	1.00
20501			01	1.00
20520			01	1.00
20525			03	1.00
20550			09	1.00
20605			01	1.00
20610			01	1.00
20615			01	1.00
20650			03	1.00
20661			03	1.00
20662			03	1.00
20663			03	1.00
20664			02	1.00
20665			01	1.00
20670			01	1.00
20680			03	1.00
20690			03	1.00
20692			03	1.00
20693			01	1.00
20694			01	1.00
20900			03	1.00
20902			04	1.00
20910			02	1.00
20912			03	1.00
20920			03	1.00
20922			03	1.00
20924			03	1.00
20926			03	1.00
20955			04	1.00
20956			04	1.00
20957			03	1.00
20962			04	1.00
20969			04	1.00
20970			04	1.00
20972			04	1.00
20973			04	1.00
20975			02	1.00
21010			02	1.00

Code	PA	EPSDT	Grp	Limit
21025			02	1.00
21026			02	1.00
21029			02	1.00
21030			02	1.00
21031			02	1.00
21032			02	1.00
21034			03	1.00
21040			02	1.00
21041			03	1.00
21044			02	1.00
21050			03	1.00
21060			02	1.00
21070			03	1.00
21076	PA		03	1.00
21077	PA		03	1.00
21100			01	1.00
21206			05	1.00
21208			07	1.00
21209			05	1.00
21210			07	1.00
21215			07	1.00
21230			07	1.00
21235			07	1.00
21240			04	1.00
21242			05	1.00
21243			05	1.00
21244			07	1.00
21245			07	1.00
21246			07	1.00
21248			07	1.00
21249			07	1.00
21267			07	1.00
21270			05	1.00
21275			07	1.00
21280			05	1.00
21282			05	1.00
21300			01	1.00
21310			09	1.00
21315			09	1.00
21320			09	1.00
21325			02	1.00
21330			03	1.00
21335			03	1.00
21337			01	1.00
21338			02	1.00
21339			02	1.00
21340			03	1.00
21343			03	1.00
21345			03	1.00
21355			03	1.00
21356			03	1.00
21360			03	1.00
21365			04	1.00
21385			05	1.00
21386			05	1.00
21387			05	1.00
21390			07	1.00
21395			07	1.00
21400			02	1.00
21401			03	1.00
21406			04	1.00
21407			05	1.00
21421			04	1.00
21422			05	1.00
21440			03	1.00
21445			04	1.00
21450			01	1.00
21451			03	1.00
21452			02	1.00

Code	PA	EPSDT	Grp	Limit
21453			03	1.00
21454			03	1.00
21461			04	1.00
21462			03	1.00
21465			04	1.00
21470			04	1.00
21480			01	1.00
21485			01	1.00
21490			03	1.00
21493			03	1.00
21494			03	1.00
21495			03	1.00
21497			02	1.00
21501			02	1.00
21502			02	1.00
21510			03	1.00
21550			01	1.00
21555			02	1.00
21556			03	1.00
21600			02	1.00
21610			03	1.00
21620			02	1.00
21700			02	1.00
21720			02	1.00
21725			03	1.00
21805			02	1.00
21810			02	1.00
21820			01	1.00
21920			01	1.00
21925			01	1.00
21930			01	1.00
21935			03	1.00
22100			03	1.00
22101			03	1.00
22102			03	1.00
22103			03	1.00
22305			01	1.00
22310			01	1.00
22315			02	1.00
22325			03	1.00
22326			03	1.00
22327			03	1.00
22328			03	1.00
22505			02	1.00
22900			03	1.00
23000			02	1.00
23020			02	1.00
23030			01	1.00
23031			01	1.00
23035			03	1.00
23040			03	1.00
23044			03	1.00
23065			09	1.00
23066			01	1.00
23075			01	1.00
23076			01	1.00
23077			03	1.00
23100			02	1.00
23101			04	1.00
23105			04	1.00
23106			04	1.00
23107			04	1.00
23120			03	1.00
23125			05	1.00
23130			03	1.00
23140			03	1.00
23145			05	1.00
23146			05	1.00
23150			04	1.00

Code	PA	EPSDT	Grp	Limit
23155			05	1.00
23170			02	1.00
23172			02	1.00
23174			02	1.00
23180			04	1.00
23182			04	1.00
23184			04	1.00
23190			04	1.00
23195			05	1.00
23330			01	1.00
23331			01	1.00
23350			01	1.00
23395			05	1.00
23397			07	1.00
23400			07	1.00
23405			02	1.00
23406			02	1.00
23410			05	1.00
23412			07	1.00
23415			05	1.00
23420			07	1.00
23430			04	1.00
23440			04	1.00
23450			05	1.00
23455			07	1.00
23460			05	1.00
23462			07	1.00
23465			05	1.00
23466			07	1.00
23480			04	1.00
23485			07	1.00
23490			03	1.00
23491			03	1.00
23500			01	1.00
23505			01	1.00
23515			02	1.00
23520			01	1.00
23525			01	1.00
23530			02	1.00
23532			03	1.00
23540			01	1.00
23545			01	1.00
23550			02	1.00
23552			03	1.00
23570			01	1.00
23575			01	1.00
23585			03	1.00
23600			01	1.00
23605			02	1.00
23616			04	1.00
23620			01	1.00
23625			02	1.00
23650			01	1.00
23655			01	1.00
23660			03	1.00
23665			02	1.00
23670			03	1.00
23675			02	1.00
23680			03	1.00
23700			01	1.00
23800			04	1.00
23802			07	1.00
23921			03	1.00
23930			01	1.00
23931			01	1.00
23935			02	1.00
24000			03	1.00
24065			01	1.00
24066			01	1.00

Code	PA	EPSDT	Grp	Limit
24075			02	1.00
24076			02	1.00
24077			03	1.00
24100			01	1.00
24101			03	1.00
24102			04	1.00
24105			02	1.00
24110			02	1.00
24115			03	1.00
24116			03	1.00
24120			03	1.00
24125			03	1.00
24126			03	1.00
24130			04	1.00
24134			02	1.00
24136			02	1.00
24138			02	1.00
24140			03	1.00
24145			03	1.00
24147			02	1.00
24149			04	1.00
24150			03	1.00
24151			04	1.00
24152			03	1.00
24153			04	1.00
24155			03	1.00
24160			02	1.00
24164			03	1.00
24201			02	1.00
24301			04	1.00
24305			03	1.00
24310			03	1.00
24320			03	1.00
24330			03	1.00
24331			03	1.00
24340			03	1.00
24341			03	1.00
24342			03	1.00
24350			02	1.00
24351			02	1.00
24352			02	1.00
24354			02	1.00
24356			03	1.00
24360			05	1.00
24361			05	1.00
24362			05	1.00
24363			07	1.00
24365			02	1.00
24366			03	1.00
24400			04	1.00
24410			04	1.00
24420			03	1.00
24430			03	1.00
24435			04	1.00
24470			03	1.00
24495			02	1.00
24498			03	1.00
24500			01	1.00
24505			01	1.00
24515			03	1.00
24516			04	1.00
24530			01	1.00
24535			01	1.00
24538			02	1.00
24545			04	1.00
24546			05	1.00
24560			01	1.00
24565			02	1.00
24566			02	1.00

Code	PA	EPSDT	Grp	Limit
24575			03	1.00
24576			01	1.00
24577			01	1.00
24579			03	1.00
24582			02	1.00
24586			04	1.00
24587			05	1.00
24600			01	1.00
24605			02	1.00
24615			03	1.00
24620			02	1.00
24635			03	1.00
24655			01	1.00
24665			03	1.00
24666			04	1.00
24670			01	1.00
24675			01	1.00
24685			03	1.00
24800			02	1.00
24802			04	1.00
24925			02	1.00
25000			03	1.00
25020			03	1.00
25023			03	1.00
25028			01	1.00
25031			02	1.00
25035			03	1.00
25040			02	1.00
25065			09	1.00
25066			02	1.00
25075			01	1.00
25076			02	1.00
25077			03	1.00
25085			03	1.00
25100			02	1.00
25101			02	1.00
25105			03	1.00
25107			03	1.00
25110			02	1.00
25111			02	1.00
25112			02	1.00
25115			03	1.00
25116			03	1.00
25118			02	1.00
25119			03	1.00
25120			02	1.00
25125			03	1.00
25126			03	1.00
25130			02	1.00
25135			03	1.00
25136			03	1.00
25145			03	1.00
25150			03	1.00
25151			03	1.00
25170			03	1.00
25210			03	1.00
25215			04	1.00
25230			03	1.00
25240			04	1.00
25246			01	1.00
25248			02	1.00
25250			01	1.00
25251			01	1.00
25260			02	1.00
25263			02	1.00
25265			03	1.00
25270			03	1.00
25272			02	1.00
25274			04	1.00

Code	PA	EPSDT	Grp	Limit
25280			04	1.00
25290			02	1.00
25295			02	1.00
25300			03	1.00
25301			03	1.00
25310			03	1.00
25312			04	1.00
25315			03	1.00
25316			03	1.00
25320			03	1.00
25332			05	1.00
25335			03	1.00
25337			03	1.00
25350			03	1.00
25355			03	1.00
25360			03	1.00
25365			03	1.00
25370			03	1.00
25375			04	1.00
25390			03	1.00
25391			04	1.00
25392			03	1.00
25393			04	1.00
25400			03	1.00
25405			04	1.00
25415			03	1.00
25420			04	1.00
25425			03	1.00
25426			04	1.00
25440			04	1.00
25441			05	1.00
25442			05	1.00
25443			05	1.00
25444			05	1.00
25445			05	1.00
25446			07	1.00
25447			05	1.00
25449			05	1.00
25450			03	1.00
25455			03	1.00
25490			03	1.00
25491			03	1.00
25492			03	1.00
25505			01	1.00
25515			03	1.00
25520			01	1.00
25525			04	1.00
25526			05	1.00
25535			01	1.00
25545			03	1.00
25565			02	1.00
25574			03	1.00
25575			03	1.00
25600			02	
25605			03	1.00
25611			03	1.00
25620			05	1.00
25622			01	1.00
25624			01	1.00
25628			03	1.00
25635			01	1.00
25645			03	1.00
25660			01	1.00
25670			03	1.00
25675			01	1.00
25676			02	1.00
25680			02	1.00
25685			03	1.00
25690			01	1.00

Code	PA	EPSDT	Grp	Limit
25695			02	1.00
25800			03	1.00
25805			04	1.00
25810			04	1.00
25820			03	1.00
25825			04	1.00
25830			03	1.00
25907			02	1.00
25922			02	1.00
26011			01	1.00
26020			02	1.00
26025			01	1.00
26030			02	1.00
26034			02	1.00
26035			04	1.00
26037			04	1.00
26040			03	1.00
26045			03	1.00
26055			02	1.00
26060			02	1.00
26070			02	1.00
26075			02	1.00
26080			02	1.00
26100			02	1.00
26105			01	1.00
26110			01	1.00
26115			02	1.00
26116			02	1.00
26117			03	1.00
26121			04	1.00
26123			04	1.00
26125			04	1.00
26130			03	1.00
26135			03	1.00
26140			02	1.00
26145			03	1.00
26160			02	1.00
26170			03	1.00
26180			03	1.00
26185			01	1.00
26200			02	1.00
26205			03	1.00
26210			02	1.00
26215			03	1.00
26230			02	1.00
26235			02	1.00
26236			02	1.00
26250			03	1.00
26255			03	1.00
26260			02	1.00
26261			03	1.00
26262			02	1.00
26320			02	1.00
26350			02	1.00
26352			03	1.00
26356			02	1.00
26357			02	1.00
26358			03	1.00
26370			03	1.00
26372			04	1.00
26373			03	1.00
26390			03	1.00
26392			02	1.00
26410			02	1.00
26412			03	1.00
26415			03	1.00
26416			03	1.00
26418			03	1.00
26420			03	1.00

Code	PA	EPSDT	Grp	Limit
26426			02	1.00
26428			03	1.00
26432			02	1.00
26433			02	1.00
26434			03	1.00
26437			03	1.00
26440			03	1.00
26442			03	1.00
26445			03	1.00
26449			03	1.00
26450			03	1.00
26455			03	1.00
26460			03	1.00
26471			02	1.00
26474			02	1.00
26476			02	1.00
26477			02	1.00
26478			02	1.00
26479			02	1.00
26480			02	1.00
26483			03	1.00
26485			02	1.00
26489			03	1.00
26490			03	1.00
26492			04	1.00
26494			03	1.00
26496			03	1.00
26497			03	1.00
26498			04	1.00
26499			03	1.00
26500			03	1.00
26502			04	1.00
26504			04	1.00
26508			02	1.00
26510			02	1.00
26516			01	1.00
26517			02	1.00
26518			02	1.00
26520			02	1.00
26525			02	1.00
26530			03	1.00
26531			05	1.00
26535			02	1.00
26536			03	1.00
26540			03	1.00
26541			04	1.00
26542			04	1.00
26545			03	1.00
26546			03	1.00
26548			03	1.00
26550			02	1.00
26551			04	1.00
26553			03	1.00
26554			03	1.00
26555			03	1.00
26556			03	1.00
26560			02	1.00
26561			03	1.00
26562			03	1.00
26565			03	1.00
26567			02	1.00
26568			03	1.00
26580			05	1.00
26585			05	1.00
26587			02	1.00
26590			03	1.00
26591			03	1.00
26593			03	1.00
26596			02	1.00

Code	PA	EPSDT	Grp	Limit
26597			03	1.00
26605			01	1.00
26607			02	1.00
26608			02	1.00
26615			03	1.00
26645			01	1.00
26650			02	1.00
26665			03	1.00
26675			02	1.00
26676			02	1.00
26685			02	1.00
26686			03	1.00
26705			02	1.00
26706			02	1.00
26715			03	1.00
26720			09	1.00
26725			01	1.00
26727			03	1.00
26735			03	1.00
26742			01	1.00
26746			03	1.00
26755			01	1.00
26756			02	1.00
26765			03	1.00
26775			02	1.00
26776			02	1.00
26785			02	1.00
26820			04	1.00
26841			03	1.00
26842			04	1.00
26843			03	1.00
26844			04	1.00
26850			03	1.00
26852			04	1.00
26860			02	1.00
26861			01	1.00
26862			03	1.00
26863			03	1.00
26910			04	1.00
26951			02	1.00
26952			03	1.00
26990			01	1.00
26991			01	1.00
26992			02	1.00
27000			02	1.00
27001			03	1.00
27003			03	1.00
27005			03	1.00
27006			03	1.00
27025			03	1.00
27030			03	1.00
27033			03	1.00
27035			04	1.00
27036			05	1.00
27040			01	1.00
27041			02	1.00
27047			02	1.00
27048			03	1.00
27049			03	1.00
27050			03	1.00
27052			03	1.00
27054			03	1.00
27060			03	1.00
27062			03	1.00
27065			04	1.00
27066			05	1.00
27080			03	1.00
27086			01	1.00
27087			02	1.00

Code	PA	EPSDT	Grp	Limit
27093			01	1.00
27095			01	1.00
27097			03	1.00
27100			04	1.00
27105			04	1.00
27110			04	1.00
27111			04	1.00
27140			01	1.00
27193			01	1.00
27194			02	1.00
27202			02	1.00
27230			01	1.00
27236			02	
27238			01	1.00
27246			01	1.00
27250			01	1.00
27252			02	1.00
27256			02	1.00
27257			03	1.00
27265			01	1.00
27266			01	1.00
27275			02	1.00
27301			02	1.00
27303			03	1.00
27305			03	1.00
27306			03	1.00
27307			03	1.00
27310			03	1.00
27315			02	1.00
27320			02	1.00
27323			01	1.00
27324			01	1.00
27327			01	1.00
27328			02	1.00
27330			03	1.00
27331			03	1.00
27332			03	1.00
27333			03	1.00
27334			03	1.00
27335			03	1.00
27340			03	1.00
27345			03	1.00
27347			03	1.00
27350			04	1.00
27355			03	1.00
27356			04	1.00
27360			03	1.00
27370			01	1.00
27372			04	1.00
27380			04	1.00
27381			04	1.00
27385			03	1.00
27386			03	1.00
27390			01	1.00
27391			02	1.00
27392			03	1.00
27393			02	1.00
27394			03	1.00
27395			03	1.00
27396			03	1.00
27397			03	1.00
27400			03	1.00
27403			03	1.00
27405			04	1.00
27407			04	1.00
27409			04	1.00
27418			04	1.00
27420			03	1.00
27422			04	1.00

Code	PA	EPSDT	Grp	Limit
27424			04	1.00
27425			03	1.00
27427			03	1.00
27428			04	1.00
27429			04	1.00
27430			04	1.00
27435			04	1.00
27437			04	1.00
27438			05	1.00
27440			05	1.00
27441			05	1.00
27442			05	1.00
27443			05	1.00
27500			01	1.00
27501			02	1.00
27502			02	1.00
27503			03	1.00
27507			04	1.00
27508			01	1.00
27509			03	1.00
27510			01	1.00
27511			04	1.00
27513			05	1.00
27516			01	1.00
27517			01	1.00
27520			01	1.00
27524			03	1.00
27530			01	1.00
27532			01	1.00
27535			03	1.00
27538			01	1.00
27550			01	1.00
27552			01	1.00
27556			03	1.00
27557			03	1.00
27560			01	1.00
27562			01	1.00
27566			02	1.00
27570			01	1.00
27580			04	1.00
27594			03	1.00
27596			02	
27600			03	1.00
27601			03	1.00
27602			03	1.00
27603			02	1.00
27604			02	1.00
27605			01	1.00
27606			01	1.00
27607			02	1.00
27610			02	1.00
27612			03	1.00
27613			09	1.00
27614			01	1.00
27615			03	1.00
27618			02	1.00
27619			03	1.00
27620			04	1.00
27625			04	1.00
27626			04	1.00
27630			03	1.00
27635			03	1.00
27637			03	1.00
27638			03	1.00
27640			02	1.00
27641			02	1.00
27648			01	1.00
27650			03	1.00
27652			03	1.00

Code	PA	EPSDT	Grp	Limit
27654			03	1.00
27656			02	1.00
27658			01	1.00
27659			02	1.00
27664			02	1.00
27665			02	1.00
27675			02	1.00
27676			03	1.00
27680			03	1.00
27681			03	1.00
27685			03	1.00
27686			03	1.00
27687			03	1.00
27690			04	1.00
27691			04	1.00
27692			03	1.00
27695			02	1.00
27696			02	1.00
27698			02	1.00
27700			05	1.00
27704			02	1.00
27705			02	1.00
27707			02	1.00
27709			02	1.00
27715			04	1.00
27730			02	1.00
27732			02	1.00
27734			02	1.00
27740			02	1.00
27742			02	1.00
27745			03	1.00
27750			01	1.00
27752			01	1.00
27756			03	1.00
27758			04	1.00
27759			04	1.00
27760			01	1.00
27762			01	1.00
27766			03	1.00
27780			01	1.00
27781			01	1.00
27784			03	1.00
27786			01	1.00
27788			01	1.00
27792			03	1.00
27808			01	1.00
27810			01	1.00
27814			03	1.00
27816			01	1.00
27818			01	1.00
27822			03	1.00
27823			03	1.00
27824			01	1.00
27825			02	1.00
27826			03	1.00
27827			03	1.00
27828			04	1.00
27829			02	1.00
27830			01	1.00
27831			01	1.00
27832			02	1.00
27840			01	1.00
27842			01	1.00
27846			03	1.00
27848			03	1.00
27860			01	1.00
27870			04	1.00
27871			04	1.00
27884			03	1.00

Code	PA	EPSDT	Grp	Limit
27886			03	1.00
28002			03	1.00
28003			03	1.00
28005			03	1.00
28008			03	1.00
28020			02	1.00
28022			02	1.00
28024			02	1.00
28030			03	1.00
28035			03	1.00
28043			01	1.00
28045			03	1.00
28046			02	1.00
28050			02	1.00
28052			02	1.00
28054			01	1.00
28060			02	1.00
28062			03	1.00
28070			02	1.00
28072			02	1.00
28080			02	1.00
28086			02	1.00
28088			02	1.00
28090			02	1.00
28092			02	1.00
28100			02	1.00
28102			03	1.00
28103			03	1.00
28104			02	1.00
28106			03	1.00
28107			03	1.00
28108			01	1.00
28110			02	1.00
28111			03	1.00
28112			03	1.00
28113			03	1.00
28114			03	1.00
28116			03	1.00
28118			04	1.00
28119			04	1.00
28120			03	1.00
28122			03	1.00
28124			02	1.00
28126			02	1.00
28130			03	1.00
28140			03	1.00
28150			03	1.00
28153			03	1.00
28160			03	1.00
28171			03	1.00
28173			03	1.00
28175			03	1.00
28190	PA		01	1.00
28192			02	1.00
28193			03	1.00
28200			03	1.00
28202			03	1.00
28208			03	1.00
28210			03	1.00
28220			01	1.00
28222			01	1.00
28225			01	1.00
28226			01	1.00
28230			03	1.00
28232			01	1.00
28234			01	1.00
28238			03	1.00
28240			02	1.00
28250			03	1.00

Code	PA	EPSDT	Grp	Limit
28260			03	1.00
28261			03	1.00
28262			03	1.00
28264			01	1.00
28270			02	1.00
28272			02	1.00
28280			01	1.00
28285			03	1.00
28286			03	1.00
28288			03	1.00
28289			03	1.00
28290			02	1.00
28292			02	1.00
28293			02	1.00
28294			03	1.00
28296			03	1.00
28297			03	1.00
28298			03	1.00
28299			03	1.00
28300			02	1.00
28302			02	1.00
28304			02	1.00
28305			03	1.00
28306			04	1.00
28307			03	1.00
28308			02	1.00
28309			04	1.00
28310			03	1.00
28312			03	1.00
28313			02	1.00
28315			02	1.00
28320			03	1.00
28322			04	1.00
28340			04	1.00
28341			04	1.00
28344			01	1.00
28345			02	1.00
28400			01	1.00
28405			02	1.00
28406			02	1.00
28415			03	1.00
28420			04	1.00
28435			02	1.00
28436			02	1.00
28445			03	1.00
28455			01	1.00
28456			02	1.00
28465			03	1.00
28475			01	1.00
28476			02	1.00
28485			03	1.00
28495			01	1.00
28496			02	1.00
28505			02	1.00
28515			01	1.00
28525			02	1.00
28545			01	1.00
28546			02	1.00
28555			02	1.00
28575			01	1.00
28576			03	1.00
28585			03	1.00
28605			01	1.00
28606			02	1.00
28615			03	1.00
28630			01	1.00
28635			01	1.00
28636			03	1.00
28645			02	1.00

Code	PA	EPSDT	Grp	Limit
28665			01	1.00
28666			03	1.00
28675			02	1.00
28705			04	1.00
28715			04	1.00
28725			04	1.00
28730			04	1.00
28735			04	1.00
28737			04	1.00
28740			03	1.00
28750			03	1.00
28755			03	1.00
28760			04	1.00
28810			02	1.00
28820			02	1.00
28825			02	1.00
29035		EQ	09	1.00
29065			09	2.00
29125			09	2.00
29305		EQ	09	1.00
29325			01	
29345		EQ	09	
29365			09	2.00
29405			09	2.00
29425			09	1.00
29450			01	1.00
29515			09	1.00
29580		EQ	09	2.00
29700			09	
29705			09	
29710			09	
29720			01	1.00
29800			01	
29804			01	
29815			03	1.00
29819			03	1.00
29820			03	1.00
29821			03	1.00
29822			03	1.00
29823			03	1.00
29825			03	1.00
29826			03	1.00
29830			03	1.00
29834			03	1.00
29835			03	1.00
29836			03	1.00
29837			03	1.00
29838			03	1.00
29840			03	
29843			03	
29844			03	
29845			03	
29846			03	
29847			03	
29848			03	
29850			04	
29851			04	
29855			04	
29856			04	
29860			02	1.00
29861			02	1.00
29862			03	1.00
29863			02	1.00
29870			03	1.00
29871			03	1.00
29874			03	1.00
29875			04	1.00
29876			04	1.00
29877			04	1.00

Code	PA	EPSDT	Grp	Limit
29879			03	1.00
29880			04	1.00
29881			03	1.00
29882			03	1.00
29883			03	1.00
29884			03	1.00
29885			03	1.00
29886			03	1.00
29887			03	1.00
29888			03	1.00
29889			03	1.00
29891			03	1.00
29892			03	1.00
29893			01	1.00
29894			03	1.00
29895			03	1.00
29897			03	1.00
29898			03	1.00
29909	PA		04	1.00
30000			01	1.00
30020			01	1.00
30100			01	1.00
30110			01	1.00
30115			02	1.00
30117			03	1.00
30118			03	1.00
30120			01	1.00
30124			01	1.00
30125			02	1.00
30130			02	1.00
30140			02	1.00
30150			03	1.00
30160			04	1.00
30310			01	1.00
30320			02	1.00
30400	PA		03	1.00
30410	PA		04	1.00
30420	PA		04	1.00
30430	PA		03	1.00
30435	PA		04	1.00
30450	PA		05	1.00
30460			03	1.00
30462			03	1.00
30520			04	1.00
30540			04	1.00
30545			04	1.00
30560			02	1.00
30580			04	1.00
30600			04	1.00
30620			05	1.00
30630			05	1.00
30801			01	1.00
30802			02	1.00
30901			01	1.00
30903			01	1.00
30905			01	1.00
30906			01	1.00
30915			02	1.00
30920			03	1.00
30930			01	1.00
31000			01	1.00
31002			01	1.00
31020			02	1.00
31030			03	1.00
31032			03	1.00
31050			02	1.00
31051			03	1.00
31070			02	1.00
31075			04	1.00

Code	PA	EPSDT	Grp	Limit
31080			04	1.00
31086			04	1.00
31090			05	1.00
31200			02	1.00
31201			04	1.00
31205			03	1.00
31225			03	1.00
31231			02	1.00
31233			02	1.00
31235			01	1.00
31237			02	1.00
31238			02	1.00
31239			02	1.00
31240			02	1.00
31250			01	1.00
31252			02	1.00
31254			03	1.00
31255			03	1.00
31256			03	1.00
31258			03	1.00
31260			02	1.00
31263			03	1.00
31265			03	1.00
31267			03	1.00
31268			03	1.00
31270			01	1.00
31275			02	1.00
31276			03	1.00
31277			03	1.00
31285			03	1.00
31287			03	1.00
31288			03	1.00
31290			04	1.00
31291			04	1.00
31292			04	1.00
31293			04	1.00
31294			04	1.00
31300			05	1.00
31320			02	1.00
31500			01	1.00
31505			01	1.00
31510			01	1.00
31511			01	1.00
31512			01	1.00
31513			01	1.00
31515			02	1.00
31520			02	1.00
31525			02	1.00
31526			02	1.00
31527			02	1.00
31528			02	1.00
31529			02	1.00
31530			02	1.00
31531			03	1.00
31535			02	1.00
31536			03	1.00
31540			03	1.00
31541			04	1.00
31560			05	1.00
31561			05	1.00
31570			02	1.00
31571			02	1.00
31575			02	1.00
31576			02	1.00
31577			02	1.00
31578			02	1.00
31579			02	1.00
31580			05	1.00
31582			05	1.00

Code	PA	EPSDT	Grp	Limit
31584			04	1.00
31585			01	1.00
31586			02	1.00
31588			05	1.00
31590			05	1.00
31595			02	1.00
31600			02	1.00
31601			02	1.00
31611			04	1.00
31612			01	1.00
31613			02	1.00
31614			02	1.00
31615			01	1.00
31622			01	1.00
31623			01	1.00
31624			01	1.00
31625			02	1.00
31628			02	1.00
31629			02	1.00
31630			02	1.00
31631			02	1.00
31635			02	1.00
31640			02	1.00
31641			02	1.00
31645			01	1.00
31646			01	1.00
31656			01	1.00
31700			01	1.00
31708			01	1.00
31710			01	1.00
31715			01	1.00
31717			01	1.00
31720			01	1.00
31730			01	1.00
31750			05	1.00
31755			02	1.00
31785			04	1.00
31800			02	1.00
31820			01	1.00
31825			02	1.00
31830			02	1.00
32000			01	1.00
32002			02	1.00
32005			02	1.00
32020			02	1.00
32400			01	1.00
32405			01	1.00
32420			01	1.00
32601			02	1.00
32602			02	1.00
32603			02	1.00
32604			02	1.00
32605			02	1.00
32606			02	1.00
32650			03	1.00
32651			03	1.00
32652			03	1.00
32653			03	1.00
32654			03	1.00
32655			03	1.00
32656			03	1.00
32657			03	1.00
32658			03	1.00
32659			03	1.00
32660			03	1.00
32661			03	1.00
32662			03	1.00
32663			03	1.00
32664			03	1.00

Code	PA	EPSDT	Grp	Limit
32665			03	1.00
32997			02	1.00
33010			02	1.00
33011			02	1.00
33496				1.00
35460				1.00
35471			02	1.00
35473			01	1.00
35474			01	1.00
35476			01	1.00
35761			01	1.00
35860			01	1.00
35875			01	1.00
36000			09	1.00
36010			02	1.00
36260			04	
36261			02	
36262			01	1.00
36415				
36430				5.00
36440		EQ	01	1.00
36455			01	1.00
36488			01	1.00
36489			01	1.00
36490			01	1.00
36491			01	1.00
36493			01	1.00
36500			01	1.00
36520			01	1.00
36521			01	1.00
36530			03	1.00
36531			02	1.00
36532			01	1.00
36533			02	1.00
36534			01	1.00
36535			01	1.00
36550			01	1.00
36640			01	1.00
36800			03	1.00
36810			03	1.00
36815			03	1.00
36819			03	1.00
36821			03	1.00
36825			04	1.00
36830			04	1.00
36831			01	
36832			04	1.00
36833			04	1.00
36835			04	1.00
36860			02	1.00
36861			03	1.00
37201			01	1.00
37203			01	1.00
37204			01	1.00
37205			01	1.00
37609			02	1.00
37700			02	1.00
37720			03	1.00
37730			03	1.00
37735			03	1.00
37760			03	1.00
37780			03	1.00
37785			03	1.00
37788			03	1.00
38300			01	1.00
38305			02	1.00
38308			02	1.00
38500			02	1.00
38505			01	1.00

Code	PA	EPSDT	Grp	Limit
38510			02	1.00
38520			02	1.00
38525			02	1.00
38530			02	1.00
38542			02	1.00
38550			03	1.00
38555			04	1.00
38700			02	1.00
38740			02	1.00
38745			04	1.00
38760			02	1.00
38790			01	1.00
38792			01	1.00
39400			02	1.00
40500			02	1.00
40510			02	1.00
40520			02	1.00
40525			02	1.00
40527			02	1.00
40530			02	1.00
40650			03	1.00
40652			03	1.00
40654			03	1.00
40700			03	1.00
40701			03	1.00
40702			03	1.00
40720			03	1.00
40761			04	1.00
40801			02	1.00
40805			02	1.00
40806			01	1.00
40808			09	1.00
40810			01	1.00
40814			02	1.00
40816			02	1.00
40818			01	1.00
40819			01	1.00
40820			01	1.00
40831			01	1.00
40840			02	1.00
40842			03	1.00
40843			03	1.00
40844			05	1.00
40845			05	1.00
41000			01	1.00
41005			01	1.00
41006			01	1.00
41007			01	1.00
41008			01	1.00
41009			01	1.00
41010			01	1.00
41015			01	1.00
41016			01	1.00
41017			01	1.00
41018			01	1.00
41100			01	1.00
41105			02	1.00
41108			01	1.00
41110			01	1.00
41112			02	1.00
41113			02	1.00
41114			02	1.00
41115			01	1.00
41116			01	1.00
41120			05	1.00
41250			02	1.00
41251			02	1.00
41252			02	1.00
41500			01	1.00

Code	PA	EPSDT	Grp	Limit
41510			01	1.00
41520			02	1.00
41800			01	1.00
41805			01	1.00
41806			01	1.00
41825			02	1.00
41826			02	1.00
41827			02	1.00
41850			02	1.00
41872		EQ	03	1.00
42000			02	1.00
42100			01	1.00
42104			02	1.00
42106			02	1.00
42107			02	1.00
42120			04	1.00
42140			02	1.00
42145			05	1.00
42160			01	1.00
42180			01	1.00
42182			02	1.00
42200			05	1.00
42205			05	1.00
42210			05	1.00
42215			07	1.00
42220			05	1.00
42225			05	1.00
42235			05	1.00
42260			04	1.00
42281			03	1.00
42300			01	1.00
42305			02	1.00
42310			01	1.00
42320			01	1.00
42325			02	1.00
42330			01	1.00
42335			03	1.00
42340			02	1.00
42405			02	1.00
42408			03	1.00
42409			03	1.00
42410			05	1.00
42415			05	1.00
42420			05	1.00
42425			05	1.00
42440			03	1.00
42450			02	1.00
42500			03	1.00
42505			04	1.00
42507			03	1.00
42508			04	1.00
42509			04	1.00
42510			04	1.00
42600			01	1.00
42650			01	1.00
42665			01	1.00
42700			01	1.00
42720			01	1.00
42725			02	1.00
42800			01	1.00
42802			01	1.00
42804			01	1.00
42806			02	1.00
42808			02	1.00
42809			01	1.00
42810			03	1.00
42815			04	1.00
42820			04	1.00
42821			04	1.00

Code	PA	EPSDT	Grp	Limit
42825			04	1.00
42826			04	1.00
42830			03	1.00
42831			03	1.00
42835			03	1.00
42836			04	1.00
42860			03	1.00
42870			03	1.00
42900			01	1.00
42950			02	1.00
42955			02	1.00
42960			01	1.00
42962			02	1.00
43030			04	1.00
43200			01	1.00
43202			01	1.00
43204			01	1.00
43205			02	1.00
43215			01	1.00
43216			01	1.00
43217			01	1.00
43219			01	1.00
43220			01	1.00
43226			01	1.00
43227			02	1.00
43228			02	1.00
43234			01	1.00
43235			01	1.00
43239			02	1.00
43241			02	1.00
43243			02	1.00
43244			02	1.00
43245			02	1.00
43246			02	1.00
43247			02	1.00
43248			02	1.00
43249			01	1.00
43250			02	1.00
43251			02	1.00
43255			02	1.00
43258			03	1.00
43259			03	1.00
43260			02	1.00
43261			02	1.00
43262			02	1.00
43263			02	1.00
43264			02	1.00
43265			02	1.00
43267			02	1.00
43268			02	1.00
43269			02	1.00
43271			02	1.00
43272			02	1.00
43280			04	1.00
43305			03	1.00
43400			03	1.00
43450			01	1.00
43453			01	1.00
43456			02	1.00
43458			02	1.00
43600			01	1.00
43653			02	1.00
43750			02	1.00
43760			01	1.00
43761			01	1.00
43870			04	1.00
43880		EQ	07	1.00
44015			01	1.00
44100			01	1.00

Code	PA	EPSDT	Grp	Limit
44200			04	1.00
44201			03	1.00
44312			01	1.00
44340			03	1.00
44345			04	1.00
44346			04	1.00
44360			02	1.00
44361			02	1.00
44363			02	1.00
44364			02	1.00
44365			02	1.00
44366			02	1.00
44369			02	1.00
44372			02	1.00
44373			02	1.00
44376			02	1.00
44377			02	1.00
44378			02	1.00
44380			01	1.00
44382			01	1.00
44385			01	1.00
44386			01	1.00
44388			01	1.00
44389			01	1.00
44390			01	1.00
44391			01	1.00
44392			01	1.00
44393			01	1.00
44394			02	1.00
44500			01	1.00
44950			03	1.00
44955			01	1.00
44970			04	1.00
45000			01	1.00
45005			02	1.00
45020			02	1.00
45100			01	1.00
45108			02	1.00
45130			02	1.00
45160			03	1.00
45170			02	1.00
45190			03	1.00
45300			01	1.00
45303			01	1.00
45305			01	1.00
45307			01	1.00
45308			02	1.00
45309			02	1.00
45315			02	1.00
45317			02	1.00
45320			02	1.00
45321			02	1.00
45330			01	1.00
45331			01	1.00
45332			01	1.00
45333			01	1.00
45334			01	1.00
45337			02	1.00
45338			02	1.00
45339			01	1.00
45355			01	1.00
45378			02	1.00
45379			02	1.00
45380			02	1.00
45382			02	1.00
45383			02	1.00
45384			02	1.00
45385			02	1.00
45500			02	1.00

Code	PA	EPSDT	Grp	Limit
45505			02	1.00
45560			02	1.00
45805			01	1.00
45900			01	1.00
45905			01	1.00
45910			01	1.00
45915			01	1.00
46030			01	1.00
46040			03	1.00
46045			02	1.00
46050			01	1.00
46060			02	1.00
46080			03	1.00
46083			09	1.00
46200			02	1.00
46210			02	1.00
46211			02	1.00
46220			01	1.00
46221			02	1.00
46230			02	1.00
46250			03	1.00
46255			03	1.00
46257			03	1.00
46258			03	1.00
46260			03	1.00
46261			03	1.00
46262			03	1.00
46270			03	1.00
46275			03	1.00
46280			03	1.00
46285			01	1.00
46288			03	1.00
46600			01	1.00
46604			01	1.00
46606			01	1.00
46608			01	1.00
46610			01	1.00
46611			01	1.00
46612			01	1.00
46614			01	1.00
46615			01	1.00
46700			03	1.00
46705			03	1.00
46750			03	1.00
46751			03	1.00
46753			03	1.00
46754			02	1.00
46760			02	1.00
46900			01	1.00
46910			01	1.00
46916			01	1.00
46917			02	1.00
46922			01	1.00
46924			01	1.00
46937			02	1.00
46938			02	1.00
46940			01	1.00
46945			02	1.00
46946			02	1.00
47000			01	1.00
47001			01	1.00
47500			01	1.00
47510			02	1.00
47511			02	1.00
47525			01	1.00
47530			01	1.00
47552			02	1.00
47553			03	1.00
47554			03	1.00

Code	PA	EPSDT	Grp	Limit
47555			03	1.00
47556			03	1.00
47560			03	1.00
47561			03	1.00
47562			03	1.00
47563			03	1.00
47564			04	1.00
47630			03	1.00
49000			04	1.00
49020			04	1.00
49021			04	1.00
49060				1.00
49080			02	1.00
49081			02	1.00
49085			03	1.00
49180			01	1.00
49200			02	1.00
49201			02	1.00
49250			02	1.00
49255			02	1.00
49320			03	1.00
49321			04	1.00
49322			04	1.00
49323			04	1.00
49329	PA		03	1.00
49400			01	1.00
49420			01	1.00
49421			01	1.00
49422			01	1.00
49423			01	1.00
49424			01	1.00
49425			02	1.00
49426			02	1.00
49427			01	1.00
49428			01	1.00
49429			01	1.00
49495			04	1.00
49496			04	1.00
49500			04	1.00
49501			04	1.00
49505			04	1.00
49507			04	1.00
49520			04	1.00
49521			04	1.00
49525			04	1.00
49540			03	1.00
49550			04	1.00
49555			04	1.00
49560			04	1.00
49561			04	1.00
49565			04	1.00
49566			04	1.00
49568			01	1.00
49570			04	1.00
49572			04	1.00
49580			04	1.00
49582			04	1.00
49585			02	1.00
49587			04	1.00
49590			03	1.00
49600			03	1.00
49650			04	1.00
49651			07	1.00
50020			02	1.00
50021			02	1.00
50040			03	1.00
50200			01	1.00
50205			03	1.00
50390			01	1.00

Code	PA	EPSDT	Grp	Limit
50392			01	1.00
50393			01	1.00
50394			01	1.00
50395			01	1.00
50396			01	1.00
50398			01	1.00
50520			01	1.00
50551			01	1.00
50553			01	1.00
50555			01	1.00
50557			01	1.00
50559			01	1.00
50561			01	1.00
50570			01	1.00
50572			01	1.00
50574			01	1.00
50576			01	1.00
50578			01	1.00
50580			01	1.00
50590			08	1.00
50684			01	1.00
50686			01	1.00
50688			01	1.00
50690			01	1.00
50920			01	1.00
50951			01	1.00
50953			01	1.00
50955			01	1.00
50957			01	1.00
50959			01	1.00
50961			01	1.00
50970			01	1.00
50972			01	1.00
50974			01	1.00
50976			01	1.00
50978			01	1.00
50980			01	1.00
51005			01	1.00
51010			01	1.00
51020			04	1.00
51030			04	1.00
51040			03	1.00
51045			04	1.00
51050			04	1.00
51060			04	1.00
51065			04	1.00
51080			03	1.00
51500			03	1.00
51520			03	1.00
51525			04	1.00
51530			04	1.00
51535			04	1.00
51550			04	1.00
51600			01	1.00
51605			01	1.00
51610			01	1.00
51710			01	1.00
51715			02	1.00
51725			09	1.00
51726			09	1.00
51736			09	1.00
51741			09	1.00
51772			01	1.00
51784			09	1.00
51785			01	1.00
51845			03	1.00
51860			02	1.00
51865			04	1.00
51880			01	1.00

Code	PA	EPSDT	Grp	Limit
51900			04	1.00
51920			03	1.00
52000			01	1.00
52005			02	1.00
52007			02	1.00
52010			02	1.00
52204			02	1.00
52214			02	1.00
52224			02	1.00
52234			02	1.00
52235			03	1.00
52240			03	1.00
52250			04	1.00
52260			02	1.00
52265			02	1.00
52270			02	1.00
52275			02	1.00
52276			03	1.00
52277			02	1.00
52281			02	1.00
52282			02	1.00
52283			02	1.00
52285			02	1.00
52290			02	1.00
52300			02	1.00
52301			02	1.00
52305			02	1.00
52310			02	1.00
52315			02	1.00
52317			01	1.00
52318			02	1.00
52320			04	1.00
52325			04	1.00
52327			04	1.00
52330			03	1.00
52332			03	1.00
52334			03	1.00
52335			03	1.00
52336			04	1.00
52337			04	1.00
52338			04	1.00
52340			03	1.00
52450			03	1.00
52500			03	1.00
52510			03	1.00
52601			04	1.00
52606			01	1.00
52612			02	1.00
52614			01	1.00
52620			01	1.00
52630			02	1.00
52640			02	1.00
52647			04	1.00
52648			04	1.00
52700			02	1.00
53000			01	1.00
53010			01	1.00
53020			01	1.00
53025			01	1.00
53040			02	1.00
53080			02	1.00
53085			03	1.00
53200			01	1.00
53210			04	1.00
53215			04	1.00
53220			02	1.00
53230			02	1.00
53235			03	1.00
53240			02	1.00

Code	PA	EPSDT	Grp	Limit
53250			02	1.00
53260			02	1.00
53265			02	1.00
53275			02	1.00
53400			03	1.00
53405			02	1.00
53410			02	1.00
53415			02	1.00
53420			03	1.00
53425			02	1.00
53430			02	1.00
53440			02	1.00
53442			01	1.00
53445			02	1.00
53447			01	1.00
53449			01	1.00
53450			01	1.00
53460			01	1.00
53502			02	1.00
53505			02	1.00
53510			02	1.00
53515			02	1.00
53520			02	1.00
53605			02	1.00
53620			01	1.00
53621			01	1.00
53660			01	1.00
53661			01	1.00
53665			01	1.00
54001			01	1.00
54015			01	1.00
54057			01	1.00
54060			01	1.00
54065			01	1.00
54100			01	1.00
54105			01	1.00
54110			02	1.00
54111			03	1.00
54112			03	1.00
54115			01	1.00
54120			02	1.00
54125			02	1.00
54152			01	1.00
54160			09	1.00
54161			02	1.00
54205			01	1.00
54220			01	1.00
54230			01	1.00
54231			02	1.00
54300			03	1.00
54304		EQ	05	1.00
54322			03	1.00
54324			04	1.00
54326			04	1.00
54332			03	1.00
54340			03	1.00
54360			03	1.00
54400		EQ	05	1.00
54401		EQ	05	1.00
54402		EQ	03	1.00
54405		EQ	07	1.00
54407		EQ	05	1.00
54409		EQ	03	1.00
54420			04	1.00
54430			04	1.00
54435			04	1.00
54440			04	1.00
54450			01	1.00
54500			01	1.00

Code	PA	EPSDT	Grp	Limit
54505			01	1.00
54510			02	1.00
54520			03	1.00
54530			04	1.00
54550			03	1.00
54600			04	1.00
54620			02	1.00
54640			04	1.00
54660			02	1.00
54670			03	1.00
54680			03	1.00
54690				1.00
54700			02	1.00
54800			01	1.00
54820			01	1.00
54830			03	1.00
54840			04	1.00
54860			03	1.00
54861			04	1.00
54900			04	1.00
54901			04	1.00
55040			03	1.00
55041			05	1.00
55060			04	1.00
55100			01	1.00
55110			02	1.00
55120			02	1.00
55150			01	1.00
55175			01	1.00
55180			02	1.00
55200			02	1.00
55250			01	1.00
55400			01	1.00
55500			03	1.00
55520			04	1.00
55530			04	1.00
55535			04	1.00
55540			05	1.00
55600			01	1.00
55605			01	1.00
55650			01	1.00
55680			01	1.00
55700			02	1.00
55705			02	1.00
55720			01	1.00
55725			02	1.00
55859			03	1.00
55860			03	1.00
56405			01	1.00
56420			01	1.00
56440			02	1.00
56441			01	1.00
56501			01	1.00
56515			03	1.00
56605			01	1.00
56620			01	1.00
56625			02	1.00
56700			01	1.00
56720			01	1.00
56740			03	1.00
56800			03	1.00
56805			03	1.00
56810			03	1.00
57000			02	1.00
57010			02	1.00
57020			02	1.00
57061			01	1.00
57065			02	1.00
57100			01	1.00

Code	PA	EPSDT	Grp	Limit
57105			02	1.00
57130			02	1.00
57135			02	1.00
57180			01	1.00
57200			01	1.00
57210			02	1.00
57220			03	1.00
57230			03	1.00
57240			05	1.00
57250			05	1.00
57260			05	1.00
57265			07	1.00
57268			03	1.00
57284			04	1.00
57300			03	1.00
57310			03	1.00
57311			04	1.00
57320			03	1.00
57330			03	1.00
57400			02	1.00
57410			02	1.00
57415			04	1.00
57452			01	1.00
57454			01	1.00
57460			01	1.00
57500			01	1.00
57505			01	1.00
57511			01	1.00
57513			02	1.00
57520			02	1.00
57522			02	1.00
57530			03	1.00
57550			03	1.00
57700			01	1.00
57720			03	1.00
57800			01	1.00
57820			03	1.00
58100			01	1.00
58120			02	1.00
58301	PA		01	1.00
58340			01	1.00
58400			04	1.00
58410			04	1.00
58550				1.00
58551			05	1.00
58555			01	1.00
58558			03	1.00
58559			02	1.00
58560				1.00
58561			03	1.00
58563			04	1.00
58600			04	1.00
58615			04	
58660			05	1.00
58661			05	
58662			05	1.00
58670			03	1.00
58671			03	1.00
58672			05	1.00
58673			05	1.00
58700			04	1.00
58800			05	1.00
58805			05	1.00
58820			05	1.00
58823			04	1.00
58825			05	1.00
58900			03	1.00
58940			03	1.00
59000			01	1.00

Code	PA	EPSDT	Grp	Limit
59020			09	1.00
59025			09	1.00
59121			04	1.00
59150			04	1.00
59151			04	1.00
59160			02	1.00
59320			01	1.00
59812			02	1.00
59820			02	1.00
59821			02	1.00
59841			02	1.00
59871			09	1.00
60000			01	1.00
60001			01	1.00
60200			02	1.00
60210			02	1.00
60212			02	1.00
60220			02	1.00
60225			03	1.00
60260			03	1.00
60280			04	1.00
60281			04	1.00
60521			03	1.00
61020			01	1.00
61026			01	1.00
61050			01	1.00
61055			01	1.00
61070			01	1.00
61215			03	1.00
61500		EQ	04	1.00
61790			03	1.00
61791			03	1.00
61793			04	1.00
61885			02	1.00
61886			02	
61888			01	1.00
62194			01	1.00
62225			01	1.00
62230			02	1.00
62256			02	1.00
62263			01	
62268			01	1.00
62269			01	1.00
62270			01	1.00
62272			01	1.00
62273			01	1.00
62280			01	1.00
62281			01	1.00
62282			01	1.00
62290			01	1.00
62294			03	1.00
62310			01	1.00
62311			01	1.00
62318			01	1.09
62319			01	
62350			02	1.00
62351			02	1.00
62355			02	1.00
62360			02	1.00
62361			02	1.00
62362			02	1.00
62365			02	1.00
62367			02	1.00
62368			02	1.00
63030			05	1.00
63042			05	1.00
63600			02	1.00
63610			01	1.00
63650			02	1.00

Code	PA	EPSDT	Grp	Limit
63660			01	1.00
63685			02	1.00
63688			01	1.00
63744			03	1.00
63746			02	1.00
64400			01	1.00
64402			01	1.00
64405			01	1.00
64408			01	1.00
64410			01	1.00
64412			01	1.00
64413			01	1.00
64415			01	1.00
64417			01	1.00
64418			01	1.00
64420			01	1.00
64421			01	1.00
64425			01	1.00
64430			01	1.00
64435			01	1.00
64445			01	1.00
64450			01	1.00
64470			01	
64472			01	
64475			01	1.00
64476			01	1.00
64479			01	1.00
64480			01	1.00
64483			01	1.00
64484			01	1.00
64510			01	1.00
64520			01	1.00
64530			01	1.00
64575			01	1.00
64590			02	1.00
64595			01	1.00
64600			01	1.00
64605			01	1.00
64610			01	1.00
64612			01	1.00
64613			01	1.00
64620			01	1.00
64622			01	1.00
64623			01	1.00
64626			01	1.00
64627			01	1.00
64630			02	1.00
64640			01	1.00
64680			02	1.00
64702			01	1.00
64704			01	1.00
64708			02	1.00
64712			02	1.00
64713			02	1.00
64714			02	1.00
64716			03	1.00
64718			02	1.00
64719			02	1.00
64721			02	1.00
64722			01	1.00
64726			01	1.00
64727			01	1.00
64732			02	1.00
64734			02	1.00
64736			02	1.00
64738			02	1.00
64740			02	1.00
64742			02	1.00
64744			02	1.00

Code	PA	EPSDT	Grp	Limit
64746			02	1.00
64771			02	1.00
64772			02	1.00
64774			02	1.00
64776			03	1.00
64778			02	1.00
64782			03	1.00
64783			02	1.00
64784			03	1.00
64786			03	1.00
64787			02	1.00
64788			03	1.00
64790			03	1.00
64792			03	1.00
64795			02	1.00
64802			02	1.00
64831			04	1.00
64832			01	1.00
64834			02	1.00
64835			03	1.00
64836			03	1.00
64837			01	1.00
64840			02	1.00
64856			02	1.00
64857			02	1.00
64858			02	1.00
64859		EQ	01	1.00
64861			03	1.00
64862			03	1.00
64864			03	1.00
64865			04	1.00
64870			04	1.00
64872			02	1.00
64874			03	1.00
64876			03	1.00
64885			02	1.00
64886			02	1.00
64890			02	1.00
64891			02	1.00
64892			02	1.00
64893			02	1.00
64895			03	1.00
64896			03	1.00
64897			03	1.00
64898			03	1.00
64901			02	1.00
64902			02	1.00
64905			02	1.00
64907			01	1.00
65091			03	1.00
65093			03	1.00
65101			03	1.00
65103			03	1.00
65105			04	1.00
65110			05	1.00
65112			05	1.00
65114			07	1.00
65125			02	1.00
65130			03	1.00
65135			02	1.00
65140			03	1.00
65150			02	1.00
65155			03	1.00
65175			01	1.00
65222			01	1.00
65235			02	1.00
65260			03	1.00
65265			04	1.00
65270			01	1.00

Code	PA	EPSDT	Grp	Limit
65272			02	1.00
65273			02	1.00
65275			03	1.00
65280			04	1.00
65285			04	1.00
65290			03	1.00
65400			01	1.00
65410			02	1.00
65420			02	1.00
65426			05	1.00
65450			02	1.00
65710			07	1.00
65730			07	1.00
65750			07	1.00
65755			07	1.00
65772			04	1.00
65800			01	1.00
65805			01	1.00
65810			03	1.00
65815			02	1.00
65820			02	1.00
65850			02	1.00
65855			02	1.00
65860			01	1.00
65865			01	1.00
65870			04	1.00
65875			04	1.00
65880			04	1.00
65900			05	1.00
65920			07	1.00
65930			05	1.00
66020			01	1.00
66030			01	1.00
66130			07	1.00
66150			04	1.00
66155			04	1.00
66160			02	1.00
66165			04	1.00
66170			04	1.00
66172			04	1.00
66180			04	1.00
66220			03	1.00
66225			04	1.00
66250			02	1.00
66500			01	1.00
66505			01	1.00
66600			03	1.00
66605			03	1.00
66625			03	1.00
66630			03	1.00
66635			03	1.00
66680			03	1.00
66682			02	1.00
66700			02	1.00
66710			03	1.00
66720		EQ	03	1.00
66740			03	1.00
66761			01	1.00
66762			01	1.00
66770			01	1.00
66820			04	1.00
66821			04	1.00
66825			02	1.00
66830			04	1.00
66840			04	1.00
66850			07	1.00
66852			07	1.00
66920			04	1.00
66930			05	1.00

Code	PA	EPSDT	Grp	Limit
66940			05	1.00
66983			08	1.00
66984			08	1.00
66985			06	1.00
66986			05	1.00
66999	PA		01	1.00
67005			04	1.00
67010			04	1.00
67015			01	1.00
67025			01	1.00
67028			02	1.00
67030			01	1.00
67031			02	1.00
67036			04	1.00
67038			05	1.00
67039			05	1.00
67040			05	1.00
67101			04	1.00
67105			05	1.00
67107			05	1.00
67108			05	1.00
67110			05	1.00
67112			05	1.00
67115			02	1.00
67120			02	1.00
67121			02	1.00
67141			02	1.00
67145			01	1.00
67208			01	1.00
67210			01	1.00
67218			05	1.00
67220			02	1.00
67227			01	1.00
67228			02	1.00
67250			03	1.00
67255			03	1.00
67311			03	1.00
67312			04	1.00
67314			04	1.00
67316			04	1.00
67318			04	1.00
67320			04	1.00
67331			04	1.00
67332			04	1.00
67334			04	1.00
67340			04	1.00
67343			04	1.00
67345			03	1.00
67350			01	1.00
67400			03	1.00
67405			04	1.00
67412			05	1.00
67413			05	1.00
67414			03	1.00
67415			01	1.00
67420			05	1.00
67430			05	1.00
67440			05	1.00
67445			05	1.00
67450			05	1.00
67500			09	1.00
67550			04	1.00
67560			02	1.00
67570			03	1.00
67700			09	1.00
67710			02	1.00
67715			01	1.00
67800			01	1.00
67801			01	1.00

Code	PA	EPSDT	Grp	Limit
67805			01	1.00
67808			02	1.00
67820			01	1.00
67825			01	1.00
67830			02	1.00
67835			02	1.00
67840			01	1.00
67850			01	1.00
67875			01	1.00
67880			03	1.00
67882			03	1.00
67900			03	1.00
67901			05	1.00
67902			05	1.00
67903			03	1.00
67904			04	1.00
67906			05	1.00
67908			04	1.00
67909			03	1.00
67911			01	1.00
67914			01	1.00
67916	PA		04	1.00
67917	PA		04	1.00
67921			01	1.00
67923	PA		04	1.00
67924	PA		04	1.00
67930			02	1.00
67935			02	1.00
67938			01	1.00
67950			02	1.00
67961			03	1.00
67966			03	1.00
67971			03	1.00
67973			03	1.00
67974			03	1.00
67975			03	1.00
67999	PA		03	1.00
68020			01	1.00
68040			01	1.00
68100			01	1.00
68110			02	1.00
68115			02	1.00
68130			02	1.00
68320			04	1.00
68325			04	1.00
68326			04	1.00
68328			04	1.00
68330			04	1.00
68335			04	1.00
68340			04	1.00
68360			02	1.00
68362			02	1.00
68500			03	1.00
68505			03	1.00
68510			01	1.00
68520			03	1.00
68525			01	1.00
68530			02	1.00
68540			03	1.00
68550			03	1.00
68700			02	1.00
68705			01	1.00
68720			04	1.00
68745			04	1.00
68750			04	1.00
68760			02	1.00
68801			01	1.00
68811			01	1.00
68815			01	1.00

Code	PA	EPSDT	Grp	Limit
68840			09	1.00
69005			02	1.00
69100			01	1.00
69105			01	1.00
69110			01	1.00
69120			02	1.00
69140			02	1.00
69145			02	1.00
69150			03	1.00
69205			01	1.00
69210	PA	EQ	01	1.00
69220			01	1.00
69222			02	1.00
69300	PA		02	1.00
69310			03	1.00
69320			07	1.00
69400			01	1.00
69401			01	1.00
69405			01	1.00
69410			01	1.00
69420			01	1.00
69421			01	1.00
69424			01	1.00
69433			01	1.00
69436			01	1.00
69440			03	1.00
69450			01	1.00
69501			07	1.00
69502			07	1.00
69505			07	1.00
69511			07	1.00
69530			07	1.00
69540			09	1.00
69550			05	1.00
69552			07	1.00
69601			07	1.00
69602			07	1.00
69603			07	1.00
69604			07	1.00
69605			07	1.00
69610			02	1.00
69620			02	1.00
69631			05	1.00
69632			05	1.00
69633			05	1.00
69635			07	1.00
69636			07	1.00
69637			07	1.00
69641			07	1.00
69642			07	1.00
69643			07	1.00
69644			07	1.00
69645			07	1.00
69646			07	1.00
69650			07	
69660			05	
69661			05	1.00
69662			04	
69666			04	1.00
69667			04	1.00
69670			03	1.00
69676			03	1.00
69700			03	1.00
69710			03	
69711			01	
69720			05	1.00
69725			05	1.00
69740			05	1.00
69745			05	1.00

Code	PA	EPSDT	Grp	Limit
69801			05	
69949	PA	EQ		
69990			03	1.00
70010				
70015				
70030				
70100				
70110				
70120				
70130				
70134				
70140				
70150				
70160				
70170				
70190				
70200				
70210				
70220				
70240				
70250				
70260				
70300				
70310				
70320				
70328				
70330				1.00
70332				
70336	PA		01	1.00
70350				
70355				1.00
70360				
70370				
70373				
70380				
70390				
70450				1.00
70460				1.00
70470				1.00
70480				1.00
70481				1.00
70482				1.00
70486				1.00
70487				1.00
70488				1.00
70490				1.00
70491				1.00
70492				1.00
70541				1.00
70551				1.00
70552				1.00
70553				1.00
71010				
71015				
71020				
71021				
71022				
71023				
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71034				
71035				
71036				
71040				
71060				1.00
71090				
71100				
71101				
71110				1.00
71111				1.00

Code	PA	EPSDT	Grp	Limit
71120				
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71270				1.00
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72040				
72050				
72052				
72069				
72070				
72072				
72074				
72080				
72090				
72100				
72110				
72114				
72120				
72125				1.00
72126				1.00
72127				1.00
72128				1.00
72129				1.00
72130				
72131				1.00
72132				1.00
72133				1.00
72141				1.00
72142				1.00
72143		EQ		1.00
72144		EQ		1.00
72146				1.00
72147				1.00
72148				1.00
72149				1.00
72156				1.00
72157				1.00
72158				1.00
72170				
72190				
72192				1.00
72193				1.00
72194				1.00
72196		EQ		1.00
72200				
72202				
72220				
72240				
72255				
72265				
72270				
72275				1.00
72285				
72295				
73000				
73010				
73020				
73030				
73040				
73050				1.00
73060				
73070				
73080				
73085				
73090				
73092				
73100				

Code	PA	EPSDT	Grp	Limit
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73115				
73120				
73130				
73140				
73200				1.00
73201				1.00
73202				1.00
73220		EQ		1.00
73221				1.00
73500				
73510				
73520				1.00
73525				
73530				
73540				
73542				1.00
73550				
73560				
73562				
73564				
73565				1.00
73580				1.00
73590				
73592				
73600				
73610				
73615				
73620				
73630				
73650				
73660				
73700				1.00
73701				1.00
73702				1.00
73720		EQ		1.00
73721				1.00
74000				
74010				
74020				
74022				
74150				1.00
74160				1.00
74170				1.00
74181		EQ		1.00
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74230				
74235				
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74246				
74247				
74249				
74250				
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74270				
74280				
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74291				
74300				
74301				
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74327				
74328				

Code	PA	EPSDT	Grp	Limit
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74360				
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74740				
74775				
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75658				
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75662				1.00
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75671				1.00
75676				
75680				1.00
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75724				1.00
75726			01	
75731				
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75736				
75741				
75743				1.00
75746				
75756				
75774				
75790				
75801				
75803				1.00
75805				
75807				1.00
75809				
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75840				
75842				1.00
75860				
75870				
75872				
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Code	PA	EPSDT	Grp	Limit
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75889				
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75893				
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75898				
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75940				
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75961				
75962				
75964				
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75978				
75980				
75982				
75984				
75989				
76000				
76003				
76005				1.00
76010				
76020				
76040				
76061				
76062				
76065				
76066				
76070				
76075				
76076				1.00
76078				1.00
76080				
76086				
76088				
76090				1.00
76091				1.00
76092				1.00
76095				
76096				
76098				
76100				
76101				
76102				1.00
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76150				
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76355				
76360				
76365				
76370				
76375				
76380				
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76506				1.00
76511				1.00
76512				1.00
76516				1.00
76519				1.00
76529				1.00
76536				
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76645				1.00

Code	PA	EPSDT	Grp	Limit
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76873				1.00
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76885				1.00
76886				1.00
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76932				
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76936				3.00
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76942				
76945				3.00
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76950				
76960				
76965				1.00
76970				
76975				
76977				1.00
76986				
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77305				
77310				
77315				
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77407				
77408				
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77412				
77413				
77414				

Code	PA	EPSDT	Grp	Limit
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77750				
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77763				
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77778				
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77790				1.00
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78003				
78006				
78007				
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78185				
78195				
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Code	PA	EPSDT	Grp	Limit
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78351				
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78660				
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78700				
78701				
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78708				1.00
78709				1.00
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78761				
78800				
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78802				
78805				
78806				

Code	PA	EPSDT	Grp	Limit
78807				
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78891				
78990				
79000				1.00
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79440				
79900				1.00
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80076				
80090				
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80299				
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80417				1.00

Code	PA	EPSDT	Grp	Limit
80418	PA			
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80422				
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82175				
82180				
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82205				
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82240				
82247				1.00

Code	PA	EPSDT	Grp	Limit
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82607				
82608				
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
82996		EQ		
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83527				
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Code	PA	EPSDT	Grp	Limit
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83897				1.00
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
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Code	PA	EPSDT	Grp	Limit
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87495				
87496				
87510				
87511				
87515				
87516				
87520				
87521				
87525				

Code	PA	EPSDT	Grp	Limit
87526				
87528				
87529				
87531				
87532				
87534				1.00
87535				1.00
87536				1.00
87537				1.00
87538				1.00
87539				1.00
87540				
87541				
87550				
87551				
87555				
87556				
87560				
87561				
87580				
87581				
87590				
87591				
87620				
87621				
87650				
87651				
87797				
87798				
87810				
87850				
87880				
87899				
88104				
88106				
88107				
88108				
88125				
88130				
88140				
88141				1.00
88142				1.00
88143				1.00
88148				1.00
88152				
88154				1.00
88155				1.00
88160				
88161				
88162				
88164				1.00
88165				1.00
88166				1.00
88170				
88171				
88172				
88173				
88180				
88182				
88230				
88233				
88235				2.00
88237				
88239				
88240				
88241				
88245				
88248				
88249				

Code	PA	EPSDT	Grp	Limit
88261				1.00
88262				1.00
88263	PA			1.00
88264				
88267				2.00
88269				1.00
88271				
88272				
88273				
88274				
88275				
88280				2.00
88283				1.00
88285				1.00
88289				1.00
88291				1.00
88300				
88302				
88304				
88305				
88307				
88309				
88311				
88312				
88313				
88314				
88318				
88319				
88323				
88331				
88332				
88342				
88346				
88347				
88348				
88349				
88355				
88356				
88358				
88365				
88371				
88372				
89050				
89051				
89060				
89100				
89105				
89125				
89130				
89132				
89135				
89136				
89140				
89141				
89160				
89190				
89300				
89310				
89320				
89325				
89329				
89330				
89350				
89355				
89360				
89365				
89399	PA			
90935				
90937				

Code	PA	EPSDT	Grp	Limit
90945				
90947				
90989				
91010				
91011				
91012				
91030				
91032				
91033				
91052				
91065				
91105				
91122				
92018			01	
92019			01	
92060				
92235				1.00
92240			02	1.00
92467		EQ		
92502			01	
92506	PA	EQ		1.00
92507	PA	EQ		1.00
92508		EQ		1.00
92520				
92531		EQ		
92532		EQ		
92533		EQ		
92534		EQ		
92541		EQ		
92542		EQ		
92543		EQ		
92544		EQ		
92545		EQ		
92546		EQ		
92547		EQ		
92548				1.00
92551	PA	EQ		
92552	PA	EQ		
92553	PA	EQ		
92555	PA	EQ		
92556	PA	EQ		
92557	PA	EQ		
92560	PA	EQ		
92561	PA	EQ		
92562	PA	EQ		
92563	PA	EQ		
92564	PA	EQ		
92565	PA	EQ		
92568	PA	EQ		
92569	PA	EQ		
92571	PA	EQ		
92572	PA	EQ		
92573	PA	EQ		
92575	PA	EQ		
92576	PA	EQ		
92577	PA	EQ		
92582	PA	EQ		
92583	PA	EQ		
92584	PA	EQ		
92585				3.00
92589	PA	EQ		
92597				1.00
92950		EQ		
92960				
92961				
92978			09	1.00
92982			03	
92984				
93005				

Code	PA	EPSDT	Grp	Limit
93012				
93017				
93024				
93041				
93225				
93231				
93232				
93270				1.00
93278				
93303				1.00
93304				1.00
93307				
93308				
93312				
93313				
93314				
93315				1.00
93320				
93321				
93325				
93350				
93501				
93503			01	
93505				
93508				1.00
93510				
93511				
93514				
93524				
93526				
93527				
93528				
93529				
93530				1.00
93531				1.00
93532				1.00
93533				1.00
93536			01	
93539				
93540				
93541				
93542				
93543				
93544				
93545				
93555				1.00
93556				1.00
93561				
93562				
93600				
93602				
93603				
93607				
93609				
93610				
93612				
93615				
93616				
93618				
93619				
93620				
93624				
93631				
93640				
93641				
93642				
93875				
93880				
93882				

Code	PA	EPSDT	Grp	Limit
93886				
93888				
93922				1.00
93923				
93924				1.00
93925				
93926				
93930				
93931				
93965				
93970				
93971				
93975				
93976				
93978				
93979				
93980				1.00
93981				1.00
94010				1.00
94060				1.00
94070				
94200				1.00
94240				1.00
94260				
94350				1.00
94360				1.00
94370				1.00
94620				1.00
94642				
94650				1.00
94660				1.00
94664				1.00
94665				1.00
94667		EQ		1.00
94680				1.00
94720				1.00
94760				
94761				
94762				
94770				1.00
94772				
95805				
95806				1.00
95807				
95808				
95810				
95811				1.00
95812				1.00
95813				1.00
95816				1.00
95819				1.00
95822		EQ		1.00
95831		EQ		1.00
95832				1.00
95833				1.00
95834		EQ		1.00
95851				10.00
95860				1.00
95861				1.00
95863				1.00
95864				1.00
95869				
95870				1.00
95900				
95903				8.00
95904				
95921				1.00
95922				1.00
95923				1.00

Code	PA	EPSDT	Grp	Limit
95925				1.00
95926				1.00
95930				1.00
95934				1.00
95936				
95937				
95950				1.00
95951				1.00
95957				
96408				
96410				
96412				
96414				
96420				
96422				
96423				
96425				
96450			01	
96520				
96530				
96570			01	1.00
96571				1.00
97001				1.00
97002				1.00
97003		EQ		1.00
97004		EQ		1.00
97010	PA	EQ		1.00
97012	PA	EQ		1.00
97014	PA	EQ		4.00
97016	PA	EQ		1.00
97018	PA	EQ		1.00
97020	PA	EQ		0.00
97022	PA	EQ		1.00
97024	PA	EQ		1.00
97026	PA	EQ		1.00
97028	PA	EQ		1.00
97032	PA	EQ		4.00
97034				4.00
97035				4.00
97036				4.00
97110	PA	EQ		4.00
97112	PA	EQ		1.00
97113	PA	EQ		1.00
97116	PA	EQ		1.00
97124	PA	EQ		1.00
97139		EQ		
97150	PA	EQ		1.00
97504				4.00
97520	PA	EQ		4.00
97530	PA	EQ		4.00
97535				4.00
97542				4.00
97703		EQ		4.00
97750				4.00
97770	PA	EQ		
99001		EQ		
99080				
99170				
99183				1.00
99195				
99281				
99282				
99283				
99284				
99285				
A6154		EQ		
A6196		EQ		
A6197		EQ		
A6199		EQ		

Code	PA	EPSDT	Grp	Limit
A6200		EQ		1.00
A6201		EQ		1.00
A6202		EQ		1.00
A6203		EQ		
A6204		EQ		
A6207		EQ		
A6209		EQ		
A6210		EQ		
A6211		EQ		
A6212		EQ		
A6214		EQ		
A6216				
A6217				
A6219		EQ		
A6220		EQ		
A6222		EQ		
A6223		EQ		
A6224		EQ		
A6229		EQ		
A6234		EQ		
A6235		EQ		
A6236		EQ		
A6237		EQ		
A6238		EQ		
A6240		EQ		
A6241		EQ		
A6242		EQ		
A6243		EQ		
A6244		EQ		
A6245		EQ		
A6246		EQ		
A6247		EQ		
A6248		EQ		
A6251		EQ		
A6252		EQ		
A6253		EQ		
A6254		EQ		
A6255		EQ		
A6257		EQ		
A6258		EQ		
A6259		EQ		
A6263		EQ		
A6264		EQ		
A6265		EQ		
A6266		EQ		
A6402				
A6403				
A6405		EQ		
A6406		EQ		
L3650		EQ		
L3660		EQ		
L3670		EQ		
L3700		EQ		
L3800		EQ		
L3805		EQ		
L3810				
L3820				
L3845		EQ		
L3855				
L3860				
L3906				
L3907				
L3908		EQ		
L3914		EQ		
L3922				
L3924				
L3932				
L3934				
L3936				

Code	PA	EPSDT	Grp	Limit
L3938				
L3940				
L3942		EQ		
L3944				
L3946				
L3948				
L3954				
L3980		EQ		
L3984		EQ		
L4210		EQ		
S9905	PA	EQ		
S9908	PA	EQ		
X1573				
X1574				
Z4998				1.00
Z5158	PA		02	1.00
Z5256				
Z5266				
Z5294				10.00
Z5295				10.00
Z5363			02	
Z5380				1.00
Z5414				
Z5415				

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J Provider Explanation of Benefits (EOB) Codes

This appendix lists codes that may appear on a Provider Explanation of Payments (EOP). Section J.1, EOB Codes, lists codes that display next to each denied claim on the EOP under the heading “Denied Claims”. Section J.2, Adjustment EOB Codes, lists codes that display on the EOP under the heading “Paid Adjustments” when a claim has been adjusted.

The Provider Electronic Solutions (PES) software performs up-front edits before claims go into the system. PES assigns an error message to each rejected claim, which providers may then correct and resubmit into the system. These up-front error messages are listed in Section J.3, Electronic Up-Front Rejections.

J.1 EOB Codes

EOB Code	***Description***
001	The FROM date of service is invalid.
002	The admission date is invalid.
003	The TO/THROUGH date of service is invalid.
004	The total noncovered charge is invalid.
005	The surgical date is not between ADMIT and THROUGH dates of service.
006	Submitted charge for line item is equal to or less than noncovered charge.
007	Number of days billed and billing period disagree.
008	Services(s) past the maximum Medicaid filing limit.
009	The discharge date is earlier than the admission date. Transportation: Describe other charges.
010	Emergency facility procedure codes may be billed with revenue code 450 only.
011	Recipient eligible for BAY Health Plan. Please file to BAY Health for consideration.
012	No Level III base value for anesthesia for the Date of Service billed.
013	Revenue code 172, 175, or 179 cannot be billed in conjunction with a normal diagnosis (V30).
014	This service requires an appropriate modifier.
015	The diagnosis code is not valid for transportation providers.
016	IP- DOS must not span 2 calendar years, span a rate change, or exceed 99 days.
019	HIV codes must be billed in conjunction with family planning codes Z5181 - Z5183 or Z5190.
020	Family Planning procedure Z5190 must be billed with Z5195.
021	Outpatient physical therapy cannot be billed in conjunction with any other service.

EOB Code	***Description***
022	Covered days billed are invalid.
023	Organ transplants (except Cornea) require prior authorization. Contact Alabama Medicaid.
025	Unborn recipient's Medicaid # should be used only for infant services.
026	EPSDT referred therapy services are restricted to place of service "11" or "99".
027	The modifier may only be billed on Medicare related claims.
029	Type of bill is invalid.
030	Unit(s) billed is missing or invalid.
031	Units (total days) x rate does not equal the total accommodation charge.
032	Modifier not effective for this date of service.
033	Revenue codes 170 - 171 must be billed under mother's number; revenue codes 172, 175 or 179 must be billed under the baby’s number.
034	Cataract services require proper modifier to be billed.
036	Submitted rate, units, and detail charge do not balance.
037	Revenue codes 170 – 171 must not exceed 10 units under the mother's number.
038	Pricing file indicates zero price. Call EDS.
039	Services are not covered for indicated diagnosis.
040	Procedure code limited to QMB or EPSDT related claims.
042	EPSDT referred services are restricted to recipients under 21 on the date of service.
043	Billed amount must be numeric and greater than zero.
044	Medicare paid amount is missing or invalid.

EOB Code	Description
045	The Medicare allowed amount is missing or calculated incorrectly.
046	Medicare total billed amount is missing or invalid.
047	The coinsurance amount is invalid.
048	Referring provider must be a valid EPSDT screening provider.
050	EPSDT screenings may only be billed by an EPSDT screening provider. Contact the Provider Enrollment Unit at EDS.
051	Patient status invalid.
052	Medicare header allowed amount does not equal the sum of detail Medicare allowed amounts.
053	Net billed amount not equal to sum of detail charges less TPL amount.
054	The sum of the detail non-covered charge does not equal the header non-covered charge.
055	Billed amount not equal to sum of the detail charge amounts.
056	The Medicare header paid amount does not equal the sum of the detail Medicare paid amounts.
057	Ten units of code Z5294 must be billed prior to any units of Z5295.
060	This recipient is not eligible for maternity waiver services.
061	Injectable and non-injectable procedures cannot be billed together.
062	FQHC services billed at POS-21 (Inpatient Hospitals) cannot be billed on the same claim with other FQHC services.
063	Recipient's county of residence for claim dates of service are not on file. Resubmit.
065	Procedure code billed is invalid for provider.
066	Admit type is invalid as billed.
067	OB services are not covered separately for this recipient. Contact primary provider in your area.
068	This service was covered in full by Medicare.
069	Dental sealants are not payable for this recipient or tooth number.
071	Invalid place of service for FQHC provider.
072	Provider/procedure code not on Level I Pricing file.
073	Family planning service not covered for this recipient.
074	EPSDT-only provider must bill EPSDT referral.
076	The diagnosis code billed is not covered.
078	Critical care procedure cannot span more than two days.
081	Procedure cannot be billed with a non-patient visit (type of bill 141).
082	Not SOBRA or QMB covered for entire claim. Obtain SOBRA/QMB dates and split bill.

EOB Code	Description
084	Service is not covered for a SOBRA adult recipient.
086	Recipient not eligible for targeted case management.
087	Different targeted case management procedure codes must be billed on separate claims.
088	CLIA number not on file/invalid or provider not authorized to bill procedure code.
089	Medicare paid in full.
090	Global delivery procedure code cannot be span dated. Use date of delivery.
093	Claim spans more than one managed care plan. Obtain managed care data and split bill.
098	Service not covered by Medicaid.
099	Medicare deductible amount is invalid.
100	Detail FROM date of service is a future date or invalid.
101	The TO date is invalid or prior to the FROM date.
102	Service (s) past the maximum Medicaid filing limit.
103	Therapy code payable only with therapeutic treatment.
105	This service is included in the facility fee (Revenue Code 450).
107	Recipient enrolled in Patient 1st Program; Services require PMP referral.
109	Observation must be billed in conjunction with facility fee.
110	Invalid deductible amount for skilled nursing facility.
111	Inpatient/Outpatient non-covered revenue codes for EPSDT referred claims.
112	There is no provider number on the long term care file for this recipient.
113	The procedure code is not covered when provided by an Ambulatory Surgical Center.
114	Service non-payable for recipient less than six months of age.
115	Payment amount added to claims payment.
116	Recoupment – This amount is withheld from your check.
117	Refund check amount credited to your IRS year total.
118	Returned check amount credited to your IRS year total.
119	Payment applied to receivable
125	Dispensed date invalid (PH).
126	The tooth surface is missing or invalid.
128	A valid tooth number is required for procedure.
129	Procedure code is not covered for tooth number.
130	Invalid claim type for Plan First Program.

EOB Code	Description
131	Service is only covered under the Plan First Program.
132	Birth control polls must be received from a physician for the Plan First Program.
133	Plan First recipient must be seen by a Plan First network provider.
134	Plan First recipient is only eligible for Plan First services.
136	Place of service code is invalid.
144	Place of service is not valid for provider type.
145	Modifier is invalid.
146	Procedure/revenue code is inappropriate for provider type.
147	Modifier 50 is invalid for procedure code billed.
148	Place of service code is invalid for procedure.
149	Procedure/revenue code/NDC is not covered for recipient's age.
150	This service is not reimbursable for a recipient of this sex.
151	Revenue/procedure code/NDC invalid for DOS.
152	Drug code is invalid.
153	Diagnosis is inappropriate for the procedure being billed.
154	Procedure code is not covered for this provider specialty.
155	Procedure/Revenue code is invalid for claim type.
156	Procedure code is on review for the provider.
160	Part-B charges billed by NH provider are not covered by Medicaid (LT).
161	Procedure code or revenue code is invalid.
162	Units billed exceed maximum allowed per day.
163	This procedure code is not covered for Non-Medicare related claims.
164	Accommodation revenue code is not present on inpatient claim or claim denied because covered charges for days billed equal noncovered charges.
176	Third party file indicates Medicare Comprehensive Insurance for recipient.
179	Sterilization denied because documentation does not meet HHS/Medicaid requirements.
180	Hysterectomy denied because documentation does not meet HHS/Medicaid requirements.
181	Abortion denied because documentation does not meet HHS/Medicaid requirements.
182	No consent form on file for recipient’s date of surgery. Resubmit with consent form attached.
183	Date of service is prior to recipient's date of birth.
190	Primary diagnosis code is invalid.
191	Secondary diagnosis code is invalid.
192	Third diagnosis code is invalid.

EOB Code	Description
193	Fourth diagnosis code is invalid.
194	Primary diagnosis code is not appropriate for recipient's age.
195	Other diagnosis code is not appropriate for recipient's age.
196	Primary diagnosis code is not appropriate for recipient's sex.
197	Other diagnosis code is not appropriate for recipient's sex.
205	Detail diagnosis is not on file.
206	The detail diagnosis is not appropriate for the recipient's sex.
207	The detail diagnosis code is not appropriate for the recipient's age.
220	Provider does not have authorization to bill electronically.
221	Enrollment file indicates billing provider is deceased for date of service billed.
222	Mail returned for invalid address. Contact EDS Provider Enrollment unit.
223	Billing provider is suspended from the Medicaid Program.
224	Enrollment file indicates billing provider number is not valid for dates of service.
225	Provider rate not found for the date of service billed.
226	Claim type is not valid for this provider.
227	Provider is enrolled in the Medicaid Program for crossover claims only.
228	Dates of service are not within approved provider enrollment period.
229	Provider number is invalid, not on file or name/number disagree.
230	The attending physician's license number is not on file..
233	The referring provider is not on file.
235	The billing provider must be the group provider number.
236	Performing provider cannot be group provider number.
237	The performing provider number is not on file.
238	Performing provider not associated with the group.
239	Provider eligible only for QMB recipients or EPSDT referrals.
248	QMB-only recipient limited to crossover claims.
250	The recipient's 13-digit Medicaid number is missing or invalid.
251	Recipient has unusable record – Contact EDS.
253	DOS is after the recipient date of death on the recipient master file.
254	Records show this recipient is totally ineligible for Medicaid for header date(s) of service.

EOB Code	Description
255	Records show this recipient is partially ineligible for Medicaid for header date(s) of service.
256	Payment of this claim has been authorized beyond the two-year filing limit.
258	Recipient is locked in to a specific pharmacy/no pharmacy selected.
259	The recipient name does not match the name on file for Medicaid number.
262	Records show this recipient is totally ineligible for Medicaid for detail date(s) of service.
263	Records show this recipient is partially ineligible for Medicaid for detail date(s) of service.
264	Recipient ineligible for geriatric or inpatient psychiatric services.
265	Recipient must be 21 years of age or younger as of admission date shown in FL-15.
267	Census data is not on file for provider for the previous month.
270	This recipient is not listed on the Long Term Care file for DOS indicated.
272	Provider does not match provider on the LTC file for the recipient.
276	Recipient is not eligible for waivered services according to Medicaid's file.
280	Recipient has other medical coverage; file third party carrier first.
281	TPL pay and list edit.
282	Recipient has Medicare coverage, bill Medicare first.
283	Modifier billed is not valid for the procedure code billed.
285	Procedure billed not covered for FQHC facility.
295	Production provider cannot bill claims for test recipient and or test provider cannot bill claims for production recipient.
300	Provider not enrolled for VFC program.
304	The operating physician's license number is missing.
310	Detail submitted charge amount invalid.
311	The noncovered charge amount is invalid.
313	Admitting diagnosis code is invalid.
314	Outpatient Span billing is limited to no more than one calendar month per claim.
315	DOS cannot span 1999 and 2000. Split bill claim.
319	Covered days are greater than certified days. Refile only for certified days up to Medicaid's limitation.
320	PSRO/UR data is invalid.
322	Date of surgery is invalid or operating physician's license is missing.
325	This service is pending approval and code assignment. Contact EDS for information.
326	Injectable is currently on the list.

EOB Code	Description
333	Claim adjudicated previous to September 30, 1999.
355	Procedure code missing/invalid or invalid modifier.
356	This drug is not available as an injectable.
357	Payment amount, if any, represents the maximum payment allowed by Medicaid.
361	Payment has been reduced or denied due to the application of copay.
362	Copay and Medicare and other third party payments have reduced/denied payments.
363	Payment, if any, represents the allowance made by Medicaid after considering Medicare liability.
364	Medicaid allowed amount reduced by other insurance.
365	Fee adjusted to maximum allowable.
366	Other insurance paid an amount greater than or equal to our allowed amount. Medicaid cannot make any additional payment.
367	Paid in full by Medicaid.
368	This service is not covered by Medicaid.
369	This service was covered in full by Medicare.
370	The assistant surgeon's fee for this procedure is not covered.
371	Recipient resources exceed the Medicaid allowed amount.
389	Claim was denied because EDS had no record of the prior authorization.
390	Provider number on claim does not match provider number on PA file.
391	The DOS spans a PA segment change. Call EDS Provider Assistance Center at 1-800-688-7989 for assistance.
392	Units of service exceed the authorized units on the PA file.
393	Recipient's Medicaid number does not match the Medicaid number on the PA file.
397	Prior authorization number shown on the claim is invalid.
398	Claim allowed charge is more than the authorized amount on the PA file.
399	Service requires Prior Authorization.
400	Procedure is limited to six (6) per calendar month.
401	Procedure is limited to fifteen (15) per calendar month.
402	Procedure is limited to one (1) every two years.
403	Procedure is limited to thirty (30) per month.
404	Procedure is limited to sixty (60) per calendar month.
405	Procedure code is limited to 100 per month.
409	Procedure code is limited to forty (40) per calendar month.

EOB Code	Description
410	This procedure is limited to sixteen (16) units per calendar year.
412	Family Planning periodic follow-up is limited to four (4) visits per year.
414	OB ultrasound limit has been reached for this recipient. Any further billing will require prior authorization.
415	Screening mammography is limited to one per year.
416	The limit of two units per month has been exceeded for this procedure.
417	Procedure code not covered when billed on the same day.
418	Provider specialties within the same group cannot bill services for the same recipient for the same date of service.
419	The same recipient cannot be billed for the same date of service with the same diagnosis code.
421	Subsequent procedure included in primary anesthesia charge.
423	The quantity dispensed exceeds the maximum quantity allowed for the drug code prescribed.
424	Medicaid has no liability for this claim since Medicare/Medicaid days run concurrently.
425	Provider eligibility determination is being made. Please do not rebill.
426	Claim in process due to review of claim history. Please do not resubmit.
427	Claim still in process. Please do not rebill.
428	Third party liability suspect.
429	Recipient eligibility determination is being made. Please do not rebill.
430	Please do not rebill. Claim is being reviewed by medical consultant.
437	Vision and hearing screening is limited to one per year.
441	Number of Home Health visits exceed limit.
442	The yearly limit for this procedure has been exceeded.
443	The yearly limit for this procedure has been exceeded.
444	The yearly limit for this procedure has been exceeded.
445	The yearly limit for this procedure has been exceeded.
452	The quantity dispensed is not numeric or exceeds the maximum quantity allowed for the drug code prescribed.
473	This procedure is limited to eighteen (18) units per calendar year.
476	Lab services must be billed with combination code. See CPT.
478	This claim does not contain required data to determine Medicaid liability for coinsurance days/lifetime reserve days.

EOB Code	Description
483	The limit of four units per month has been exceeded for this procedure.
484	The limit of three units per month has been exceeded for this procedure.
489	The limit for these services has been reached for this contract year.
491	Exact duplicate of another pharmacy claim.
493	Duplicate RX code, refill number, and NDC.
501	Our records show this service for the date(s) of service billed is a duplicate.
505	Our records show this service for the date(s) of service billed is a duplicate.
511	Our records show this service for the date(s) of service billed is a duplicate.
513	Our records show this service for the date(s) of service billed is a duplicate.
515	Our records show this service for the date(s) of service billed is a duplicate.
531	Our records show this service for the date(s) of service billed is a duplicate.
532	Our records show this service for the date(s) of service billed is a duplicate.
535	Our records show this service for the date(s) of service billed is a duplicate.
538	A cardiologist or a radiologist cannot bill this procedure code on the same day.
539	This procedure code is limited to one per calendar month.
542	Procedure code is not covered when billed on the same day.
544	Our records show this service for the date(s) of service billed is a duplicate.
559	Inpatient/outpatient/ASC visits have been exceeded for the calendar year.
560	Outpatient visits have been exceeded for the calendar year.
564	This ambulance service procedure code is limited to 4 units per calendar month.
571	Dialysis ultrafiltration codes Z5256 and Z5266 are limited to a total of 3 per recipient.
574	More than one contact lens fitting cannot be billed for the same date of service.
576	This procedure is part of another procedure performed on the same day.
577	Units billed for procedure code exceed maximum units allowed.
579	Independent rural health clinic cannot be paid for more than one service per day.
580	Administration fee may not be billed on the same day as an office visit and/or vaccine replacement.
587	Procedure limited to 720 hours per calendar year.
592	Vision and hearing screens must be billed with a regular screen and are limited to once per year.

EOB Code	Description
593	The yearly limit for this procedure has been exceeded.
597	A screening/assessment has already been paid for this recipient for this calendar year.
599	Duplicate ICN on History.
618	01351 is limited to once per tooth per recipient's lifetime.
622	This procedure is limited to one per post partum period.
624	Procedure code Z5181 will not be paid on same date of service as Z5182-Z5184 for the same recipient.
625	Fails when global fee paid to ophthalmologist or claim for follow-up care paid to optometrist.
628	EPSDT visit has been paid for this recipient for same date of service.
632	Only one type of respite care is allowed for a given date of service.
633	Residential services and respite care are not allowed for the same date of service.
634	Procedure limited to 720 hours per waiver year October 1 - September 30.
638	More than one encounter code cannot be billed on same date of service without justification excluding dental.
639	Vaccine cannot be billed on the same day.
641	This procedure is limited to one episode a year.
642	This procedure is limited to 52 units a year.
643	This procedure is limited to 10 units per year.
644	Procedure code is limited to 104 units a year.
647	This procedure is limited to 365 episodes a year.
649	This procedure is limited to 832 units per calendar year.
651	Procedure code is limited to 208 units a year.
653	Procedure is limited to 120 units a year.
654	Procedure is limited to 260 units a year.
658	Procedure is limited to 8 units a year.
659	Procedure code is limited to 312 units a year.
660	Procedure is limited to 1040 units a year.
662	This procedure is limited to 2016 units a year.
663	Procedure codes 92553, 92556 and 92557 cannot be billed on the same day by the same or different provider.
665	Services cannot be billed on the same day by the same provider.
670	Procedure code is limited to 130 units per calendar year.
671	Procedure code is limited to twenty (20) per calendar month.
672	Procedure code is limited to 120 times per calendar year.
673	Procedure code is limited to 365 times per calendar year.

EOB Code	Description
674	Services cannot be billed on the same day for the same recipient.
676	Procedure cannot be billed on the same day as critical care.
677	Services cannot be billed on the same day for the same recipient.
678	Services cannot be billed on the same day by the same provider.
679	Services cannot be billed on the same day by the same provider.
680	Services cannot be billed on the same day by the same provider.
681	This service is not allowed on the same day as day treatment.
683	Yearly limit for crisis intervention has been exceeded.
685	Services cannot be billed on the same day by the same provider.
686	Only one service is payable per date of service.
687	Clinic codes Z5145-Z5149 cannot be billed on the same day with same unique number as 99241-99245 and 99282-99285.
688	Dental encounter (09430) limit one per day, per recipient, per provider.
689	Only one hospital admission may be billed per hospital stay.
691	Post partum visit will not be paid on the same day as prenatal visit.
695	Procedure code A0330 is an inclusive code. Only mileage and return trip oxygen may be billed in addition.
696	Prenatal visit not covered for the same date of service as family planning.
707	Initial screening is limited to once per lifetime.
708	Psychotherapy services are limited to twelve per calendar year at place of service "21" (Inpatient).
710	Diagnostic assessments are limited to one encounter per calendar year.
711	Individual therapy and group therapy may not be billed on the same day.
718	New patient code Z5147 may only be billed once per lifetime per recipient.
719	The procedure code billed is limited to one unit per day.
723	Procedure code is limited to 156 units per calendar year.
728	Procedure code is limited to 12 per lifetime.
733	This service is included in the facility fee.
739	Combination Lens Codes cannot be billed for the same date of service.
741	MHSP Clinic visit limit has been exceeded.
743	Provider may not bill for newborn resuscitation unless life threatening.
744	EPSDT screening limit has been exceeded.
746	Hospitalization day treatment Z5432 is limited to 60 units per year.

EOB Code	Description
752	Maximum care coordination units have been reached for this recipient.
753	More than one obstetrical delivery code may not be bill within six months.
758	Chemistry profiles must be billed using one multichannel test code.
760	Initial visit is limited to one per recipient, per provider, per lifetime.
761	This procedure code is limited to one every calendar year.
762	Procedure code Z5183 not covered on the same day as Z5185.
763	Family Planning Counseling not covered on the same day as prenatal visit.
764	This procedure is not covered when billed with medical psychotherapy codes.
767	Procedure limited to 624 units per calendar year.
769	Secondary surgical procedure within the same incision paid at 50% of Medicaid allowed.
770	Procedure code is limited to one occurrence every six months.
771	Maximum unit limit has been exceeded.
773	Procedure codes 95115, 95117 or Z4998 shall not be paid on the same day as procedure codes 95120-95134.
774	Procedure codes 95120 - 95134 shall not be paid on the same day as procedure codes 95135 - 95170.
775	Procedure code not allowed on the same day (95115 and 95117).
776	Procedure codes not allowed on the same day as (95130 - 95134).
777	Procedure not covered when billed with procedure codes 90918-90947.
778	Only one outpatient observation visit may be billed per day.
779	Procedure code cannot be billed on the same day with procedure codes Z5181-Z5184 and Z5185.
780	Procedure code is limited to one per recipient within 60 days of delivery.
781	Prenatal visit will not be paid on the same day as postpartum visit.
782	Prenatal visit not covered for the same date of service as family planning.
784	Procedure not covered when billed with 76805, 76810 or 76816 on the same day.
785	Procedure not covered when billed with 76805 on the same day.
788	Procedure code 11975 is limited to one every 365 days and procedure code 11977 cannot be billed within 60 months of insertion.
789	Only one initial NICU procedure may be billed per hospital stay.
790	Procedure is limited to two per year.
791	The same physician may not bill intubation and newborn resuscitation on the same day.

EOB Code	Description
793	Binaural Hearing Aid Repair is limited to two every six months.
794	Standby/resuscitation cannot be billed together on the same day as NICU code.
795	These Norplant services must be billed using the appropriate combination code only.
799	Requested inpatient hospital services partially exceed limit of 16. Rebill for remaining date.
801	The allowed lens limitation has been exceeded.
802	Newborn code may not be billed more than once.
804	The allowed frames limitation has been exceeded.
805	The allowed eye exam limitation has been exceeded.
806	Batteries may not be purchased within 60 days of purchase of hearing aid.
807	Procedure limited to one service during 60-day postpartum period.
808	Monaural hearing aid batteries are limited to one package every two months.
809	Monaural earmolds are limited to one every four months.
810	Hearing aid repair is limited to once every six months.
812	Chemistry profile and chemical panel cannot be billed on the same day.
814	The purchase of a hearing aid stethoscope is limited to one every two years.
815	Electroshock therapy may not be on the same day as a hospital visit.
816	The limit of three units per month has been exceeded for this procedure.
818	Multiple urinalysis tests cannot be billed on the same day.
820	The allowed fitting limitation has been exceeded.
821	EPSDT screening has been exceeded.
822	This procedure code is limited to one per month.
823	Full series/panoramic X-rays are limited to one every 3 calendar years.
824	Salpingectomy will not be paid on the same day as a tubal ligation.
825	Procedure is limited to one service every three months.
826	Multiple chemistry test cannot be billed on the same day. Please rebill with appropriate chemistry profile.
827	Code, service, procedure, NDC, or stay requires prior authorization.
828	Our records indicate that this service has already been performed on this recipient.
829	Binaural are limited to two every four months.
830	Specimen collection fee is limited to one per day.
831	Components of a CBC may not be billed on the same day as a complete CBC.

EOB Code	Description
832	Binaural hearing aid batteries are limited to two packages every two months.
833	Emergency room visit/initial hospital visit may not be billed on the same day.
837	Procedure code is limited to one in a series.
839	Professional components and hospital visits may not be billed on the same day.
842	Comprehensive dental exam may only be billed once per lifetime per provider.
845	EPSDT vision screen and external ocular photography not covered on the same day.
846	Prevocational services and supported employment shall not be paid on the same day.
847	More than three office visits may not be billed with pregnancy diagnosis.
849	This procedure cannot be billed in addition to the delivery code billed.
850	Biopsy of ovary may not be billed with another exam on the same day.
851	Exploratory lap/lysis of adhesions may not be billed on the same day with other related surgery.
852	This x-ray procedure may not be billed within thirty days of a root canal.
853	Procedure code not covered when billed on the same day as Z5270, Z5271, or Z5272.
854	Emergency oral exam may not be billed with definitive treatment on the same day.
855	The same physician may not bill hospital visit and discharge visit on the same day.
858	Components of a urinalysis may not be billed on the same day as a urinalysis.
859	The same provider may not bill more than one new patient office visit per recipient in a three-year period.
860	Screening provider may not bill for screening exam and inclusive medical services on the same day.
861	Antepartum, postpartum care/vaginal delivery may not be billed with global OB care.
862	Leg bags are limited to two per month.
864	Hysterectomy ancillary codes may not be paid in addition to the hysterectomy procedure code.
865	Hospital admission/visits may not be billed on or after OB global.
867	Subsequent hospital care may not be billed on same day as initial hospital care.
868	Local anesthesia procedures are covered in the total OB cost and may not be billed separately with a delivery procedure code.
869	Family planning periodic revisit is limited to 4 - 6 visits per calendar year.
870	The same provider may not bill hospital visits/psychotherapy on the same day.
871	The same provider may not bill psychotherapy/office visits on the same day.

EOB Code	Description
872	Procedure is limited to one service at the time of or within 30 days prior to Norplant insertion.
873	Routine ancillary services associated with an abortion are covered in the total abortion cost and are not reimbursable separately.
875	Inpatient days have been exceeded for this calendar year.
877	Procedure is limited to one (1) every three years.
878	Physician is limited to one visit per day per recipient.
879	Admin fee may not be billed with this procedure.
883	Initial critical care limited to the 1st continuous/interrupted session. Resubmit with medical record.
885	Hospital visits and subsequent critical care may not be billed on same day.
886	Visual fields/tonometry is covered in the complete eye exam.
887	Catheters, catheter trays, and drainage bags are limited to two per month.
888	Post-operative physician services for the same diagnosis may not be billed within 62 days of surgery.
889	Requested inpatient hospital services exceed limit of 16.
890	Procedure code is not covered when outpatient surgical procedure is billed.
891	Physician office visit limitation has been exceeded.
893	More than one obstetrical delivery code may not be billed within six months.
895	Routine prenatal lab, office/hospital visits may not be billed with global OB procedure.
896	Postpartum services may not be billed with global OB on or within 62 days of delivery.
897	Outpatient chemotherapy and emergency department service codes may not be billed on the same day.
900	Prescription number cannot be spaces or zeros.
901	The quantity dispensed is missing or invalid.
902	Medicaid billing authorization form (XIX-TPD-1-76) is required for this claim.
903	Days supply is greater than authorized days, or is invalid.
904	Date prescribed is invalid.
905	Emergency indicator is invalid.
906	This schedule II drug is not refillable.
907	The prescribing provider's license number is missing or invalid.
908	Dispense date is earlier than date prescribed.

EOB Code	Description
909	The claim net charge is missing, calculated incorrectly or equal to zero.
910	EPSDT indicator is invalid.
911	Refill number is invalid or greater than the refill authorization.
912	Detail DOS not within the header DOS.
914	The admission hour field must be numeric and between 00 and 23.
915	Employment Indicator invalid.
916	Discharge hour is invalid; must be between 00 and 23.
917	Non-covered days are invalid.
918	Occurrence code 1, 2, 3, or 4 is invalid.
919	The occurrence dates are invalid or a future date.
920	Occurrence date 1, 2, 3, 4, or 5 is not between FROM and TO dates of service.
921	Condition codes are invalid. Refer to Alabama Medicaid guidelines.
922	Payment denied because third party amount is greater than total submitted charge, missing or not numeric.
923	Surgery, occurrence, and/or condition count is missing or invalid.
924	Occurrence span code is invalid.
925	Occurrence span date is invalid.
926	Accident related indicator is invalid. Medical billing authorization form (XIX-TPD-1-76) is required for this claim.
929	Detail count missing or invalid.
930	Dispense as written code invalid.
950	DUR conflict, intervention, or outcome codes are invalid.
951	Previous DUR alerted claim cannot be found.
952	Previously alerted claim cannot be overridden.
995	Claim Recouped. Provider must resubmit services on separate claims in order to be considered for payment by Medicaid.
997	Claim contains 15 or more errors and therefore cannot be processed as billed.
998	Claim has been suspended temporarily and will release next cycle.

J.2 Adjustment EOB Codes

EOB Code	Description
953	Special adjustments - Please refer to our mini message included in your Explanation of Payment.
954	This claim has been adjusted to reflect a change in codes as billed.
955	This claim has been adjusted to reflect changes in the number of units billed and paid.
956	This claim has been adjusted to reflect a change in the type of service.
957	This payment has been recouped to enable payment to the correct provider.
958	This claim has been adjusted to reflect a change in the original amount billed.
959	This claim has been recouped to enable the processing of a corrected billing.
960	This claim has been adjusted to reflect payment by other insurance.
961	This claim has been adjusted to reflect a change in coinsurance and/or deductibles.
962	Other - If you have any questions resulting from this adjustment, please contact our correspondence/inquiry unit.
963	Claim adjusted to correct the number of RN/Aide visits.
964	This claim has been adjusted to reflect correct recipient resources.
965	This claim has been adjusted to make changes to the dates of service.
966	This claim was a retroactive adjustment due to recipient's eligibility.
967	This claim has been recouped to reflect claim payment by other insurance.
968	Claim adjusted to reflect a rate charge.
969	Claim adjusted/recouped because inpatient/outpatient visits have been exceeded for a calendar year.
970	This claim has been recouped/adjusted due to a duplicate payment.
971	Refer questions resulting from this recoupment to Third Party, Alabama Medicaid Agency (334)242-5253.
972	Claim adjusted due to the receipt of a refund check.
973	As a result of a drug rebate review, this claim has been adjusted to correct the quantity dispensed.
974	Claim adjusted to reflect a change in the revenue code.
975	Claim adjusted to reflect a change in the place of service.
976	Claim recouped because no XIX-TPD form was attached to the original claim. Please refile with XIX-TPD.

EOB Code	Description
977	Adjustment/recoupment due to surveillance/ utilization review.
978	Claim recouped because inpatient stay and outpatient visit not allowed on same day.
979	Claim adjusted to correct erroneous copay deduction.
980	Claim adjusted to add/delete modifier.
981	Claim adjusted/recouped because inpatient physician dates of service are limited to 16 per year.
982	As a result of the drug rebate review, this claim has been recouped/adjusted to correct the NDC.
983	Claim adjusted/recouped because physician office visits have been exceeded for calendar year.
984	Claim adjusted/recouped because home health visits have been exceeded for the calendar year.
985	Claim adjusted/recouped because ASC visits have been exceeded for the calendar year.
986	Claim adjusted recouped to correct the EPSDT referring information.
987	Claim adjusted/recouped because rural health visits have been exceeded for the calendar year.
988	Claim adjusted/recouped because FQHC visits have been exceeded for the calendar year.
989	This claim was recouped per your request.
990	This claim has been adjusted to reflect a change in the dispense as written value code.
991	Recipient has become retroactively eligible for Medicare for dates of service billed. File Medicare.
992	This claim was recouped because the PMP did not authorize the referred service
994	Claim recouped because recipient retroactively added as member of BAY Health Plan. File claim to BAY Health Plan.

J.3 Electronic Up-Front Rejections

Rejection Code	Description
0010	HEADER from date of service invalid
0011	HEADER from date of service cannot be a future date
0012	Census date cannot be a future date
0013	Census date is invalid
0014	Census date cannot be for current month
0020	Admission date is invalid
0021	The Admit date cannot be in the future
0022	The Admit date cannot be Greater than the Billing From date of service
0030	Header TO date of service invalid
0031	Header TO date of service cannot be a future date
0032	Header to DOS cannot be prior to the from DOS
0040	Total Non covered Charge is invalid
0050	Surgery date 1 not between admit and to DOS
0051	Surgery date 2 not between admit and to DOS
0052	Surgery date 3 not between admit and to DOS
0060	Detail billed amount equal or less than detail non-covered charge
0070	Number days / billing period disagree
0080	Header To DOS is beyond the 365-day filing limit
0081	Header To DOS is beyond the 120-day filing limit
0082	Header To DOS is beyond the PHP filing limit
0083	Previous RA Date is invalid or beyond the 365-day filing limit
0100	Procedure limited to revenue code 450
0110	Recipient eligible for Bay Health Plan, file w/ Bay Health
0130	Neonatal revenue code/diagnosis code mismatch
0140	Modifier is required for billed procedure
0141	Modifier is required for transportation related service
0150	Transportation service must be medically necessary
0170	Recipient is not eligible
0180	Home health / therapy services cannot be billed together
0190	HIV counseling code billed without HIV Planning code
0200	Family planning procedure code Z5190 must be accompanied by procedure code Z5195
0210	Physical therapy cannot be billed with other services

Rejection Code	Description
0220	Days covered invalid
0230	Organ transplants require prior approval
0250	Unborn recipient eligible only for infant services
0260	EPSDT referred therapy services restricted to POS 11 or 99
0270	Modifier 1 valid only on crossover claims
0271	Modifier 2 valid only on crossover claims
0290	Type of bill invalid
0300	Units must be numeric
0301	Units must be greater than zero
0310	Detail rate submitted is invalid
0320	Modifier 1 not effective for DOS
0321	Modifier 2 not effective for DOS
0330	Invalid revenue code for recipient over one year old
0331	Invalid revenue code for recipient one year old or younger
0340	Cataract services require proper modifier to be billed
0360	Submitted rate, units, and detail charge do not balance
0370	Nursery days must not exceed 10 under mother's number
0371	Nursery days/revenue codes invalid
0380	Pricing file indicates zero price – contact EDS
0390	Services not covered for indicated diagnosis
0400	QMB/EPSDT service limited to QMB/EPSDT related claim
0401	SNF can only bill for QMB recipient
0420	Services must be EPSDT referred for recipient's over 21
0430	Billed amount must be greater than zero
0431	Billed amount must be numeric
0440	Medicare paid amount is Missing or Invalid
0450	Medicare Allowed amount is Missing or Invalid
0451	Medicare allowed amount must be greater than zero
0460	Medicare Total Bill amount is Missing or Invalid
0470	Co-insurance amount is invalid
0471	Co-insurance amount does not balance
0480	Referring physician required on EPSDT referral
0481	Referring physician not on file
0482	Referring physician must be an EPSDT screening provider
0500	EPSDT screenings limited to EPSDT screening providers

Rejection Code	***Description***
0510	Patient status invalid
0520	Medicare header allow amount not equal sum of detail Medicare allow amounts
0530	Net billed amount not equal to sum of detail charges less TPL amount
0540	Sum of detail non-covered charges does not equal header non-covered charges
0550	Billed amount not equal to sum of the detail charge amounts
0560	Medicare header Paid amount not equal sum of detail Medicare Paid amounts
0570	Ten units of Z5294 must be billed before Z5295
0580	Service for Maternity Waiver/Care recipient must be billed with Global Service Fee
0590	Maternity Waiver/Care Claim must be billed by Contract Provider
0591	Maternity Waiver/Care Contract Provider can only bill Maternity Waiver/Care claims
0600	Recipient is ineligible for maternity waiver services
0610	Injectable/non-injectable procedures cannot be billed together for EPSDT County Health providers
0620	Inpatient FQHC services cannot be billed with other FQHC services
0630	Recipient has no county code on eligibility file
0640	Invalid procedure for FQHC crossover claim
0650	Procedure code billed is invalid for the provider
0660	Admit type is invalid as billed
0670	Maternity waiver restriction
0680	Hospice coinsurance amount exceeds $100
0681	Hospice claim requires coinsurance amount
0690	Dental sealants not payable for this recipient
0691	Dental sealant not payable for tooth number specified
0710	Invalid place of service for FQHC provider
0720	Provider has no Level 1 records on file
0721	Procedure code not on Level 1 for the provider and date of service
0722	Procedure code no longer covered for provider
0730	Family planning service not covered for this recipient
0731	Family planning services (surg code 1) not covered for this recipient
0732	Family planning services (surg code 2) not covered for this recipient
0733	Family planning services (surg code 3) not covered for this recipient
0740	EPSDT only provider must bill EPSDT referral
0760	Diagnosis code billed is not covered for MHSP
0780	Critical care procedures cannot span more than two days

Rejection Code	***Description***
0790	Procedure code not valid for Renal Dialysis Facility
0810	Procedure code cannot be billed with type of bill 141
0820	Dates exceed SOBRA/QMB eligibility
0840	Service is not covered for a SOBRA eligible recipient
0860	Recipient not eligible for targeted case management
0870	Different TCM procedure codes must be billed on separate claims
0880	CLIA number not on file
0881	CLIA number invalid for DOS
0882	Provider certified for CLIA PPMP or waiver procedure codes only
0883	Provider certified for CLIA waivered procedure codes only
0890	Medicare Paid amount equal 100%
0900	Global delivery procedure code cannot be span dated
0930	Details covered by more than one plan within managed care program, split bill
0931	Not all details covered by same managed care program, split bill
0932	Recipient partially covered by managed care plan, split bill
0933	Recipient partially covered by subcontract managed care plan, split bill
0934	Services partially covered by managed care plan, split bill
0980	Service not covered by Medicaid
0981	Revenue code not covered by Medicaid
0990	Medicare Deductible amount is invalid
1000	Detail from date of service invalid
1001	Detail from date of service cannot be a future date
1010	Detail TO date of service invalid
1011	Detail TO date of service cannot be a future date
1012	Detail to DOS cannot be prior to the from DOS
1020	Detail DOS beyond the 365-day filing limit
1021	Detail DOS beyond the 120-day filing limit
1022	Detail DOS beyond the 180-day filing limit
1023	Previous RA Date is invalid or beyond the 365-day filing limit
1030	Therapy code payable only with therapeutic treatment
1050	Service included in revenue code 450 facility fee
1070	Patient 1st claim requires PMP provider on claim
1090	Observation code must be billed with facility fee
1100	Invalid deductible amount for skilled nursing facility

Rejection Code	Description
1110	Inpatient/Outpatient non-covered revenue codes for EPSDT referred claims
1130	Procedure not covered for an Ambulatory Surgical Center
1140	Service non-payable for recipient < six months of age
1260	Tooth surface is required for procedure
1261	Tooth surface is invalid
1263	Duplicate tooth surface indicated
1280	Tooth number is required for procedure
1281	Tooth Number is invalid
1300	Invalid claim type for Plan First Program
1310	Service is only covered under the Plan First Program
1320	Birth control pills must be received from a physician for the Plan First Program
1330	Plan First Recipient must be seen by a Plan First Network Provider
1340	Plan First Recipient is only eligible for Plan First Services
1360	Place of service code is invalid.
1440	Place of service is not valid for provider type
1450	First modifier is invalid
1451	Second modifier is invalid
1460	Procedure code is inappropriate for this provider type
1470	First modifier is invalid for procedure code billed
1471	Second modifier is invalid for procedure code billed
1480	Place of service code is invalid for procedure
1490	Procedure code is inappropriate for the recipient's age
1491	Revenue code is inappropriate for the recipient's age
1499	NDC is inappropriate for the recipient's age
1500	Procedure code is inappropriate for the recipient's Sex
1501	Revenue code is inappropriate for the recipient's Sex
1509	NDC is inappropriate for the recipient's Sex
1510	Procedure code not found for DOS
1511	Revenue code not found for DOS
1515	Service dates span procedure code effective date segments
1516	Service dates span revenue code effective date segments
1519	NDC is invalid for DOS
1520	Service code missing or invalid
1521	Revenue code missing or invalid
1529	NDC is not on file

Rejection Code	Description
1530	Diagnosis is inappropriate for the procedure being billed
1540	Procedure code is inappropriate for this provider specialty
1550	Procedure code invalid for claim type
1551	Revenue code invalid for claim type
1560	Procedure code is on review for the provider
1610	Procedure invalid for service performed
1611	Revenue code invalid or not on file
1620	Units Billed Exceed Max Allowed Per Day
1640	Accommodation units do not equal covered days
1641	No accommodation revenue codes billed
1790	Sterilization claim requires prior consent
1791	Sterilization claim is not permitted for recipient less than 21
1800	Hysterectomy claim requires prior consent
1810	Abortion claim requires prior consent
1820	No consent form on file for recipient and date of consent
1900	Primary diagnosis is not on file
1910	Secondary diagnosis is invalid
1920	Third diagnosis is invalid
1930	Fourth diagnosis is invalid
1940	Primary diagnosis is not appropriate for recipient age
1950	Secondary diagnosis is not appropriate for recipient age
1951	Header diagnosis 3 is not appropriate for recipient age
1952	Header diagnosis 4 is not appropriate for recipient age
1960	Primary diagnosis is not appropriate for recipient sex
1970	Secondary diagnosis is not appropriate for recipient sex
1971	Header diagnosis 3 is not appropriate for recipient sex
1972	Header diagnosis 4 is not appropriate for recipient sex
2050	Detail diagnosis is not on file
2060	Detail diagnosis is not appropriate for recipient sex
2070	Detail diagnosis is not appropriate for recipient age
2200	Provider does not have authorization to bill electronically
2210	Provider is deceased on DOS being billed
2220	Provider address on file is not current – mail returned
2230	Provider suspended from the Medicaid program
2240	Provider has been canceled

Rejection Code	***Description***
2250	Provider rate not found for the date of service billed
2260	Claim type is not valid for this provider
2261	Census transaction not valid for this provider
2270	Provider not eligible for Medicaid
2280	Provider is ineligible on DOS being billed
2281	Provider is ineligible for census date
2290	Provider number is invalid
2291	Provider number is not on file
2292	Provider name and number disagree
2293	Provider specialty not found for date of service submitted
2300	Attending Physician's License Number Is Missing
2330	Referring provider not on file or not a valid referring provider
2350	Billing provider must be group provider number
2360	Performing provider cannot be group provider number
2370	Provider number is Not on File
2371	Provider Action reason code segment is 40,42,49 or 50 Canceled
2372	Provider Action reason code segment is 41 - Deceased
2380	Performing provider not associated with the group
2390	Provider eligible for only QMB recipients
2480	Eligible for Medicare only-no Medicaid or QMB benefits
2500	Recipient number not on file
2501	Recipient number missing or zeroes
2502	Recipient on Xref but not on Base-Call EDS
2510	Recipient has an unusable record – contact EDS
2530	Recipient is deceased before the request date
2540	Recipient is totally ineligible for header DOS
2550	Recipient is partially ineligible for header DOS
2580	Recipient is locked in to a specific provider/locked out of a specific drug
2581	Recipient is locked in to a different provider
2582	Recipient is locked out of specific drugs
2583	Recipient is locked out of controlled substances
2590	Recipient's ID is invalid for the recipient's first name
2591	Recipient's name is missing or invalid
2620	Recipient is totally ineligible for detail DOS
2630	Recipient is partially ineligible for detail DOS
2640	Recipient ineligible for geriatric or inpatient psychiatric services
2670	Census data not on file for provider for the previous month

Rejection Code	***Description***
2700	Recipient is not on the LTC eligibility file for the date of service
2720	Provider does not match provider on LTC file for recipient
2760	Recipient ineligible for waivered service
2761	Recipient ineligible for waivered services from this provider
2762	Provider not eligible for waivered services
2800	Recipient has other medical coverage – file third party carrier first
2820	Recipient is Medicare suspect
2830	Type Of Service Not Valid For Modifier 1
2831	Type Of Service Not Valid For Modifier 2
2850	FQHC Facility Restricted Services through Dos 12/31/97
2920	Procedure code / TOS invalid for radiology facility
2950	Production provider cannot bill claims for test recipient
2951	Test provider cannot bill claims for production recipient
3000	Vaccine procedure only payable under vaccines for children program
3040	Surgery provider number is invalid
3100	Charge amount is invalid
3110	Non covered charge amount is invalid
3130	Admitting diagnosis is not on file
3140	From DOS and to DOS must be within the same month
3150	From DOS and to DOS must not span the calendar year 1999 to 2000
3190	Covered days greater than certified days
3200	PSRO approved from date is invalid
3201	PSRO approved to date cannot be a date in the future
3202	PSRO approved to date is invalid
3203	PSRO approved from date cannot be after the PSRO approved to date
3220	Surgery date 1 required if surgery procedure code 1 present
3221	Surgery date 2 required if surgery procedure code 2 present
3222	Surgery date 3 required if surgery procedure code 3 present
3229	Operating physician required if surgery procedure(s)are present
3570	Submitted Charge Greater Than Six Times The Allowed
3890	Prior authorization number is not on file
3891	Prior authorization number is not numeric
3900	Claim and prior authorization provider do not match

Rejection Code	Description
3910	Prior authorization required dates overlap dates of service on claim
3970	PA number does not match procedure billed
3971	PA number does not match dates of service billed
3980	Allowed charges exceed authorized dollars on PA file
3990	Prior authorization required
3991	Prior authorization required for inpatient pysch related services
3992	Prior authorization required for certain transportation services
3993	Prior authorization required for place of service billed
3994	Prior authorization required for personal care/private duty nursing
3995	Private duty nursing services require PA and a EPSDT screening referral
3996	Inpatient services for Plan First recipients limited to prior authorized tubal ligations
4910	Duplicate pharmacy claim for date of service and GCN
4930	Duplicate RX code, refill number, and NDC
9000	Prescription number is missing or invalid
9010	Drug quantity cannot be zero
9011	Drug quantity must be numeric
9030	Days supply greater than authorized days
9031	Days supply equal to zero
9032	Days supply must be numeric
9040	Date prescribed is invalid or missing
9070	Prescribing provider's license number is not on file
9071	Prescribing provider's license number is inactive
9080	Date dispensed is prior to date prescribed
9110	Refill number exceeds refills allowed for NDC
9111	Refill indicator not numeric
9300	Medical necessity (DAW) indicator is invalid
9301	Medical necessity (DAW) indicator is not numeric
9500	DUR conflict code is invalid
9501	DUR intervention code invalid
9502	DUR outcome code invalid
9510	Previous DUR alerted claim cannot be found
9520	Previously alerted claim cannot be overridden – corresponding alert not found
9521	Previously alerted claim cannot be overridden – outcome indicates no change, DUR fields changed
9522	Previously alerted claim cannot be overridden – outcome indicates change, DUR fields not changed

Rejection Code	Description
9523	Previously alerted claim cannot be overridden – alert requires a PA override
A030	Max quantity exceeded for 30-day period
Z010	EPSDT screening type is invalid
Z030	Employment related indicator is invalid
Z040	Accident related indicator is invalid
Z050	Emergency indicator is invalid
Z090	Net billed amount is invalid
Z100	EPSDT indicator is invalid
Z110	Detail DOS not within the header DOS
Z111	Calculated TDOS not within header DOS
Z140	Admission hour is invalid
Z160	Discharge hour is invalid
Z170	Non-Covered days are invalid
Z180	Occurrence code 1 is invalid
Z181	Occurrence code 2 is invalid
Z182	Occurrence code 3 is invalid
Z183	Occurrence code 4 is invalid
Z184	Occurrence code 5 is invalid
Z190	Occurrence Date 1 is invalid
Z191	Occurrence Date 2 is invalid
Z192	Occurrence Date 3 is invalid
Z193	Occurrence Date 4 is invalid
Z194	Occurrence Date 5 is invalid
Z200	Occurrence date 1 not between from and to DOS
Z201	Occurrence date 2 not between from and to DOS
Z202	Occurrence date 3 not between from and to DOS
Z203	Occurrence date 4 not between from and to DOS
Z204	Occurrence date 5 not between from and to DOS
Z210	Condition code 1 is invalid
Z211	Condition code 2 is invalid
Z212	Condition code 3 is invalid
Z213	Condition code 4 is invalid
Z214	Condition code 5 is invalid
Z220	Invalid TPL indicator
Z221	TPL amount must be numeric
Z222	TPL denial date required if TPL amount = zero
Z223	TPL denial date cannot be a future date
Z224	TPL denial date invalid
Z225	Third party amount (TPL) exceeds total billed
Z226	TPL amount present/TPL indicator missing
Z227	Third party rejection must be billed on paper with doco attached

Rejection Code	***Description***
Z230	Surgery count missing or invalid
Z231	Occurrence count missing or invalid
Z232	Condition count missing or invalid
Z240	Total licensed beds must be equal or less than on file
Z250	Medicaid recipient counts must be numeric
Z251	Medicaid applicant counts must be numeric
Z252	Non-Medicaid recipient counts must be numeric
Z253	Non-Medicaid admit counts must be numeric
Z254	Non-Medicaid death counts must be numeric
Z255	Non-Medicaid transfer counts must be numeric
Z256	Non-Medicaid discharge counts must be numeric
Z310	Social Security number not found
Z311	No recipient found that matches request
Z312	Multiple recipients found, resubmit with additional and/or corrected information, or use recipient ID
Z313	Last name does not match SSN
Z314	First name does not match SSN
Z315	Middle initial does not match SSN
Z316	Date of birth does not match SSN
Z800	Claim has already been reversed.
Z801	RX number not found on claim
Z802	Duplicate RX on file, cannot reverse claim.
Z803	RX number is not numeric
Z810	Invalid ICN
Z811	ICN not found on claim file.
Z812	Invalid ICN for claim type.
Z813	Claim has already been reversed.
Z820	Recipient ID/claim record mismatch
Z830	Provider ID/claim record mismatch
Z840	Claim can only be reversed the same day as submitted
Z990	Detail count missing or invalid

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	A A R P 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
00461	Prudential Insurance Company	Jacksonville, FL

Company Code	***Company Name***	***City, State***
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
02001	Federal Employee Program, BCA/BSA	Birmingham, AL

Company Code	*Company Name*	*City, State*
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
10571	Travelers	Charlotte, NC
10579	Great West Life	Atlanta, GA
10655	New E R A	Houston, TX

Company Code	***Company Name***	***City, State***
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
98928	Tyson Foods	Heflin, AL
98929	Tyson Foods	Blountsville, AL
98930	Tyson Foods	Ashland, AL

Company Code	Company Name	City, State
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
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

Company Code	***Company Name***	***City, State***
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
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

Company Code	*Company Name*	*City, State*
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
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

Company Code	*Company Name*	*City, State*
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
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

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, drug and procedure code pricing, and prior authorization requirements. 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.
Inquiring About Prior Authorization Information	Selecting the appropriate menu option and entering valid data to access information about approved prior authorizations.

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.1.2, Special Function Keys, that provides number combinations that correspond 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 EDS 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 on Saturdays, 9:00 AM to 5:00 PM 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, including check amount for the current checkwrite, and the number of suspended claims and total pending billed 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 EOP date for claim denials • Procedure code that denied (for non-pharmacy claims, as appropriate) • ICN and date the claim was voided for voided claims • ICN and date the claim was refunded for refunded claims

Press Menu Option	*To Retrieve Information About*
3	Recipient eligibility verification, 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 • County code • Message to indicate whether recipient has other insurance (if recipient has other insurance, providers should access the Other Insurance menu option that follows the eligibility response) • Maternity Care information, if applicable • Recipient aid category • Lock-in, lock-out, Long Term Care, and waiver information • 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; and other counts • **Other insurance** (option 3 on the sub-menu), including buyin information, HIC number, and the following third party policy information (for up to three policies): – Policy number – Company code – Subscriber name and SSN – Coverage dates – Policy coverage information – Coverage limitation (values are No restriction; Accident; Cancer; Medicare Supplement; and Managed Care) – Health Insurance Premium (HIP) information
4	Drug pricing information for the dispense date entered
5	Procedure code pricing information, including prior authorization requirements
6	Prior authorization verification, including recipient number, procedure code or NDC, start date, stop date, units authorized, and units used for the PA number entered

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 ‘05/14/99’ 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, most providers have nine-digit numbers, but some have eight-digit numbers), 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 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

Void Data

If you enter a string of data (for instance, a provider number or recipient number), and make a mistake, enter two asterisks (**) to indicate that all the data you have entered in the current field should be deleted, and the data following the asterisk should be used in its place. This does not delete any data you entered as a result of a previous AVRS prompt. The following example demonstrates this functionality:

You enter	1245**123456789
AVRS reads back this number	123456789
You enter	*21224***22224
AVRS reads back this number	B224

Cancel Function

To cancel a transaction, press *99# at any prompt. AVRS will return to the main menu.

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 prior authorization number

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 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)
- 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 Alabama Medicaid provider number. After AVRS verifies your provider number, the system returns the following information:

- Check amount for the current checkwrite
- Number of suspended claims and total pending billed 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 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 EOP 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 EOP 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 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.
- Allowed amount, from your Explanation of Medicare Benefits, 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 EOP date for claim denials
- Line item number, procedure or revenue code, and EOB code for each denied line item
- Message that claim has been voided, and the ICN for voided claim
- Message that claim has been partially refunded and ICN for partially refunded claim
- Message that claim has been fully refunded, and ICN for previous 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.5 Verifying Recipient Eligibility

To verify recipient eligibility, press 3 (the number three) from the Main Menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- A valid Alabama Medicaid recipient number, 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
- 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 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.5.1 General Eligibility Information

You can receive a faxed copy of the eligibility response. Instructions are provided below. 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
- County code
- Message to indicate whether recipient has other insurance (if recipient has other insurance, providers should access the Other Insurance menu option that follows the eligibility response)
- Maternity Care information, if applicable
- Recipient aid category
- Lock-in, lock-out, Long Term Care, and waiver information
- Managed care information, including plan name, PMP name, PMP 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 receive a fax of the eligibility information
- Press 3 to continue

Receiving a Fax

When you select Option 2, 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 and will repeat the menu options listed above.

Selecting Option 3 to Continue

Option 3 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.5.2 Benefit Limits

To access benefit limits 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 other counts
- Press 4 for screening information
- 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 receive a fax
- Press 3 to inquire on other limits for the recipient you entered
- Press 4 to continue

To receive a fax, select the appropriate option and enter your ten-digit fax number (three-digit area code plus seven-digit number), followed by the pound sign. If you select Option 4 (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

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
- 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.5.3 Other Insurance

AVRS provides Medicare and non-Medicare related information when you select the Other Insurance option. First, AVRS will identify whether the recipient you entered has no Medicare coverage, Medicare Part A, Medicare Part B, or both A and B. If the recipient has Medicare coverage, AVRS provides the Medicare HIC number.

AVRS then indicates the number of third party policies on file for the recipient. AVRS will provide the following information for up to three (3) third party policies:

- Policy number
- Company code
- Subscriber name and SSN
- Coverage dates
- Policy coverage information
- Coverage limitation (values are No restriction; Accident; Cancer; Medicare Supplement; and Managed Care)
- Health Insurance Premium (HIP) information

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

- Press 1 to repeat the response
- Press 2 to receive a fax
- Press 3 to continue

To receive a fax, select the appropriate option and enter your ten-digit fax number (three-digit area code plus seven-digit number), followed by the pound sign. 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.

L.6 Accessing Pricing Information

AVRS allows you to verify pricing information for NDCs and procedure codes.

L.6.1 Drug Pricing

To verify pricing information for drugs, press 4 (the number 4) from the main menu. AVRS prompts you for the following:

- Your Alabama Medicaid provider number, followed by the pound sign
- A valid, 11-digit NDC, followed by the pound sign
- The dispense date in MMDDCCYY format, followed by the pound sign.

AVRS performs a query and responds with the MAC 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 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.6.2 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 Alabama Medicaid provider number, followed by the pound sign
- A valid, five-digit procedure code, followed by the pound sign
- The date of service in MMDDCCYY format, followed by the pound sign.
- The type of service code, followed by the pound sign.

AVRS performs a query and responds with the price on file and whether the procedure code 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 procedure code 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

NOTE:

A cross-reference table for type of service to procedure codes is included at the end of this Quick Reference Guide. Please ensure that your selection matches the procedure code for which you are requesting pricing information.

L.7 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 Alabama Medicaid provider number, 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

L.8 Type of Service Cross Reference Table

Inclusion or exclusion of a procedure, supply, product, or service does not imply Medicaid coverage or reimbursement. The pricing file must be verified to determine coverage and reimbursement amounts.

If you bill on a HCFA-1500 or Medical Medicaid/Medicare-related Claim Form, use the TOS identified for the procedure on the TOS Cross Reference Table below, except for Medical Medicaid/Medicare-related claims for Ambulatory Surgical Centers, use TOS S.

To verify coverage and reimbursement for the professional component (Modifier 26) of a procedure, use TOS X.

To verify coverage and reimbursement for the technical component (Modifier TC) of a procedure, use TOS S.

To verify coverage and reimbursement for the rental (Modifier RR) of a Durable Medical Equipment procedure, use TOS R.

To compute reimbursement for the surgical assistant fees (Modifiers 80, 81, or 82) of a procedure, use the TOS given on the table for the procedure to determine the reimbursement rate for the procedure, then multiple the rate for the procedure by 16%.

The administrative fee for the Vaccine for Children program is $8.00 for all procedures. The price listed for TOS 1 is not applicable for VFC.

If you bill on a UB-92 or Institutional Medicaid/Medicare-related Claim Form, use TOS “S” for all procedures except for:

- Injectable drugs use TOS given on the table
- Home health providers use TOS given on the table

If you bill on the dental claim, use TOS D.

From Procedure	*To Procedure*	*TOS*
00100	01999	7
10000	36414	2
36415	36415	5
36416	63689	2
63690	63691	5
63692	69979	2
69990	69990	2
70010	75893	4
75894	75896	6
75897	75898	4
75900	75969	6
75970	75971	4
75978	75990	6
75992	76091	4
76092	76092	C
76093	76935	4
76936	76943	6
76945	76945	4
76946	76965	6
76970	77260	4
77261	77799	6
78000	78999	4
79000	79999	6
80002	80440	5
80500	80502	3
81000	88319	5
88321	88332	3
88342	89399	5
90000	90654	1
90657	90660	V
90665	90665	1
90669	90669	V
90675	90723	1
90724	90724	V
90725	90731	1
90732	90732	V
90733	90749	1
90780	90799	1
90801	90899	1
90901	90911	1
90918	90921	M
90922	90999	1
91000	91299	2
92002	92510	1
92511	92511	2
92512	92534	1
92541	92596	5
92597	92598	1
92599	92599	5

From Procedure	*To Procedure*	*TOS*
92950	92971	1
92975	92998	2
93000	93350	5
93501	93659	2
93660	93661	5
93662	93667	2
93668	93668	9
93669	93726	5
93727	93727	1
93728	93740	5
93741	93744	1
93745	94621	5
94640	94668	1
94680	94799	5
95000	95199	1
95805	95999	5
96100	96117	1
96400	96912	1
96913	96913	5
96999	97804	1
98925	99069	1
99070	99071	9
99075	99090	1
99100	99142	7
99170	99170	5
99172	99173	Q
99175	99199	1
99201	99239	1
99241	99275	3
99281	99440	1
99450	99456	9
99499	99499	1
A0010	A0999	9
A1344	A1344	9
A2000	A2000	1
A4035	A4035	9
A4190	A4205	9
A4206	A4212	P
A4213	A4213	9
A4214	A4214	P
A4215	A4300	9
A4301	A4460	P
A4462	A4462	S
A4464	A4595	P
A4608	A4608	P
A4610	A4610	9
A4611	A4613	P
A4614	A4614	9
A4615	A4641	P

From Procedure	***To Procedure***	***TOS***
A4642	A4643	9
A4644	A4649	P
A4650	A4927	L
A5051	A5507	P
A5508	A5508	J
A6020	A6024	S
A6025	A6025	9
A6154	A6406	S
A7000	A7020	P
A7501	A7509	P
A9150	A9190	9
A9270	A9300	9
A9500	A9510	4
A9600	A9605	6
A9700	A9700	4
A9900	A9901	9
ATP02	ATP22	5
B4034	B5200	P
B9000	B9999	9
D0110	D9999	D **(see *)**
E0100	E0143	P
E0144	E0144	R
E0145	E0326	P
E0350	E0352	9
E0370	E0373	P
E0424	E0435	P
E0439	E0445	P
E0450	E0455	P
E0457	E0550	P
E0555	E0565	P
E0570	E0589	P
E0590	E0590	R
E0591	E0601	P
E0602	E0602	9
E0603	E0616	P
E0617	E0617	9
E0618	E0731	P
E0740	E0740	9
E0744	E0783	P
E0784	E0786	9
E0787	E1389	P
E1390	E1390	R
E1391	E1702	P
E1800	E1830	P
E1900	E1900	P
GV263	GV263	9
G0001	G0001	5
G0002	G0002	2
G0004	G0007	5
G0008	G0009	V

From Procedure	***To Procedure***	***TOS***
G0010	G0010	1
G0015	G0016	5
G0025	G0025	P
G0026	G0027	5
G0030	G0050	4
G0051	G0053	2
G0054	G0060	5
G0061	G0061	2
G0062	G0063	4
G0064	G0066	1
G0071	G0094	1
G0095	G0098	5
G0100	G0100	5
G0101	G0102	1
G0103	G0103	5
G0104	G0105	2
G0106	G0106	4
G0107	G0107	5
G0108	G0113	1
G0114	G0114	3
G0115	G0116	1
G0120	G0120	4
G0121	G0121	2
G0122	G0122	4
G0123	G0124	5
G0125	G0126	4
G0127	G0127	2
G0128	G0128	1
G0129	G0129	9
G0130	G0132	4
G0133	G0133	9
G0141	G0148	5
G0151	G0156	1
G0159	G0160	2
G0161	G0161	6
G0163	G0165	4
G0166	G0169	1
G0170	G0171	2
G0172	G0172	9
G0173	G0174	2
G0175	G0175	1
G0176	G0179	U
G0180	G0182	1
G0183	G0188	2
G0190	G0201	1
G9001	G9016	1
H0001	H0030	9
H5010	H5010	P
H5030	H5030	1
H5060	H5060	1
H5300	H5300	U

From Procedure	*To Procedure*	*TOS*
J0110	J0110	1
J0120	J7508	1
J7509	J7599	G
J7608	J7608	1
J7618	J7619	1
J7620	J7627	9
J7628	J7629	1
J7630	J7630	9
J7631	J7631	1
J7632	J7634	9
J7635	J7639	1
J7640	J7641	9
J7642	J7644	1
J7645	J7647	9
J7648	J7649	1
J7650	J7657	9
J7658	J7659	1
J7668	J7669	1
J7670	J7679	9
J7680	J7684	1
J7685	J7799	9
J7610	J7799	9
J8499	J9999	1
KOO16	KOO16	P
KOO53	KOO53	P
K0001	K0007	P
K0010	K0045	P
K0047	K0118	P
K0119	K0125	G
K0126	K0165	P
K0166	K0167	G
K0168	K0284	P
K0285	K0285	9
K0400	K0400	P
K0401	K0401	J
K0402	K0406	S
K0407	K0412	P
K0417	K0452	P
K0453	K0453	1
K0455	K0455	R
K0456	K0461	P
K0462	K0462	9
K0501	K0530	P
K0531	K0534	R
K0538	K0547	P
L0100	L8699	P
L9900	L9900	9
M0005	M0101	1
M0300	M0301	2
M0302	M0302	5
M0702	M0702	1

From Procedure	*To Procedure*	*TOS*
P0023	P2025	5
P2028	P7001	5
P9010	P9040	0
P9041	P9044	9
P9603	P9615	5
Q0005	Q0009	1
Q0020	Q0034	1
Q0035	Q0035	5
Q0036	Q0047	1
Q0059	Q0062	2
Q0068	Q0068	5
Q0081	Q0086	1
Q0091	Q0091	1
Q0092	Q0092	4
Q0093	Q0094	1
Q0095	Q0102	5
Q0103	Q0104	1
Q0105	Q0107	P
Q0108	Q0110	1
Q0111	Q0116	5
Q0117	Q0123	1
Q0124	Q0124	V
Q0125	Q0125	1
Q0126	Q0126	5
Q0132	Q0132	1
Q0134	Q0134	P
Q0136	Q0136	1
Q0144	Q0144	1
Q0156	Q0158	1
Q0160	Q0161	1
Q0163	Q0181	1
Q0183	Q0185	S
Q0186	Q0187	1
Q1001	Q1005	F
Q2001	Q2022	1
Q3001	Q3012	4
Q9920	Q9940	1
R0070	R0076	4
S7050	S7050	S
S9120	S9120	P
S9905	S9908	S
T1000	T7010	2
V0100	V0105	1
V2020	V2615	9
V2623	V2628	P
V2629	V2799	9
V5008	V5020	K
V5030	V5220	9
V5230	V5299	K
V5336	V5336	1
V5362	V5364	1

From Procedure	*To Procedure*	*TOS*
WW010	WW080	1
W0200	W4165	9
W9200	W9210	9
W9220	W9840	9
X0285	X0285	9
X1015	X1745	1
X2035	X2073	9
X2074	X2074	P
X2091	X2095	9
X2098	X2098	P
X2780	X2780	9
X2920	X2920	9
X4100	X4100	P
X4120	X4120	P
X4310	X4310	9
X5140	X5146	9
X6200	X6200	P
X6202	X6202	9
X6205	X6215	P
X6218	X6218	P
X6220	X6222	9
X6224	X6224	9
X6226	X6233	9
Y4100	Y8172	9
Z0001	Z4999	1
Z5015	Z5015	2
Z5027	Z5027	2
Z5061	Z5062	9
Z5064	Z5074	9
Z5076	Z5109	5
Z5114	Z5116	1
Z5117	Z5117	P
Z5119	Z5122	P
Z5124	Z5134	P
Z5135	Z5144	9
Z5145	Z5149	1
Z5150	Z5152	9
Z5153	Z5155	1
Z5158	Z5158	S
Z5159	Z5172	9
Z5173	Z5178	1
Z5179	Z5180	9
Z5181	Z5191	1
Z5192	Z5192	2
Z5193	Z5193	9
Z5194	Z5195	1
Z5196	Z5198	9
Z5199	Z5219	1
Z5220	Z5223	P
Z5225	Z5226	2
Z5227	Z5254	1

From Procedure	*To Procedure*	*TOS*
Z5255	Z5255	5
Z5256	Z5266	S
Z5267	Z5272	1
Z5273	Z5293	9
Z5294	Z5295	S
Z5296	Z5298	1
Z5299	Z5301	S
Z5302	Z5310	1
Z5311	Z5315	P
Z5316	Z5320	1
Z5321	Z5321	9
Z5322	Z5358	1
Z5363	Z5363	S
Z5367	Z5369	1
Z5370	Z5370	9
Z5371	Z5371	1
Z5373	Z5381	1
Z5382	Z5382	2
Z5383	Z5391	1
Z5392	Z5392	9
Z5393	Z5396	1
Z5397	Z5399	9
Z5400	Z5400	P
Z5401	Z5410	1
Z5411	Z5411	S
Z5412	Z5413	1
Z5414	Z5430	S
Z5431	Z5438	1
Z5439	Z5439	P
Z5440	Z5442	1
Z5443	Z5448	9
Z5449	Z5475	1
Z5476	Z5476	9
Z5562	Z5562	2
Z7000	Z9501	9

***Only four dental procedure codes (D8080, D8680, D9310 and D9430) can be billed on a HCFA claim form.**

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N Alabama Medicaid Contact Information

N.1. Important Telephone Numbers for the Alabama Medicaid Agency

Dental Services 334-242-5997

Durable Medical Equipment

Administration 334-242-5657

Hospital, psychiatric, admission 1-800-456-7993

Long Term Care 334-242-5657

- Home Health Services
- Hospice Services
- Personal Care (for children under 21 only)
- Private Duty Nursing (for children under 21 only)

Managed Care Customer Service 334-353-5773

- Patient 1st
- Maternity Care Program
- Partnership Hospital Program (PHP)
- Prenatal Care
- Prenatal Education

Medical Services Customer Service 334-242-5524

- Adolescent Pregnancy Prevention
- Ambulatory Surgical Centers
- EPSDT (Early and periodic screening, diagnosis, and treatment/Child Health Checkups)
- Eye Care
- Family Planning
- Federally Qualified Heath Centers
- Hearing Services
- Hospital Programs
- Laboratory Services
- Pharmacy Program
- Physician's Program
- Radiology Services
- Renal Dialysis
- Rural Health Clinics
- Therapist, in home (for children under 21 only)
- Transplants
- Transportation, air (for children under 21 only)

Nursing Home Care

Administration of Program 334-242-5657

Admissions..... 334-242-5684

Prior Authorization

Durable Medical Equipment..... 334-242-5141

Dental..... 334-242-5997

Eye Care 334-353-5997

Hospice Services 334-242-5687

Personal Care (for children under 21 only)..... 334-242-5141

Pharmacy Services (prior approval of NSAIDs) 1-800-338-6046

Pharmacy Services (prior approval of non-NSAIDs prescription drugs) 1-800-338-6046

Private Duty Nursing (for children under 21 only)..... 334-242-5141

Therapies, in home (for children under 21 only)..... 334-242-5141

Third Party Division 334-242-5248

N.2. General Information

For anyone to call 334-242-5000

For Medicaid recipients only 1-800-362-1504

For Medicaid providers only 1-800-688-7989

N.3. Important Telephone Numbers for EDS

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 1-800-688-7989

EDS 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:

Pharmacy, Dental, and UB-92 Claims	EDS Post Office Box 244033 Montgomery, AL 36124-4033
HCFA-1500 Claims	EDS Post Office Box 244034 Montgomery, AL 36124-4034
Inquiries, Provider Enrollment Information, Provider Relations	EDS Post Office Box 244035 Montgomery, AL 36124-4035
Medicare-related Claims	EDS Post Office Box 244037 Montgomery, AL 36124-4037
Prior Authorization Unit	EDS Post Office Box 244036 Montgomery, AL 36124-4036
Adjustments	EDS Post Office Box 244038 Montgomery, AL 36124-4038

N.5. Web Site Address

Refer to the Alabama Medicaid Agency's web site at http://www.medicaid.state.al.us 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 found in Appendix H, Alabama Medicaid Injectable Drug Listing, all laboratory services, which are CLIA certified, and the following CPT codes.

Code	***Description***	***See Note***
Q0091	Collection of pap smear specimen sent to an outside lab	
Z4998	Administration fee for injectable drugs, valid through 09/30/99	
Z5115	EPSDT screening, normal findings	1
Z5116	EPSDT screening, abnormal findings	1
Z5154	Periodic EPSDT screening, normal findings	1
Z5155	Periodic EPSDT screening, abnormal findings	1
Z5181	Family Planning, initial visit	
Z5182	Family Planning, annual visit	
Z5183	Family Planning, periodic revisit	
Z5190	Family Planning, extended counseling visit	
Z5272	Family Planning, physical/counseling office visit for Norplant	
Z5316	EPSDT vision screen	1
Z5317	EPSDT hearing screen	1
Z5319	Family Planning, hormonal (Progestasent) IUD	
Z5320	Family Planning, mechanical (Paragord) IUD	
11975	Insertion, implantable contraceptive capsules	
11976	Removal of implantable contraceptive capsules	
11977	Removal with reinsertion, implantable contraceptive capsules	
11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	
36415	Routine venipuncuture or finger/heel/ear stick for collection of specimen sent to an outside lab **(must use modifier 90)**	
57170	Family Planning, diaphragm or cervical cap fitting with instructions	
58300	Family Planning, insertion of intrauterine device (IUD)	
58301	Family Planning, removal of intrauterine device (IUD)	
62270	Spinal Puncture, lumbar, diagnostic	2
92567	Tympanometry impedance testing	
92950	Cardiopulmonary resuscitation	
93005	Electrocardiogram, routine ECG with at least 12 leads	
94010	Spirometry, including graphic record, total and timed vital capacity	
94150	Vital capacity, total	
94375	Respiratory flow volume loop	
94640	Nonpressurized inhalation treatment for acute airway obstruction	
94650	Intermittent Positive Pressure Breathing Treatment (IPPB)	
94651	IPPB, subsequent	
94652	IPPB, newborn infants	
94760	Non-invasive ear or pulse oximetry for oxygen saturation: single determination	
94761	Non-invasive ear or pulse oximetry for oxygen saturation: multiple determinations	
95165	Professional services for the supervision and provision of antigens	
96400	Chemotherapy administration, subcutaneous or intramuscular	
96408	Chemotherapy administration, intravenous, push technique	
96410	Chemotherapy administration, infusion technique, up to one hour	

Code	*Description*	*See Note*
96412	Chemotherapy administration, infusion technique, 1 to 8 hours, each additional hour	
96414	Chemotherapy administration, infusion technique, more than 8 hrs	
99201	Office visit, new patient, problem focused	
99202	Office visit, new patient, expanded problem focused	
99203	Office visit, new patient, detailed history	
99204	Office visit, new patient, comprehensive, moderate complexity	
99205	Office visit, new patient, comprehensive history, high complexity	
99211	Office Visit, established patient, minimal	
99212	Office Visit, established patient, problem focused, straightforward	
99213	Office Visit, established patient, problem focused, low complexity	
99214	Office Visit, established patient, detailed	
99215	Office Visit, established patient, comprehensive	
99301	Nursing facility services evaluation and management(E&M), straightforward or low complexity	
99302	Nursing facility services E&M, moderate to high complexity	
99303	Nursing facility services E&M, comprehensive, moderate to high complexity	
99311	Subsequent nursing facility care, problem focused	
99312	Subsequent nursing facility care, expanded problem focused	
99313	Subsequent nursing facility care, detailed	
99315	Nursing facility discharge services,30 minutes or less	
99316	Nursing Facility Discharge Services, more than 30 minutes	
99321	Domiciliary or rest home visit, new patient, problem focused	
99322	Domiciliary or rest home visit, new patient, expanded problem focused	
99323	Domiciliary or rest home visit, new patient, detailed	
99331	Domiciliary or rest home visit, established patient, problem focused	
99332	Domiciliary or rest home visit, established patient, expanded problem focused	
99333	Domiciliary or rest home visit, established patient, detailed	
99341	Home visit, new patient, problem focused	
99342	Home visit, new patient, expanded problem focused	
99343	Home visit, new patient, detailed	
99344	Home visit, new patient, comprehensive, moderate complexity	
99345	Home visit, new patient, comprehensive, high complexity	
99347	Home visit, established patient, problem focused	
99348	Home visit, established patient, expanded problem focused	
99349	Home visit, established patient, detailed	
99350	Home visit, established patient, comprehensive	
99391	Interperiodic screening, infant age under 1 year	1
99392	Interperiodic screening, early childhood age 1 through 4 years	1
99393	Interperiodic screening, late childhood age 5 through 11 years	1
99394	Interperiodic screening, adolescent age 12 through 17	1
99395	Interperiodic screening, age 18 through 20 years	1
99401	Family Planning visit, HIV pre-test counseling	
99402	Family Planning visit, HIV post-test counseling	
99432	Normal newborn care in other than hospital or birthing room setting	
99433	Newborn care, subsequent hospital care	2

NOTE:

1 Indicates an EPSDT screening. The PA or CRNP must be enrolled with the program to bill these codes

2 Covered for neonatal nurse practitioners only

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
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
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
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	Medicaid's best estimate of the price providers generally pay for a drug. Medicaid establishes the AEAC for each drug based on the package size providers most frequently purchase.
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 HCFA-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
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.
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 EDS 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.
Drug price review (DPR)	A weekly updating of drug prices, at average wholesale price (AWP), from the American Druggist Blue Book. Price maximums are subsequently established.
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
EDS	The fiscal agent for the Medicaid program
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
EOP(Explanation of Payment)	Notice advising Medicaid providers on claim status (paid, denied, returned, or suspended). EDS mails EOPs to providers biweekly.
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 1500	A universal form, developed by the government agency known as the Health Care Financing Administration (HCFA), for providers of services to bill professional fees to health carriers
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
HIPC	Health insurance purchasing cooperative
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
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
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.
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
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
Maximum allowable cost (MAC) list	Specified multi-source prescription medications that will be covered at a generic product cost level established by the plan. This list, distributed to participating pharmacies is subject to periodic review and modification by the plan. The MAC list may require covered persons to pay a cost differential for a brand name product.
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).
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
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 EDS 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
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
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
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

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 EDS 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.

U

U&C	Usual and customary
UB-92	The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-92, requiring the hospitals to send additional itemized bills. The UB-92 replaced the UB-82 in 1993.
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.
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 are 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

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